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	495156	A. BUILDING ______ B. WING ______	C 08/05/2021

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ACCORDIUS HEALTH AT ROANOKE	324 KING GEORGE AVE SW ROANOKE, VA 24016

(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 8/01/21 through 8/05/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/01/21 through 8/05/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Nine (9) complaints were investigated during the survey. The census in this 130 certified bed facility was 57 at the time of the survey. The survey sample consisted of 25 current resident reviews and 5 closed record reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by:	F 607		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jayne Burnette, Administrator — TITLE — (X6) DATE: 09/13/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 607	Continued From page 1 Based on staff interview, employee record review and facility document review the facility staff failed to implement facility abuse and neglect policy for 4 of 25 new hire employees, #16, #17, #18 and #19. The finding included: For new hire employee #16 the facility failed to obtain a criminal background check. For new hire #17, #18, and #19 the facility staff failed to obtain a sworn disclosure statement. Surveyor reviewed 25 new hire employee files on 08/03/21. For new hire #16, who is employed as the facility maintenance director, the surveyor could not locate a Virginia State Police criminal background check. For new hire #17, who is employed as a chef, the surveyor could not locate a sworn disclosure statement. For new hires #18 and #19, who are employed in dietary, the surveyor could not locate sworn disclosure statements. Surveyor spoke with the facility BOM (business office manager) on 08/03/21 regarding the missing information in the employees' files. BOM stated that employee #17, #18, and #18 were employed through a contract agency. No explanation was provided regarding employee #16. Surveyor reviewed the facility policy entitled "Abuse, Neglect and Exploitation" which read in part, "Staff includes employees, the medical director, consultants, contractors, volunteers, caregivers who provide care and services to residents on behalf of the facility, students in the facility's nurse aide training program, and	F 607	F607 1. Employee # 16: background check received with no barrier crimes noted. Employee #17, #18, and #19 was not employed/hired by Next Level Dietary Services. 2. BOM, Next Level Managers, and Adaptative Therapy will audit each current employee file and any missing information being corrected for required documentation. 3. Education of BOM, Next Level Managers, and Adaptative Therapy on September 10, 2021 for Abuse, Neglect and Exploitation policy requiring criminal background checks and sworn disclosure statements prior to employment. 4. Director of HR and/or designee will conduct weekly audits of new hire paperwork x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability. 5. Date of Compliance: September 19, 2021.	

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F 607	Continued From page 2 students from affiliated academic institutions, including therapy, social and activity programs" and "The components of the facility abuse prohibition plan are discussed herein: 1. Screening A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1 Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. 3. The facility will maintain documentation of proof that the screening occurred." The concern of the facility not implementing the abuse policy was discussed with the administrative team (administrator, director of nursing, regional vice-president of clinical services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm. No further information was provided prior to exit.	F 607		
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	F 609		

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Continued From page 3

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 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, clinical record review, and facility document review, the facility staff failed to ensure an injury of unknown source was reported for 1 of 30 residents in the survey sample, Resident #31.

The findings included:

For Resident #31, the facility staff failed to report swelling and bruising to the right eye from an unidentified source.

Resident #31's diagnosis list indicated diagnoses, which included, but not limited to Dementia in Other Diseases Classified Elsewhere without Behavioral Disturbance, Typical Atrial Flutter, Chronic Obstructive Pulmonary Disease Unspecified, Acute on Chronic Systolic (Congestive) Heart Failure, Primary Open-Angle Glaucoma Bilateral Severe Stage, and Unspecified Blepharitis Left Eye Upper and Lower

F 609

F609

1. **MD notified, and Resident #31 was assessed with no noted injury at time of assessment. Resident #31 was assessed at time of injury with noted resolving bruise to R eye.**
2. **Audit of last 30 days incident Reports to identify possible areas of UKO.**
3. **Education of nursing staff on September 10, 2021 for Abuse, Neglect and Exploitation policy requiring the reporting on bruises of unknown origins.**
4. **DON and/or designee weekly Audits of progress notes x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.**
5. **Date of Compliance:** September 19, 2021.

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Eyelids.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 6/17/21 coded the resident as being severely impaired with cognitive skills for daily decision making with short-term and long-term memory problems. Resident #31 was unable to complete the BIMS (brief interview for mental status) interview.

During the review of Resident #31's clinical record, surveyor noted a nursing progress note dated 7/04/21 17:47 (5:47 pm) which stated "this nurse was setting tray up in front of rsd. (resident) to so (he/she) could eat and observed swelling and bruising to right eye. When asking rsd. What happened, did (he/she) hit (his/her) face (he/she) stated (he/she) don't know. vitals are obtained WNL (within normal limits). All RPs (responsible parties) are notified will cont. (continue) to monitor".

Resident #31 was seen by the NP (nurse practitioner) on 7/05/21, the progress note stated in part, "Pt (patient) seen today following staff request to assess right eye, ecchymosis and edema per staff. Upon exam mild fading ecchymosis noted, no edema or sxs (signs) of further injury. Hx (history) of dementia, pt denies recent injury or fall. Denies pain upon exam".

Surveyor was unable to locate documentation in Resident #31's clinical record regarding the source of the swelling and bruising to the resident's right eye. On the afternoon of 8/02/21, surveyor met with the administrator and requested the investigation and FRI (facility reported incident) report for Resident #31. The

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F 609		F 609		

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administrator stated they did not have an investigation or FRI report for this because the incident was not reported to them. The administrator further stated if it had been reported to them, an FRI would have been completed.

Surveyor requested and received the facility policy entitled, "Abuse, Neglect and Exploitation" which states in part:
VII. Reporting/Response
A. The facility will have written procedures that include:
1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other
required agencies (e.g. law enforcement when applicable) within specified timeframes:
a. 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
b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in
serious bodily injury.
B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was
received, and to report the results of the investigation when final within 5 working days of the incident, as
required by state agencies.

On 8/04/21 at 5:20 pm, surveyor met with the administrator, director of nursing, Regional Vice President of Clinical Services, and the Regional Director of Operations and discussed the concern of the facility not reporting an injury of unknown

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F 609	Continued From page 6 source involving Resident #31. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/05/21.	F 609	**F610** **1. MD notified, and Resident #31 was assessed with no noted injury at time of assessment. Resident #31 was assessed at time of injury with noted resolving bruise to R eye.** **2. Audit of past 30 days incident reports for possible injury of unknown origins.** **3. Education of DON and Administrator on September 10, 2021 for Abuse, Neglect and Exploitation policy requiring the reporting on bruises of unknown origins.** **4. DON and/or designee will Complete weekly audits of progress notes x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.** 5. Date of Compliance: **September 19, 2021.**	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State 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, clinical record review, and facility document review, the facility staff failed to ensure an injury of unknown source was investigated for 1 of 30 residents in the survey sample, Resident #31. The findings included: For Resident #31, the facility staff failed to investigate swelling and bruising to the right eye	F 610		

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F 610	Continued From page 7 originating from an unidentified source. Resident #31's diagnosis list indicated diagnoses, which included, but not limited to Dementia in Other Diseases Classified Elsewhere without Behavioral Disturbance, Typical Atrial Flutter, Chronic Obstructive Pulmonary Disease Unspecified, Acute on Chronic Systolic (Congestive) Heart Failure, Primary Open-Angle Glaucoma Bilateral Severe Stage, and Unspecified Blepharitis Left Eye Upper and Lower Eyelids. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 6/17/21 coded the resident as being severely impaired with cognitive skills for daily decision making with short-term and long-term memory problems. Resident #31 was unable to complete the BIMS (brief interview for mental status) interview. During the review of Resident #31's clinical record, surveyor noted a nursing progress note dated 7/04/21 17:47 (5:47 pm) which stated "this nurse was setting tray up in front of rsd. (resident) to so (he/she) could eat and observed swelling and bruising to right eye. When asking rsd. What happened, did (he/she) hit (his/her) face (he/she) stated (he/she) don't know. vitals are obtained WNL (within normal limits). All RPs (responsible parties) are notified will cont. (continue) to monitor". Resident #31 was seen by the NP (nurse practitioner) on 7/05/21, the progress note stated in part, "Pt (patient) seen today following staff request to assess right eye, ecchymosis and edema per staff. Upon exam mild fading	F 610		

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ecchymosis noted, no edema or sxs (signs) of further injury. Hx (history) of dementia, pt denies recent injury or fall. Denies pain upon exam".

Surveyor was unable to locate documentation in Resident #31's clinical record regarding the source of the swelling and bruising to the resident's right eye. On the afternoon of 8/02/21, surveyor met with the administrator and requested the investigation and FRI (facility reported incident) report for Resident #31. The administrator stated they did not have an investigation or FRI report for this because the incident was not reported to them. The administrator further stated if it had been reported to them, an FRI would have been completed.

Surveyor requested and received the facility policy entitled, "Abuse, Neglect and Exploitation" which states in part:
V. Investigation of Alleged Abuse, Neglect and Exploitation
A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of
abuse, neglect or exploitation occur.
B. Written procedures for investigations include:
1. Identifying staff responsible for the investigation;
2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not
tampering or destroying evidence);
3. Investigating different types of alleged violations;
4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator,
witnesses, and others who might have

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F 610	Continued From page 9 knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. On 8/04/21 at 5:20 pm, surveyor met with the administrator, director of nursing, Regional Vice President of Clinical Services, and the Regional Director of Operations and discussed the concern of the facility not investigating an injury of unknown source involving Resident #31. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/05/21.	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered;	F 622		

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F 622	Continued From page 10 (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this	F 622	**F622** 1. **Resident #32 was transferred to local ER on 07/20/21. Resident #32 has since returned to the facility on 07/22/2021.** 2. **Audit of last 30 days of OSH transfers documentation to ensure proper exchange of resident information with MD, ER, and family.** 3. **Education of licensed nursing staff on September 10 and 13, 2021 for Policy on Notification of Changes documentation.** 4. **DON and/or designee will conduct weekly audits of discharge charts x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.** 5. **Date of Compliance: September 19, 2021.**	

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F 622	Continued From page 11 section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to document basis for transfer in the residents clinical record for 1 of 30 residents, Resident #32. The findings included: For Resident #32 the facility staff failed to document information regarding the resident's transfer to the hospital.	F 622		

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F 622	Continued From page 12 Resident #32's face sheet listed diagnoses which included but not limited to hemiplegia, type II diabetes mellitus, acute kidney failure, aphasia, anxiety, depression, retention of urine, anemia, dysphagia and adult failure to thrive. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) 06/17/21 failed to assign the resident a BIMS (brief interview for mental status) score, in section C, cognitive patterns. The quarterly MDS with an ARD date of 03/31/21 assigned the resident a BIMS score of 8 out of 15 in section C. This indicates that the resident is moderately cognitively impaired. Resident #32's clinical record was reviewed and contained a nurse's progress note dated 07/20/21 at 4:32 am, which read in part "ED (emergency department) doctor called and spoke with this nurse resident admitted for 'kidney injury' or 'failure'. unable to obtain a creatine level on rsd (resident)". No other documentation related to resident transfer was located in the clinical record. The concern of not having documentation for the resident's transfer to the hospital was discussed with the administrative team (administrator, director of nursing, regional vice-president of clinical services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm. No further information was provided prior to exit.	F 622		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		

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F 641	Continued From page 13 §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, clinical record review and the facility staff failed to ensure the accuracy of MDS (minimum data set) assessments for 1 of 30 residents, Resident #32. The findings included: For Resident #32, the facility staff failed to ensure the BIMS (brief interview for mental status) was completed. Resident #32's face sheet listed diagnoses which included but not limited to hemiplegia, type II diabetes mellitus, acute kidney failure, aphasia, anxiety, depression, retention of urine, anemia, dysphagia and adult failure to thrive. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) 06/17/21 failed to assign the resident a BIMS score, in section C, cognitive patterns. The quarterly MDS with an ARD date of 03/31/21 assigned the resident a BIMS score of 8 out of 15 in section C. This indicates that the resident is moderately cognitively impaired. Surveyor spoke with the MDS coordinator on 08/02/21 at approximately 4:30 pm regarding the missing BIMS score. MDS coordinator stated that the facility SW (social worker) is responsible for completing the BIMS and that they did not do it within the required timeframe, therefore it could not be included on the MDS.	F 641	**F641** **1. Resident #32 was not interviewed during assessment period. MDS is not able to be modified.** **2. Audit of MDS assessments for past 30 days to ensure BIMS interview was conducted.** **3. Education of Social Services on September 13, 2021 for Assessment of Cognitive Patterns policy requiring the timely completion.** **4. DON and/or designee will conduct weekly audits of Social Services assessments x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.** **5. Date of Compliance: September 19, 2021.**	

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F 641	Continued From page 14 The concern of the facility not completing the BIMS assessment on the MDS was discussed with the administrative team (administrator, director of nursing, regional vice-president of clinical services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm. No further information was provided prior to exit.	F 641	**F645** **1. PASARR was submitted for Residents #16 and 35.** **2. Audit of current residents' PASSAR to ensure Level I and Level II evaluations have been completed and are present in medical records.** **3. Education of Social Services on September 13, 2021 for PASARR completion upon admission.** **4. SS Director and/or designee will conduct weekly audits of new admission charts x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.** **5. Date of Compliance: September 19, 2021.**	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires	F 645		

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F 645	Continued From page 15 the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as	F 645		

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F 645	Continued From page 16 described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to obtain required PASARRs (preadmission screening and resident reviews) for 2 of 30 Residents, Resident #35 and #16. The findings included: 1. For Resident #35, the facility staff failed to complete a level I PASARR. A PASARR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care. The Residents face sheet revealed that Resident #35 had been admitted to the facility 12/28/21 and included the diagnoses anxiety disorder, bipolar disorder, depressive disorder, and paranoid schizophrenia. Section C (cognitive patterns) of Resident #35's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/23/21 included a BIMS (brief interview for mental status) summary score of 9 out of a possible 15 points. During the clinical record review, the surveyor was unable to locate a level 1 PASARR. 08/02/21 11:33 a.m., (SW) social worker #1 stated Resident #35 did not have a level 1 PASARR. 08/02/21 4:03 p.m., the Administrator, (DON)	F 645		

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F 645	Continued From page 17 director of nursing, and Regional Vice President of Clinical Services were made aware of the missing PASARR. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #16, the facility staff failed to refer the resident for a Level II PASARR (Preadmission Screening and Resident Review) evaluation and determination. Resident #16's diagnosis list indicated diagnoses, which included, but not limited to Acute Respiratory Failure with Hypoxia, Bipolar Disorder Unspecified, Anxiety Disorder Unspecified, Mental Disorder not Otherwise Specified, and Unspecified Dementia with Behavioral Disturbance. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/28/21 assigned the resident a BIMS (brief interview for mental status) score of 3 out of 15 in section C, Cognitive Patterns. Resident #16's clinical record included a Level 1 PASARR dated 10/10/19 indicating the recommendation for a Level II evaluation and determination, "MI" (mental illness) was checked under section 5 "Recommendation". Surveyor was unable to locate a Level II PASARR in Resident #16's clinical record and requested assistance in locating the Level II on 8/02/21. On 8/02/21 at 2:25 pm, the administrator stated they do not have a Level II PASARR for Resident #16 but a referral was made today. A copy of a fax cover sheet dated 8/02/21 with successful fax	F 645		

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F 645	Continued From page 18 confirmation was provided which stated in part, "To: ASCEND", "Re: Level II RR - (Resident #16)". Surveyor was also provided a social services progress note dated 8/02/21 12:58 pm stating "Review of Level I screen positive for Level II. SSD (social service director) faxed Face Sheet, Psychiatric Evaluation H&P (history and physical), 2 most recent MDS, last 7 days progress notes to ASCEND. SSD called and left a VM (voice mail) for Case Management at (hospital name omitted) to confirm if Level II was/was not completed. If completed, requested a copy". On 8/02/21 at approximately 4:00 pm, surveyor spoke with the social worker and questioned the reason for Resident #16 not having a Level II PASARR completed upon admission. The social worker stated they would go back and review. The social worker returned the following day at 10:18 am and stated they completed the Long Term Care Services and Supports training in October of 2020 and Resident #16 was admitted prior to the training and they misread the form. On 8/04/21 at 11:35 am, surveyor met with the social worker and was provided a copy of a "Memorandum" from the Commonwealth of Virginia Department of Behavioral Health and Developmental Services dated 8/02/21 which stated in part, "Following review, it was determined that a PASRR Level II final determination is not required due to the reasons indicated below: The individual has a primary diagnosis of dementia (including Alzheimer's disease) AND has a secondary diagnosis of a serious MI". The social worker stated the Level I was filled out incorrectly.	F 645		

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F 645	Continued From page 19	F 645		

Surveyor requested and received the facility policy entitled, "Admission Criteria" which states in part:
9. Potential residents with mental disorders or intellectual disabilities will only be admitted if the State mental health agency has determined (through the preadmission screening program) that the individual has a physical or mental condition that requires the level of services provided by the facility.
a. The preadmission screening program requirements do not apply to residents who, after being admitted to the facility, were transferred to a hospital.
b. The State may chose not to apply the preadmission screening requirement if:
(1) the individual is admitted directly to the facility from a hospital where he or she received acute
inpatient care;
(2) he or she requires facility services for the condition for which he or she received care in the hospital;
and
(3) the Attending Physician has certified (prior to admission) that the individual will likely need less than 30
days of care at the facility

On 8/04/21 at 5:20 pm, surveyor met with the administrator, director of nursing, Regional Vice President of Clinical Services, and the Regional Director of Operations and discussed the concern of the facility not referring Resident #16 for a Level II PASARR evaluation and determination upon admission.

No further information regarding this issue was presented to the survey team prior to the exit

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F 645	Continued From page 20 conference on 8/05/21.	F 645		
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 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	F 656	**F656** **1. Resident # 32: Care Plan updated to reflect no catheter usage. Date of update 08/19/2021.** **Resident # 10: Care Plan updated to reflect side of bed against wall. Date of update 08/27/2021.** **Resident # 31: Care Plan is current to reflect side of bed against wall.** **Resident # 17: Care Plan updated to reflect no fall mat required. Date of update 08/04/2021.** **2. MDS will conduct an audit of current fall and catheter use resident's care plans to ensure compliance and current interventions are in place.** **3. Education of MDS, Department Managers, and Licensed Nursing staff on September 10 and 13, 2021 for Care Plan development.** **4. Department Heads will conduct weekly audits of care plans and room rounds x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.** **5. Date of Compliance: September 19, 2021.**	

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F 656	Continued From page 21 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 observation, staff interview, clinical record review and facility document review the facility staff failed to develop and implement a comprehensive care plan for 4 of 30 residents, Resident #32, Resident #10, Resident #31 and Resident #17. The findings included: 1. For Resident #32 the facility staff failed to develop a care plan for catheter use. Resident #32's face sheet listed diagnoses which included but not limited to hemiplegia, type II diabetes mellitus, acute kidney failure, aphasia, anxiety, depression, retention of urine, anemia, dysphagia and adult failure to thrive. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) 06/17/21 failed to assign the resident a BIMS (brief interview for mental status) score, in section C, cognitive patterns. The quarterly MDS with an ARD date of 03/31/21 assigned the resident a BIMS score of 8 out of 15 in section C. This indicates that the resident is moderately cognitively impaired. Surveyor observed Resident #32 on 08/01/21 at 10:10 am. Resident was resting in bed, catheter drainage tubing and bag were observed hanging	F 656		

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F 656	Continued From page 22 from side of bed. Resident #32's comprehensive care plan was reviewed on 08/02/21. It contained a care plan for "...has urinary incontinence r/t (related to) subdural hematoma, rt (right) side hemiplegia, inability to control voiding pattern". Surveyor could not locate any information regarding catheter usage in the care plan. Resident #32's clinical record contained a physician's order summary for the month of August 2021, which read in part "Foley catheter used for Urinary Retention..." Surveyor requested and was provided a facility policy entitled "Comprehensive Care Plans", which read in part "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." The concern of not developing a care plan for catheter use was discussed with the administrative team (administrator, director of nursing, regional vice-president of clinical services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm. No further information was provided prior to exit. 2. For Resident #10, the facility staff failed to implement the comprehensive person-centered care plan intervention of placing the right side of the bed against the wall.	F 656		

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Resident #10's diagnosis list indicated diagnoses, which included, but not limited to Down Syndrome Unspecified, Other Generalized Epilepsy and Epileptic Syndromes not Intractable without Status Epilepticus, Repeated Falls, Dementia in Other Diseases Classified Elsewhere without Behavioral Disturbance, Dysphagia Oropharyngeal Phase, and Adult Failure to Thrive.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/10/21 coded the resident as severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems in section C, Cognitive Patterns. Resident #10 was also coded as rarely/never makes self understood and rarely/never understands others.

Surveyor observed Resident #10 in their room sitting/lying on a low bed with the head of the bed against the wall with space available for the resident to enter and exit the bed from the left or right side on 8/01/21 11:22 am and 8/02/21 8:40 am.

On 8/03/21, a review of Resident #10's comprehensive person-centered care plan revealed a focus area stating "(Resident #10) had actual fall with risk for further falls r/t (related to) safety awareness problems with Dx (diagnosis): of Dementia/Cognitive deficit, Downs Syndrome" with an intervention dated 5/17/21 stating "Right side of bed to be against the wall to aid in fall prevention".

On 8/03/21 at 12:00 pm, surveyor again observed Resident #10's bed with the head of the bed against the wall in the same position as observed

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F 656	Continued From page 24 on 8/01/21 and 8/02/21. At 2:21 pm, surveyor met with the MDS Coordinator and discussed the observation of Resident #10's current bed positioning and the care plan intervention of the right side of the bed against the wall. The MDS Coordinator returned at 3:23 pm and stated the bed is back against the wall. The following day at 8:47 am, surveyor observed Resident #10's bed positioned with the left side of the bed against the wall. Surveyor notified the DON (director of nursing) and the Unit Manager that the resident's bed had been moved and now the left side is against the wall, however, the care plan states the right side of the bed is to be against the wall. The DON and Unit Manager accompanied the surveyor to Resident #10's room and observed the left side of the bed positioned against the wall. Surveyor requested and received the facility policy entitled, "Comprehensive Care Plans" which states in part, "Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made". During a meeting with the administrator, director of nursing, Regional Vice President of Clinical Services, and the Regional Director of Operations on 8/04/21 at 5:20 pm, surveyor discussed the concern of Resident #10's care plan intervention for bed positioning not being implemented as written. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/05/21.	F 656		

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F 656	Continued From page 25 3. For Resident #31, the facility staff failed to implement the comprehensive person-centered care plan intervention of placing the right side of the bed against the wall. Resident #31's diagnosis list indicated diagnoses, which included, but not limited to Dementia in Other Diseases Classified Elsewhere without Behavioral Disturbance, Typical Atrial Flutter, Chronic Obstructive Pulmonary Disease Unspecified, Acute on Chronic Systolic (Congestive) Heart Failure, Primary Open-Angle Glaucoma Bilateral Severe Stage, and Unspecified Blepharitis Left Eye Upper and Lower Eyelids. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 6/17/21 coded the resident as being severely impaired with cognitive skills for daily decision making with short-term and long-term memory problems. Resident #31 was unable to complete the BIMS (brief interview for mental status) interview. In section G, Functional Status, the resident was coded as requiring extensive assistance with bed mobility, transfers, and personal hygiene. On 8/01/21 at 10:35 am, surveyor observed Resident #31 in bed with the head of the bed against the wall with space available for the resident to enter and exit the bed from the left or right side. On 8/03/21, a review of Resident #31's comprehensive person-centered care plan revealed a focus area stating "(Resident #31) is a high risk for falls r/t (related to) impaired mobility	F 656		

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	495156	A. BUILDING ______ B. WING ______	C 08/05/2021

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F 656	Continued From page 26 and balance, safety awareness d/t (due to) dementia" with an intervention dated 5/19/21 stating "right side against wall for fall prevention". On 8/03/21 at 12:02 pm, surveyor again observed Resident #31's bed in the same position as noted on 8/01/21, with the head of the bed against the wall. At 2:21 pm, surveyor met with the MDS Coordinator and discussed the observation of the Resident #31's bed positioning and the care plan intervention of the right side of the bed against the wall. The MDS Coordinator returned at 3:23 pm and stated the bed is now against the wall. On 8/04/21 at 8:57 am, surveyor observed Resident #31's bed with the right side of the bed against the wall. Surveyor requested and received the facility policy entitled, "Comprehensive Care Plans" which states in part, "Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made". During a meeting with the administrator, director of nursing, Regional Vice President of Clinical Services, and the Regional Director of Operations on 8/04/21 at 5:20 pm, surveyor discussed the concern of Resident #31's care plan intervention for bed positioning not being implemented as written. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/05/21. 4. For Resident #17, the facility staff failed to	F 656		

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F 656	Continued From page 27 implement the comprehensive person-centered care plan intervention for the use of a fall mat at the bedside. Resident #17's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Left Non-Dominate Side, Cerebral Infarction due to Thrombosis of Right Vertebral Artery, Aphasia, Acute on Chronic Systolic (Congestive) Heart Failure, Chronic Viral Hepatitis C, Hypothyroidism Unspecified, Unspecified Dementia without Behavioral Disturbance, and Dysphagia Following Cerebral Infarction. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/17/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, Cognitive Patterns. On 8/01/21 at 11:45 am, surveyor observed Resident #17 in bed with the left side of the bed against the wall with no fall mat in place. On 8/03/21, a review of Resident #17's comprehensive person-centered care plan revealed a focus area stating "(Resident #17) is at risk for injuries r/t (related to)fall with Hx (history): of falls r/t poor balance, poor communication/comprehension, unsteady gait, poor safety awareness, poor judgement" with an intervention initiated on 2/26/20 stating "continue current intervention of fall mat at bedside injury was prevented with current interventions". On 8/03/21 at 12:00 pm, surveyor observed Resident #17 in bed with the bed in low position	F 656		

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F 656	Continued From page 28	F 656		

with the left side of the bed against the wall, no fall mat was in place. Surveyor asked CNA (certified nursing assistant) #1 if the resident should have a fall mat in place and CNA #1 stated "I don't know". At 2:21 pm, surveyor met with the MDS Coordinator and discussed the observation of Resident #17 being in bed with no fall mat in place as care planned. The MDS Coordinator returned at 3:23 pm and stated the fall mat has been put in place.

On 8/04/21 at 8:55 am, surveyor observed Resident #17 in bed with a fall mat in place on the right side of the bed.

Surveyor requested and received the facility policy entitled, "Comprehensive Care Plans" which states in part, "Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made".

During a meeting with the administrator, director of nursing, Regional Vice President of Clinical Services, and the Regional Director of Operations on 8/04/21 at 5:20 pm, surveyor discussed the concern of Resident #17 being observed in bed without a fall mat in place per the resident's care plan.

No further information regarding this issue was presented to the survey team prior to the exit conference on 8/05/21.

F 657 SS=E — Care Plan Timing and Revision
CFR(s): 483.21(b)(2)(i)-(iii) — F 657

§483.21(b) Comprehensive Care Plans

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F 657	Continued From page 29 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, resident interview, and the review of documents, it was determined the facility staff failed review and revise comprehensive care plans for four (4) of 30 residents (Resident #10, Resident #13, Resident #14, and Resident #33). The findings include: 1. The facility staff failed to revise Resident #33's care plan to address a decline in mobility.	F 657	F657 1. Resident # 33: Care Plan update to reflect resident's decline in ambulation. Date of update 08/16/2021 Resident # 13: Care Plan updated to reflect no tube feeding. Date of update 08/03/2021 Resident # 14: Care Plan update to reflect no actual impairment to skin integrity. Date of update 08/25/2021 Resident # 10: Care Plan updated to reflect meal tray setup and no assistance required for feeding. Date of update 08/1/2021 2. Conduct audit of last 30 days of current residents who have had change of condition to ensure care plan has been revised. 3. Education of MDS staff on September 10, 2021 for Care Plan development. 4. MDS will conduct weekly audits of care plans x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability. 5. Date of Compliance: September 19, 2021.	

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F 657	Continued From page 30 Observations of Resident #33 during the survey revealed Resident #33 in either the bed or wheelchair. Resident #33 was never observed to be walking. Resident #33's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 6/17/21, was signed as completed on 6/24/21. Resident #33 was assessed as sometimes able to make self understood and as sometimes able to understand others. The resident was assessed as having problems with short-term and long-term memory. Resident #33 was assessed as requiring extensive assistance with bed mobility, transfers, dressing, and personal hygiene. Resident #33 was assessed as being dependent on staff for toilet use and bathing. Resident #33's diagnoses included, but were not limited to: high blood pressure, Alzheimer's disease, dementia, depression, anxiety, and vision problems. Resident #33's care plan included the following information: "(Resident #33) has short term memory deficits and needs cognitive stimulation. (The resident) walks in the hall ways [sic] constantly (the resident) only sits when (the resident) is very tired." During an interview on 8/4/21 at 2:20 p.m., the facility's MDS Coordinator confirmed Resident #33 had experienced a decline in ambulation. The facility's MDS Coordinator also confirmed Resident #33's care plan had not been revised to address the resident's decline in ambulation. The following information was found in a facility document titled "Care Plan Revisions Upon Status Change" (this document had an	F 657		

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F 657	Continued From page 31 implementation date of 11/1/2020): - "The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change." - "The comprehensive care plan will be reviewed, [sic] and revised as necessary, when a resident experiences a status change." - "The care plan will be updated with the new or modified interventions." On 8/5/21 at 9:18 a.m., the failure of the facility staff to review and revise Resident #33's care plan to address the residents decline with ambulation was discussed during a survey team meeting with the facility's Administrator, Director of Nursing (DON), Regional Vice-President of Clinical Services, and Regional Director of Operations. 2. For Resident #13 the facility staff failed to revise the care plan for feeding tube. Resident #13's face sheet listed diagnoses which included but not limited to urinary tract infection, cerebral infarction, hemiplegia, and hemiparesis, dysphagia, hypertension, and acute and chronic respiratory failure. Resident #13's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 06/24/21 assigned the resident a BIMS (brief interview for mental status) score of 15 of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #13's comprehensive care plan was reviewed and contained a care plan for "...requires tube feeding r/t (related to) RT (right) MCA (middle cerebral artery) with dysphagia"	F 657		

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F 657	Continued From page 32 Resident #13's clinical record was reviewed and contained a physician's order summary, which read in part "Enteral Feed Order two times a day for enteral feed. Enteral 1-Feeding: Administer Promote per PEG (percutaneous endoscopic gastrostomy)-Tube via Pump. Rate: 70 mLs/hour, for 12 hours/day, Start at 6 pm-stop at 0600". This order was marked as discontinued. Resident #13's eMAR (electronic medication administration record) for the month May 2021 was reviewed and contained an entry as above, with a D/C (discontinued) date of 05/18/21. Surveyor spoke with Resident #13 on 08/01/21 at 10:15 am. Surveyor asked Resident #13 if they have a feeding tube, and Resident stated they no longer get tube feeding. Surveyor spoke with the MDS coordinator on 08/03/21 2:30 pm regarding Resident #13's care plan for tube feeding. MDS coordinator stated that tube feeding should have been removed from the resident's care plan. On 08/03/21, MDS coordinator provided the surveyor with a corrected care plan. Surveyor requested and was provided with a facility policy entitled "Care Plan Revisions Upon Status Change", which read in part "1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. d. The care plan will be updated with the new or modified interventions." The concern of facility staff failing to update the resident's care plan was discussed with the	F 657		

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administrative team (administrator, director of nursing, regional vice-president of clinical services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm.

No further information was provided prior to exit.

3. For Resident #14 the facility staff failed to revise the care plan for pressure ulcers.

Resident #14's face sheet listed diagnoses which included but not limited to Huntington's Disease, obstructive and reflux uropathy, anxiety, depression, dysphagia, hypertension, and history of urinary tract infections.

Resident #14's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/26/21 assigned the resident a BIMS (brief interview for mental status) score of 99. This indicates that the resident was unable to complete the interview due to being severely cognitively impaired.

Resident #14's comprehensive care plan was reviewed and contained a care plan for "... has actual impairment to skin integrity r/t (related to) pressure injury of sacrum".

Resident #14's clinical record was reviewed and surveyor could not locate any information to indicate resident currently has a pressure ulcer. Surveyor could not locate any current skin assessments in the clinical record. Surveyor spoke with the unit manager on 08/03/21 at approximately 1:30 pm. Unit manager stated that resident no longer has a pressure ulcer and that skin assessment had not been done. Unit manager also stated that a plan had been put in

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F 657	Continued From page 34 place for skin assessments, but it hadn't worked. Surveyor requested and was provided with a facility policy entitled "Care Plan Revisions Upon Status Change", which read in part "1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. d. The care plan will be updated with the new or modified interventions." The concern of facility staff failing to update the resident's care plan was discussed with the administrative team (administrator, director of nursing, regional vice-president of clinical services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm. No further information was provided prior to exit. 4. For Resident #10, the facility staff failed to revise the comprehensive person-centered care plan for diet and feeding assistance. Resident #10's diagnosis list indicated diagnoses, which included, but not limited to Down Syndrome Unspecified, Other Generalized Epilepsy and Epileptic Syndromes not Intractable without Status Epilepticus, Repeated Falls, Dementia in Other Diseases Classified Elsewhere without Behavioral Disturbance, Dysphagia Oropharyngeal Phase, and Adult Failure to Thrive. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/10/21 coded the resident as severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems in section C, Cognitive Patterns. Resident #10 was	F 657		

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also coded as rarely/never makes self understood and rarely/never understands others. In section G, Functional Status, Resident #10 was coded as requiring extensive assistance in eating.

Resident #10's current physician's orders included an order dated 6/17/21 stating Fortified Foods diet, mechanical soft ground meat texture, regular/thin liquids consistency, finger foods, no straws.

Surveyor observed Resident #10 alone in their room feeding themselves lunch on 8/01/21, breakfast on 8/02/21 and 8/03/21. Each meal tray contained thin liquids in a cup with no straw and ground meat texture.

On 8/03/21, surveyor reviewed Resident #10's comprehensive person-centered care plan which included a focus area stating "(Resident #10) has returned from the hospital after having aspiration PNA (pneumonia). (He/she) was evaluated by Speech and deemed unsafe for oral consumption of food and was not deemed a candidate for tube feeding due to medical DX (diagnosis). Family also declined tube placement, anticipated decline in meal intake". An intervention initiated on 11/20/20 and revised on 5/11/21 states "All PO (oral) by spoon. NO cups or straws to be used. Can not [sp] be left alone during PO intake. 100% feeding assist". An additional focus area states in part, "Current Diet is Regular Mechanical Soft with Thin Liquids. Diet changed to Puree with FF, and Magic Cup with Honey thick liquids".

On 8/03/21 at 11:53 am, surveyor notified the Unit Manager of Resident #10's diet order discrepancy

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F 657	Continued From page 36 on the current care plan and the observation of the resident eating alone in their room and drinking from a cup. At 1:15 pm, the Unit Manager returned with a copy of a revised portion of Resident #10's care plan stating in part, "Current Diet is Regular Mechanical Soft Finger foods with Thin Liquids". Surveyor spoke with the MDS Coordinator on 8/03/21 at 2:21 pm concerning Resident #10's diet order and eating assistance/instruction documented on the current care plan and the previous observations of the resident feeding themselves alone in their room. At 3:23 pm, the MDS Coordinator returned and stated they have corrected the resident's care plan for the appropriate diet and eating assistance and provided a copy of the revised sections of the resident's care plan. A revised focus area states in part "Current Diet is AHR-Fortified Foods diet, AHR-Mechanical Soft - Ground Meat texture, AHR -Regular/Thin Liquids consistency". A revised intervention dated 8/03/21 states "Eating: requires supervision assist with set up". Surveyor requested and received the facility policy entitled, "Care Plan Revisions Upon Status Change" which states in part: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. d. The care plan will be updated with the new or modified interventions. f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. On 8/04/21 at 5:20 pm, surveyor met with the administrator, director of nursing, Regional Vice	F 657		

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F 657	Continued From page 37 President of Clinical Services, and the Regional Director of Operations and discussed the concern of the facility staff failing to revise Resident #10's comprehensive person-centered care plan. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/05/21.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to ensure that residents who was unable to carry out (ADLs) activities of daily living received the necessary care and services to maintain personal hygiene and grooming for 10 of 30. Residents #35, #40, #52, #208, #10, #31, #5, #7, #33, and #34. The findings included: 1. For Resident #35, the facility staff failed to provide ADL care. Resident #35's toenails and fingernails were observed to be long and jagged. A dark debris was present under the residents fingernails. Resident #35's (EHR) electronic health record included the diagnoses, acute and chronic respiratory failure with hypercapnia, diabetes, dysphagia, and quadriplegia.	F 677		

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Section C (cognitive patterns) of Resident #35's quarterly (MDS) minimum data set assessment with an (ARD) assessment reference date of 06/23/21 included a (BIMS) brief interview for mental status summary score of 9 out of 15. Section G (functional status) was coded 3/3 for personal hygiene indicating the resident required extensive assistance assist of two people.

Resident #35's CCP (comprehensive care plan) included the focus area ADL self-care performance deficit related to quadriparesis, ventilator and tracheotomy dependent. Interventions included, check nail length, trim, and clean on bath day and as necessary.

08/01/21 10:49 a.m., Resident #35's fingernails and toenails were observed to be long and jagged. The Residents fingernails were observed with debris underneath the nails.

08/02/21 08:18 a.m., the (DON) director of nursing and the surveyor observed Resident 35's fingernails and toenails to be long and jagged in appearance. Debris remained underneath the residents fingernails. The DON stated they were not aware and would have the podiatrist to evaluate the nails.

08/02/21 08:25 a.m., (RN) registered nurse #1 stated they would put the resident on the podiatry list to be checked.

08/02/21 9:00 a.m., the DON provided the surveyor with a progress note indicating the podiatrist had visited and treated Resident #35 on 06/16/21. The DON stated of course the debris still needed to be cleaned from underneath

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1. **Resident # 35: Fingernails were trimmed and cleaned. Resident added to podiatry list.**
2. **Audit of last 30 days current residents grooming of toenails, fingernails, and showers to ensure needs are being met. Date of podiatry visit 12/16/2021.**
   Resident # 40: Resident added to podiatry list.
   Resident # 52: Resident added to podiatry list.
   Resident # 208: Resident provided a shower.
   Resident # 10: Resident provided foot hygiene.
   Resident # 31: Resident provided shave.
   Resident # 34: Resident provided a shower.
   Resident # 7: Resident provided a shower.
   Resident # 33: Resident provided a shower.
   Resident # 5: Resident provided a shower.
3. **Education of Licensed Nursing staff and Certified Nursing Assistants for ADL care and documentation on September 10 and 13, 2021**

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F 677	Continued From page 39 Resident #35's nails. 08/02/21 4:03 p.m., the Administrator, Regional Vice President of Clinical Services, and DON were made aware of the issue with the residents nails. 2. For Resident #40, the facility staff failed to provide ADL care. Resident #40's toenails were observed to be long and jagged. Resident #40's (EHR) electronic health record included the diagnoses, chronic respiratory failure, diabetes, dysphagia, and epilepsy. Section C (cognitive patterns) of Resident #40's admission (MDS) minimum data set assessment with an (ARD) assessment reference date of 06/21/21 had been coded (0/1/1) to indicate the resident had problems with long term memory and had modified independence in cognitive skills for daily decision making. Section G (functional status) was coded (3/3) for personal hygiene to indicate the resident required extensive assistance of two persons for this tasks. 08/01/21 02:09 p.m., observation of Resident #40's toenails with (CNA) certified nursing assistant #1. Toenails observed to be long and jagged in appearance. 08/02/21 08:18 a.m., the (DON) director of nursing and the surveyor observed the residents toenails. The resident's toenails were observed to be long and jagged in appearance. The DON stated they would have the wound nurse to check the toenails. 08/02/21 4:03 p.m., the Administrator, Regional	F 677	**4. DON and/or designee will conduct weekly audits of shower sheets and room rounds x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.** **5. Date of Compliance: September 19, 2021.**	

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F 677	Continued From page 40 Vice President of Clinical Services, and DON were made aware of the issue with the residents nails. 3. For Resident #52, the facility staff failed to provide ADL care. Resident #52's toenails were observed to be long and jagged. Resident #52's (EHR) electronic health record included the diagnoses, acute on chronic diastolic congestive heart failure, chronic pain syndrome, major depressive disorder, type 2 diabetes, and age related nuclear cataract, bilateral. Section C (cognitive patterns) of the resident's quarterly (MDS) minimum data set assessment with an (ARD) assessment reference date of 07/16/2021 included a (BIMS) brief interview for mental status summary score of 15 out of a possible 15 points. Section G (functional status) was coded to indicate the resident was independent with setup help only for personal hygiene. Resident #52's (CCP) comprehensive care plan included the focus area ADL self-care performance deficit. Interventions included, but were not limited to, "Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse ..." 08/01/21 3:10 p.m., Resident #52 observed sitting in doorway of room putting lotion on their feet. The residents toenails were observed to be long and jagged. 08/02/21 8:01 a.m., Resident #52 stated they were not sure who the man was that cut their toenails.	F 677		

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08/02/21 4:03 p.m., the Administrator, Regional Vice President of Clinical Services, and (DON) director of nursing were made aware of the issue with the residents nails.

4. For Resident #208, the facility staff to provide ADL care. Resident #208 did not receive a bath from the date of admission 07/23/21 until 08/01/21. After the surveyor brought it to the facility's attention.

Resident #208's (EHR) electronic health record included the diagnoses, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, diabetes, and difficulty in walking.

There was no completed (MDS) information on this resident. However, Resident #208 was alert and orientated to person and place.

The resident's care plan included the focus area's requires assistance with ADL's due to medical condition. Interventions included, but were not limited to, assist with dressing of one person, provide set-up assist for personal hygiene and oral care, and supervision/assist with bathing.

08/01/21 10:14 a.m., Resident #208 was observed in their room resting on bed and stated they had not been given a bath since they were admitted and no reason had been given by the staff.

08/02/21 8:10 a.m., the (DON) director of nursing was made aware that Resident #208 had not received a bath since admit to the facility. The DON stated they were not aware of that and added that the resident was receiving

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occupational therapy.

08/02/21 8:15 a.m., (CNA) certified nursing assistant #3 stated they were not aware this resident had not had a bath.

08/02/21 8:23 a.m., therapy staff #1 stated they had not worked with this resident in regards to personal hygiene.

08/02/21 3:40 p.m., Resident #208 stated they had now received a shower.

08/02/21 4:03 p.m., the Administrator, Regional Vice President of Clinical Services, and DON were made aware of the issue regarding the residents bathing status.

No further information regarding this issue was provided to the survey team prior to the exit conference.

5. For Resident #10, the facility staff failed to provide assistance with foot hygiene.

Resident #10's diagnosis list indicated diagnoses, which included, but not limited to Down Syndrome Unspecified, Other Generalized Epilepsy and Epileptic Syndromes not Intractable without Status Epilepticus, Repeated Falls, Dementia in Other Diseases Classified Elsewhere without Behavioral Disturbance, Dysphagia Oropharyngeal Phase, and Adult Failure to Thrive.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/10/21 coded the resident as severely impaired in cognitive skills for daily decision making with

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F 677	Continued From page 43 short-term and long-term memory problems in section C, Cognitive Patterns. Resident #10 was also coded as rarely/never makes self understood and rarely/never understands others. In section G, Functional Status, Resident #10 was coded as requiring extensive assistance with dressing and personal hygiene and being totally dependent on staff for bathing. On 8/01/21 at 11:22 am during initial rounding, surveyor observed Resident #10 laying on their bed with their head at the foot of the bed. Surveyor observed the bottom of the resident's feet and noted both were dark with a large amount of debris stuck to the bottom of the resident's bare feet. While the surveyor was in the resident's room, they got out of bed and walked across the floor with bare feet. Food crumbs and debris were observed on the floor of the resident's room. Later that afternoon at 4:17 pm, surveyor observed Resident #10 in bed with their head at the head of the bed and there was no change in the appearance of the bottom of the resident's bare feet. The following morning at 8:40 am, surveyor observed Resident #10 sitting on their bed without socks or shoes. Surveyor observed the bottom of the resident's bare feet and noted crumbs and debris stuck to the bottom of their feet, however, they did not appear as dark in color as the prior observation on 8/01/21. Surveyor again observed the bottom of Resident #10's bare feet on 8/02/21 at 3:30 pm and noted them to be dark in color with a large amount of crumbs and debris. The sheets on the resident's bed were noted to have stains and crumbs present. At 3:34 pm, at the request of the	F 677		

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surveyor, the DON (director of nursing) entered Resident #10's room and observed the bottom of the resident's feet. The DON stated they would take care of it and thanked the surveyor for bringing it to their attention. The DON also stated they would have the floor cleaned. At approximately 4:40 pm, surveyor and RN #1 observed Resident #10 wearing clean slipper socks. RN #1 removed the resident's slipper socks and the bottom of the resident's feet were noted to be clean without debris. The resident's bed linens had been changed and the floor had been mopped.

A review of Resident #10's current comprehensive person-centered care plan included a focus area stating in part "(Resident #10) frequently removes (his/her) socks and ambulates with bare feet" with an intervention dated 4/26/19 stating "Attempt ADL's (activities of daily living) if resistive, leave and return 5-10 minutes later and attempt again".

A review of the clinical record indicated Resident #10's last documented shower was provided on 7/29/21.

On 8/04/21 at 5:20 pm, surveyor met with the administrator, director of nursing, Regional Vice President of Clinical Services, and the Regional Director of Operations and discussed the concern of Resident #10's lack of assistance with foot hygiene.

No further information regarding this issue was presented to the survey team prior to the exit conference on 8/05/21.

6. For Resident #31, the facility staff failed to

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F 677	Continued From page 45 shave/trim facial hair on the resident's chin and neck. Resident #31's diagnosis list indicated diagnoses, which included, but not limited to Dementia in Other Diseases Classified Elsewhere without Behavioral Disturbance, Typical Atrial Flutter, Chronic Obstructive Pulmonary Disease Unspecified, Acute on Chronic Systolic (Congestive) Heart Failure, Primary Open-Angle Glaucoma Bilateral Severe Stage, and Unspecified Blepharitis Left Eye Upper and Lower Eyelids. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 6/17/21 coded the resident as being severely impaired with cognitive skills for daily decision making with short-term and long-term memory problems. Resident #31 was unable to complete the BIMS (brief interview for mental status) interview. In section G, Functional Status, the resident was coded as requiring extensive assistance with bed mobility, transfers, personal hygiene, and being totally dependent on staff for bathing. On 8/01/21 at 10:36 am during initial rounds, surveyor observed Resident #31 in bed with long facial hair stubble noted along chin and neck. The resident's most recent documented shower was 7/30/21. A review of Resident #31's comprehensive person-centered care plan revealed a focus area of "(Resident #31) has an ADL (activities of daily living) Self Care Performance Deficit r/t (related to) dementia with self care deficit, impaired mobility, comfort care" with an intervention dated	F 677		

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6/04/19 to "Assist Resident in shaving/trimming (his/her) facial hair".

On 8/04/21 at 5:20 pm, surveyor met with the administrator, director of nursing, Regional Vice President of Clinical Services, and the Regional Director of Operations and discussed the concern of Resident #31's lack of assistance with shaving/trimming their facial hair.

No further information regarding this issue was presented to the survey team prior to the exit conference on 8/05/21.

7. The facility staff failed to ensure Resident #34's shower/bathing needs were consistently addressed.
Resident #34's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 5/21/21, was signed as completed on 6/11/21. Resident #34 was assessed as able to make self understood and as able to understand others. Resident #34's Brief Interview for Mental Status (BIMS) summary score was documented as 15 out of 15. Resident #34 was assessed as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene.
Resident #34's diagnoses included, but were not limited to: high blood pressure, seizures, anxiety, depression, and lung disease.

The following information was found in a facility policy titled "Bathing a Resident" (with a reviewed/revised date of 10/28/20): "It is the practice of this facility to assist residents with their choice of bathing/hygiene options to maintain proper hygiene and help prevent skin issues. At admission, and at least quarterly, resident and/or resident representative will be interviewed to

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determine choice of bathing options (shower, bed baths, combination), frequency, time of day preferred and any other preferences."

Resident #34's ADL (activity of daily living) care plan included the following intervention: "(the resident) is totally dependent on (2) staff to provide (bath/shower) (2 times weekly) and as necessary."

Resident #34's bath/shower documentation was reviewed for May 23, 2021 through July 31, 2021. It was noted during this time that three (3) weeks had Resident #34 documented as receiving fewer than two (2) baths per week.

On 8/5/21 at 9:18 a.m., Resident #34's bath/shower documentation was reviewed during a survey team meeting with the facility's Administrator, Director of Nursing (DON), Regional Vice-President of Clinical Services, and Regional Director of Operations. After reviewing additional documentation provided to the survey team, there remained one (1) week when Resident #34 had no baths/showers documented per week. This week was June 27, 2021 through July 3, 2021.

8. The facility staff failed to ensure Resident #7's shower/bathing needs were consistently addressed.

Resident #7's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 5/10/21, was signed as completed on 5/25/21. Resident #7 was assessed as being able to make self understood and as being able to understand others. Resident #7 was assessed as requiring assistance with bed mobility,

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transfers, and dressing. Resident #7 was documented as being dependent on staff for toilet use, personal hygiene, and bathing. Resident #7's diagnoses included, but were not limited to: heart failure, high blood pressure, dementia, and depression.

The following information was found in Resident #7's ADL (activity of daily living) care plan: "The resident requires (extensive assistance) by (1) staff with (bathing/showering) (2 times per week) and as necessary."

Resident #7's bath/shower documentation was reviewed for May 23, 2021 through July 31, 2021. It was noted during this time that four (4) weeks had Resident #7 documented as receiving fewer than two (2) baths/showers per week.

On 8/5/21 at 9:18 a.m., Resident #7's bath/shower documentation was reviewed during a survey team meeting with the facility's Administrator, Director of Nursing (DON), Regional Vice-President of Clinical Services, and Regional Director of Operations. After reviewing additional documentation provided to the survey team, there remained three (3) weeks that Resident #7 had only one (1) bath/shower documented. These weeks were: May 30, 2021 through June 5, 2021; July 4, 2021 through July 10, 2021; and July 11, 2021 through July 17, 2021.

9. The facility staff failed to ensure Resident #33's shower/bathing needs were consistently addressed.

Resident #33's minimum data set (MDS) assessment, with an assessment reference date

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F 677	Continued From page 49 (ARD) of 6/17/21, was signed as completed on 6/24/21. Resident #33 was assessed as sometimes able to make self understood and as sometimes able to understand others. The resident was assessed as having problems with short-term and long-term memory. Resident #33 was assessed as requiring extensive assistance with bed mobility, transfers, dressing, and personal hygiene. Resident #33 was assessed as being dependent on staff for toilet use and bathing. Resident #33's diagnoses included, but were not limited to: high blood pressure, Alzheimer's disease, dementia, depression, anxiety, and vision problems. Resident #33 was care planned to address the resident's activities of daily living (ADLs) needs; the goals for this care plan had a target date of 9/13/21. Interventions for this care planned focus included "requires total extensive assistance by (one to two) staff with bathing/showering 2 times a week and as necessary". Resident #33's bath/shower documentation was reviewed for May 23, 2021 through July 31, 2021. It was noted during this time that four (4) weeks had Resident #33 documented as receiving fewer than two (2) baths/showers per week. On 8/5/21 at 9:18 a.m., Resident #33's bath/shower documentation was reviewed during a survey team meeting with the facility's Administrator, Director of Nursing (DON), Regional Vice-President of Clinical Services, and Regional Director of Operations. After reviewing additional documentation provided to the survey team, there remained two (2) weeks that Resident #33 was documented as having only one (1) baths/showers per week. These weeks	F 677		

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were June 6, 2021 through June 12, 2021 and July 4, 2021 through July 10, 2021.

10. The facility staff failed to ensure Resident #5's shower/bathing needs were consistently addressed.

Resident #5's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 5/7/21 was signed as completed on 5/21/21. Resident #5 was assessed as rarely/never able to make self understood and as rarely/never able to understand others. Resident #5 was documented as having short-term and long-term memory problems. Resident #5 was assessed as being dependent on others for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. Resident #5's diagnoses included, but were not limited to: high blood pressure, seizure disorder, anxiety, depression, and central nervous system (CNS) disease.

Resident #5 was care planned to address the resident's activities of daily living (ADLs) needs; the goals for this care plan had a target date of 8/10/21. Interventions for this care planned focus included "requires total assistance with showers (twice a week) and (as needed)".

Resident #5's bath/shower documentation was reviewed for May 23, 2021 through July 31, 2021. It was noted during this time that three (3) weeks had Resident #5 documented as receiving fewer than two (2) baths/showers per week.

On 8/5/21 at 9:18 a.m., Resident #5's bath/shower documentation was reviewed during a survey team meeting with the facility's Administrator, Director of Nursing (DON),

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F 677	Continued From page 51 Regional Vice-President of Clinical Services, and Regional Director of Operations. After reviewing additional documentation provided to the survey team, there remained one (1) week that Resident #5 had only one (1) bath/shower documented (July 4, 2021 through July 10, 2021) and one (1) week that Resident #5 had no baths/showers documented (May 30, 2021 through June 5, 2021).	F 677		
F 684 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on interviews, the review of documents, and in the course of a complaint investigation, it was determined the facility staff failed to ensure required care was provided to for 10 of 30 sampled residents (Resident #1, Resident #5, Resident #6, Resident #13, Resident #17, Resident #19, Resident #31, Resident #46, Resident #48, and Resident #52). The findings include: 1. The facility staff failed to ensure Resident #5 received ordered care to address an area noted to the resident's scalp.	F 684		

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F 684	Continued From page 52 Resident #5's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 5/7/21, was signed as completed on 5/21/21. Resident #5 was assessed as rarely/never able to make self understood and as rarely/never able to understand others. Resident #5 was documented as having short-term and long-term memory problems. Resident #5 was assessed as being dependent on others for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. Resident #5's diagnoses included, but were not limited to: high blood pressure, seizure disorder, anxiety, depression, and central nervous system (CNS) disease. The following information was found in Resident #5's clinical record as part of a "skin/wound note" documented with an effective date of 4/30/21 at 1:32 p.m.: "Weekly skin assessment completed: Draining boil noted to posterior scalp base. Moderate amount of purulent drainage noted. (Nurse practitioner) aware and (new orders) in place for Bactroban (twice a day) and warm compresses (three times a day)." (Bactroban is used to treat skin infections.) Review of Resident #5's medication administration records (MARs) and treatment administration records (TARs) revealed the aforementioned Bactroban ointment was not documented as started until the evening of 5/3/21 and the warm compresses were not documented as started until the morning of 5/4/21. Resident #5 was care planned to address the resident's skin impairment needs. The goals for this care plan had a target date of 8/10/21. Interventions for this care planned focus included: "Administer treatments as ordered ..."	F 684	**F684** **1. Resident # 5: Medication discontinued 05/26/2021 and treatment discontinued 05/14/2021. Area has resolved.** **Resident # 6: Skin assessment completed.** **Resident # 52: MD made aware of missing weights. MD made aware of weight changes.** **Resident # 48: Skin assessment completed.** **Resident # 19: MD notified of medication not given. MD notified of weight gain.** **Resident # 13: MD notified of medication not given.** **Resident # 1: MD notified of medication not given. Skin assessment completed.** **Resident # 46: MD notified of medication not given.** **Resident # 17: MD notified of** medication **not given.** **Resident # 31: Skin assessment completed.**	

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F 684 Continued From page 53

The following information was found in a facility policy title "Medication Administration" (with an implemented date of 11/1/20): "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection."

The delay in initiating Resident #5's ordered skin care was discussed with the facility's Director of Nursing (DON), MDS Nurse, Regional Vice-President of Clinical Services, and Regional Director of Operations on 8/5/21 at 9:34 a.m.

This is a complaint deficiency.

2. The facility staff failed to complete Resident #6's weekly skin assessments.

Resident #6's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 5/7/21, was signed as being completed on 5/25/21. Resident #6 was assessed as usually able to make self understood and as usually able to understand others. Resident #6 was assessed as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #6's diagnoses included, but were not limited to: heart disease, high blood pressure, seizure disorder, depression, and diabetes.

Resident #6's care plan contained a focus area (revised on 5/17/21) which stated "(the resident) is at risk for pressure ulcer skin integrity for pressure ulcer development (related to) mobility deficit with left hemiplegia, incontinent of bladder,

F 684

2. Audit of last 30 days of current resident's weekly skin assessments, weight notification of changes, and orders received were followed timely.

3. Education of Licensed Nursing staff, Management Team, and Certified Nursing Assistants for Quality-of-Care standards and documentation of such on September 10 and 13, 2021

4. DON and/or designee will conduct weekly audits of MARS, weights, and skin assessments x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.

5. Date of Compliance: September 19, 2021.

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occasional bowel." [sic] This care planned focus area included interventions to: (a) "Follow facility policies/procedures for the prevention/treatment of skin breakdown" and (b) "Monitor/document/report (as needed) any changes in skin status: appearance, color, wound healing, (signs and symptoms) of infection, wound size (length x width x depth), stage."

The facility policy titled "Skin Assessment" (with a revised date of 10/28/20) included the following information: "A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter."

On 8/3/21 at 10:23 a.m., the facility's Administrator, Director of Nursing (DON), and Regional Vice-President of Clinical Services was asked to provide Resident #6's weekly skin assessment for May 2021, June 2021, and July 2021.

On 8/3/21 at 1:22 p.m., the facility's Regional Vice-President of Clinical Services reported Resident #6 had only one (1) skin assessment completed during May 2021, June 2021, and July 2021. The Regional Vice-President of Clinical Services stated skin assessments should be completed weekly.

The failure of the facility staff to complete Resident #6's weekly skin assessments was discussed with the Administrator, Director of Nursing (DON), Regional Vice-President of Clinical Services, and the Regional Director of Operations on 8/5/21 at 9:18 a.m.
3. For Resident #52, the facility staff failed to obtain the residents weights and notify the

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F 684	Continued From page 55 physician of a weight gain. Resident #52's (EHR) electronic health record included the diagnoses, acute on chronic diastolic congestive heart failure, chronic pain syndrome, major depressive disorder, type 2 diabetes, and abnormal weight gain. Section C (cognitive patterns) of the resident's quarterly (MDS) minimum data set assessment with an (ARD) assessment reference date of 07/16/2021 included a (BIMS) brief interview for mental status summary score of 15 out of a possible 15 points. The residents comprehensive care plan included the focus area has potential fluid deficit/overload related to diuretic use due to congestive heart failure, hypertension. Non-compliant with fluid restriction. Interventions included, but were not limited to, weigh resident per protocol/MD order. The (EHR) electronic health record included the following physician orders: Fluid Restrictions, 1500 ml fluids restriction related to acute on chronic diastolic congestive heart failure, daily weights, and notify provider if weight gain is greater than 3 pounds in 1 day or greater than 5 pounds in 3 days. Resident #52 was receiving the diuretics Furosemide 40 mg and Spironolactone 25 mg. The surveyor was unable to locate any weights for 07/10/21, 07/11/21, and 07/26/21. The EHR included the following weights: 07/08/21-270.8 07/09/21-274.0 07/12/21-280	F 684		

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F 684	Continued From page 56 07/25/21-272 07/27/21-278.2. The surveyor was unable to locate any information indicating the physician had been made aware of the weight changes or any reason for the missing weights. 08/04/21 5:14 p.m., the Administrator, (DON) director of nursing, Regional Director of Operations, and Regional Vice President of Clinical Services were made aware of the issue regarding the residents weight. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #48 the facility staff to complete skin assessments per the comprehensive person-centered care plan. Resident #48's face sheet listed diagnoses which included but not limited to mechanical complication of indwelling urethral catheter, obstructive and reflux uropathy, history of urinary tract infections, dementia, congestive heart failure, dysphagia, hypertension and retention of urine. The most recent comprehensive MDS (minimum data set) with an ARD (assessment reference date) of 06/21/21 assigned the resident a BIMS (brief interview for mental status) score of 0 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #48's comprehensive care plan was reviewed and contained a care plan for "...has the potential for developing further pressure ulcers	F 684		

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d/t (due to) Disease process, level of mobility, incontinence of bowel". Interventions for this care plan included "Obtain weekly skin checks and document, notify Dr. of any changes seen in skin integrity".

Resident #48's clinical record was reviewed and the last recorded skin assessment located was dated 05/03/21.

Surveyor spoke with the unit manager on 08/03/21 at 1:30 pm regarding the missing skin assessments. Unit manager stated they were not being done and that they had put a plan of correction in place, but it hadn't worked.

The concern of the skin assessments not being done was discussed with the administrative team (administrator, director of nursing, regional vice-president of clinical services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm.

No further information was provided prior to exit.

5. For Resident #19 the facility staff failed to follow physician's order for the administration of the medications omeprazole and torsemide, and failed to notify the physician of weight gain as ordered.

Resident #19's face sheet listed diagnoses which included but not limited to acute and chronic respiratory failure, congestive heart failure, chronic obstructive pulmonary disease, chronic kidney disease, atrial fibrillation, gastroesophageal reflux disease and depression.

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F 684	Continued From page 58 Resident #19's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 06/02/21 assigned the resident a BIMS (brief interview for mental status) score of 11 out of 15. This indicates that the resident is cognitively intact. Resident #19's CCP (comprehensive care plan) was reviewed and contained a care plan for "...has an abnormal high BMI (body mass index) indicating morbid obesity. Potential for weight changes r/t (related to) CHF (congestive heart failure) with diuretic use..." Interventions for this care plan include "Weigh per MD orders" The CCP also contained a care plan for "...is on diuretic therapy medication) r/t (related to): hypertension, CHF, CKD (chronic kidney disease) III". Interventions for this care plan include "Administer medications as ordered". The CCP also contained a care plan for "...has GERD (gastroesophageal reflux disease)". Interventions for this care plan included "Give medications as ordered..." Resident #19's clinical record was reviewed and contained a physician's order summary for August 2021, which read in part "Daily weights NOTIFY if 3 lb wt (weight) gain in 1 day or 5 lb wt gain in 1 week. every day shift", "Omeprazole Capsule Delayed Release 40 MG Give 1 capsule by mouth one time a day for gerd", and "Torsemide Tablet 20 MG Give 1 tablet by mouth two times a day for fluid". Resident #19's eMAR's (electronic medication administration record) for the month of July 2021 were reviewed and contained entries as above. The entries for Torsemide and Omeprazole were not initialed as administered on 07/15, 07/21 and	F 684		

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F 684	Continued From page 59 07/24. Surveyor spoke with the DON on 08/02/21 at 1:35 pm regarding the omissions on the eMARS. DON stated that it was all from the same nurse, and that corrective action and education will be completed. Resident #19's weight record for the month of July was reviewed and indicated that the resident experienced a 5 lb weight increase from 07/14 to 07/15, a 7 lb weight increase from 07/20 to 07/21, and a 4 lb weight increase from 07/21 to 07/22. This also indicates an 11 lb weight increase over 2 days. Surveyor reviewed resident's nurse's progress notes and could not locate a note that indicated that the physician had been notified of the weight gain. Surveyor spoke with the facility physician on 08/03/21 at 2:30 pm. Surveyor asked the physician if they had been notified of Resident #19's weight gain, and the physician stated they did not recall being notified. The concern of not following Resident #19's physician's orders was discussed with the administrative team (administrator, director of nursing, regional vice-president of clinical services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm. No further information was provided prior to exit. 6. For Resident #13 the facility staff failed to follow physician's orders for the administration of the medication enoxaparin.	F 684		

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F 684	Continued From page 60 Resident #13's face sheet listed diagnoses which included but not limited to urinary tract infection, cerebral infarction, hemiplegia, and hemiparesis, dysphagia, hypertension, and acute and chronic respiratory failure. Resident #13's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 06/24/21 assigned the resident a BIMS (brief interview for mental status) score of 15 of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #13's clinical record was reviewed and contained a physician's order summary, which read in part "Enoxaparin Sodium Solution 40 mg/0.4 ml. Inject 40 mg subcutaneously one time a day related to cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery". Resident #13's eMAR (electronic medication administration record) for the month of May 2021 was reviewed and contained an entry as above. This entry was coded "9" on 05/07, 05/08 and 05/09/21. The chart code "9" is the equivalent of "other/see nurse's notes". Resident #13's nurse's notes for the above mentioned dates were reviewed and surveyor could not locate any notes for these dates. Surveyor spoke with the DON (director of nursing) regarding the missing documentation and DON could offer no explanation. The concern of not following the physician's order for the administration of the resident's medication was discussed with the administrative team (administrator, director of nursing, regional	F 684		

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vice-president of clinical services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm.

No further information was provided prior to exit.
7. For Resident #1, the facility staff failed to follow the physician's order for the administration of Famotidine, a medication used to decrease the amount of acid produced by the stomach and failed to complete skin assessments per the physician's order.

Resident #1's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Dominant Side, Essential (Primary) Hypertension, Gastro-Esophageal Reflux Disease without Esophagitis, and Aphasia following Cerebral Infarction.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/05/21 assessed the resident as being moderately impaired in cognitive skills for daily decision making with long-term memory loss. Resident #1 was unable to complete the BIMS (brief interview for mental status) interview. In section G, Functional Status, the resident was coded as requiring extensive assistance with bed mobility and being totally dependent on staff for transfers and personal hygiene. Resident #1 was coded as being at risk of developing pressure ulcers/injuries in section M, Skin Conditions.

A review of Resident #1's current physician's orders included an order dated 4/12/21 stating "Famotidine Tablet 20 MG give 1 tablet via PEG-Tube one time a day related to Gastro-Esophageal Reflux Disease without

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F 684	Continued From page 62 Esophagitis" and an order dated 5/20/21 stating "Weekly Skin Observations every day shift every Mon". A review of Resident #1's July 2021 MAR (medication administration record) revealed Famotidine was not initialed as being administered on 7/15/21 6:00 am, 7/21/21 6:00 am, and 7/24/21 6:00 am. On 8/02/21 at 1:34 pm, surveyor spoke with the DON (director of nursing) concerning the omissions for Famotidine and the DON stated they have looked into the omissions and all were by the same nurse and corrective action and education will be done. Surveyor reviewed Resident #1's clinical record on 8/01/21 and the most recent documented skin assessment was dated 6/29/21. Surveyor requested and received the facility policy entitled, "Skin Assessment" which states in part "A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter". On 8/03/21 at 1:18 pm, surveyor spoke with the Unit Manager regarding the missing weekly skin assessments. The Unit Manager stated it is "just the nurses not doing it" and they have tried two different plan of corrections but they did not work and "it's been trial and error". Surveyor was provided with a copy of a "Weekly Skin Review" dated 8/03/21 for Resident #1 stating "Resident noted to have blanchable redness to bilateral buttocks, skin dry/flaky on	F 684		

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feet and around peg site. Toe nail on third toe right foot dark in color. No additional areas of impairment noted."

The concern of Resident #1 not receiving Famotidine as ordered and weekly skin assessments not being completed as ordered was discussed with the administrator, director of nursing, Regional Vice President of Clinical Services, and the Regional Director of Operations during a meeting with the survey team on 8/04/21 at 5:20 pm.

No further information regarding these issues was presented to the survey team prior to the exit conference on 8/05/21.

8. For Resident #46, the facility staff failed to follow the physician's order for the administration of Renvela, a medication used to control serum phosphorus in patients with chronic kidney disease on dialysis.

Resident #46's diagnosis list indicated diagnoses, which included, but not limited to Acute Systolic (Congestive) Heart Failure, Chronic Obstructive Pulmonary Disease Unspecified, End Stage Renal Disease, Dependence on Renal Dialysis, Chronic Respiratory Failure with Hypoxia, Anemia in Chronic Kidney Disease, and Paranoid Schizophrenia.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 6/29/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, Cognitive Patterns.

Resident #46's current physician's orders

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F 684	Continued From page 64 included an order for "Renvela Tablet 800 MG (Sevelamer Carbonate) give 4 tablet by mouth before meals for Renal Failure/Dialysis related to End Stage Renal Disease". A review of Resident #46's July 2021 MAR (medication administration record) revealed Renvela was not initialed as being administered on 7/15/21 6:30 am, 7/21/21 6:30 am, and 7/24/21 6:30 am. On 8/02/21 at 1:34 pm, surveyor spoke with the DON (director of nursing) concerning the omissions for Renvela and the DON stated they have looked into the omissions and all were by the same nurse and corrective action and education will be done. On 8/04/21 at 5:20 pm, surveyor met with the administrator, director of nursing, Regional Vice President of Clinical Services, and the Regional Director of Operations and discussed the concern of Resident #46 not receiving Renvela as ordered on 7/15/21, 7/21/21, and 7/24/21. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/05/21. 9. For Resident #17, the facility staff failed to follow the physician's order for the administration of Levothyroxine, a thyroid medication used to treat hypothyroidism. Resident #17's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Left Non-Dominate Side, Cerebral Infarction due to Thrombosis of Right Vertebral Artery, Aphasia, Acute on Chronic Systolic (Congestive) Heart	F 684		

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F 684	Continued From page 65 Failure, Chronic Viral Hepatitis C, Hypothyroidism Unspecified, Unspecified Dementia without Behavioral Disturbance, and Dysphagia Following Cerebral Infarction. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/17/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, Cognitive Patterns. Resident #17's current physician's orders included an order dated 5/12/21 stating "Levothyroxine Sodium Tablet 100 MCG give 1 tablet by mouth one time a day". A review of the resident's July 2021 MAR (medication administration record) revealed Levothyroxine was not initialed as being administered on 7/15/21 6:00 am, 7/21/21 6:00 am, and 7/24/21 6:00 am. On 8/02/21 at 1:34 pm, surveyor spoke with the DON (director of nursing) concerning the omissions for Levothyroxine and the DON stated they have looked into the omissions and all were by the same nurse and corrective action and education will be done. Resident #17's current comprehensive person-centered care plan included a focus area stating "(Resident #17) has dx (diagnosis): hypothyroidism" with an intervention dated 4/19/20 to "Administer medications per MD orders. Report to MD abnormal side effects and effectiveness". On 8/04/21 at 5:20 pm, surveyor met with the administrator, director of nursing, Regional Vice President of Clinical Services, and the Regional	F 684		

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F 684	Continued From page 66 Director of Operations and discussed the concern of Resident #17 not receiving Levothyroxine as ordered on 7/15/21, 7/21/21, and 7/24/21. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/05/21. 10. For Resident #31, the facility staff failed to complete skin assessments per the comprehensive person-centered care plan. Resident #31's diagnosis list indicated diagnoses, which included, but not limited to Dementia in Other Diseases Classified Elsewhere without Behavioral Disturbance, Typical Atrial Flutter, Chronic Obstructive Pulmonary Disease Unspecified, Acute on Chronic Systolic (Congestive) Heart Failure, Primary Open-Angle Glaucoma Bilateral Severe Stage, and Unspecified Blepharitis Left Eye Upper and Lower Eyelids. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 6/17/21 coded the resident as being severely impaired with cognitive skills for daily decision making with short-term and long-term memory problems. Resident #31 was unable to complete the BIMS (brief interview for mental status) interview. In section G, Functional Status, the resident was coded as requiring extensive assistance with bed mobility, transfers, personal hygiene, and being totally dependent on staff for bathing. A review of Resident #31's comprehensive person-centered care plan revealed a focus area dated 3/14/12 stating "(Resident #31) has the	F 684		

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Continued From page 67

potential for pressure ulcer development related to urinary/bowel incontinence, requires assistance with adl's [sp] (activities of daily living), immobility" with an intervention dated 3/14/12 for "Weekly skin assessments by nursing staff. Notify MD if any skin impairment".

Surveyor reviewed Resident #31's clinical record on 8/02/21 and the most recent documented skin assessment was dated 7/01/21.

Resident #31's most recent Braden Scale for Predicting Pressure Sore Risk dated 12/17/20 assessed the resident as being "at risk".

Surveyor requested and received the facility policy entitled, "Skin Assessment" which states in part "A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter".

On 8/03/21 at 1:18 pm, surveyor spoke with the Unit Manager regarding the missing weekly skin assessments. The Unit Manager stated it is "just the nurses not doing it" and they have tried two different plan of corrections but they did not work and "it's been trial and error".

Surveyor was provided with a copy of a "Weekly Skin Review" dated 8/03/21 for Resident #31 stating "Resident noted to have blanchable redness under bilateral breast. No additional areas of impairment noted."

The concern of the weekly skin assessments not being completed for Resident #31 was discussed with the administrator, director of nursing, Regional Vice President of Clinical Services, and

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	Continued From page 68 the Regional Director of Operations during a meeting with the survey team on 8/04/21 at 5:20 pm. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/05/21.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and during the course of a complaint investigation, the facility staff failed to ensure residents with pressure ulcers receive necessary treatment and services to promote healing and prevent infection for 1 of 30 residents in the survey sample, Resident #108. The findings included: For Resident #108, the facility staff failed to treat an unstageable pressure area to the sacrum and	F 686	**F686** **1. Resident #108 discharged from the facility on 04/12/2021.** **2. Audit of current residents with pressure ulcers to ensure orders, measurements, and documentation is accurate.** **3. Education of Licensed Nursing staff on transcription of orders.** **4. DON and/or designee will conduct Monday - Friday audits of new orders x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.** **5. Date of Compliance: September 19, 2021.**	

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F 686	Continued From page 69 deep tissue injuries to the right malleolus, right heel, and left heel: 1) Greers Goo ordered but records do not consistently demonstrate that it was applied. 2) Treatment administration record records did not consistently demonstrate completed treatment 3) Although the physician stated resident was receiving treatment, receipt of treatment to the sacral pressure wound from discovery on readmission on 3/16/21 until 3/22/21 could not be demonstrated. This is harm. Resident #108's diagnosis list indicated diagnoses, which included, but not limited to Sepsis Unidentified Organism, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Dysphagia Oropharyngeal Phase, Pressure Ulcer of Sacral Region Unstageable, Dementia in Other Diseases Classified Elsewhere with Behavioral Disturbance, Chronic Obstructive Pulmonary Disease, Retention of Urine Unspecified, and Acute Respiratory Failure with Hypoxia. The most recent significant change MDS (minimum data set) with an ARD (assessment reference date) of 4/06/21 assigned the resident a BIMS (brief interview for mental status) score of 9 out of 15 in section C, Cognitive Patterns. Resident #108 was coded as requiring extensive assistance with bed mobility, dressing, toilet use, personal hygiene, and being totally dependent on staff for bathing. In section M, Skin Conditions,	F 686		

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the resident was coded for the presence of one unstageable pressure ulcer with slough and/or eschar present on admission or reentry and three unstageable pressure ulcers with deep tissue injury present on admission or reentry.

A review of Resident #108's closed clinical record revealed the following documentation:

Resident #108 was readmitted from (hospital name omitted) on 3/15/21. A nursing progress note dated 3/16/21 8:36 am states in part, "Admit skin assessment complete: Stage 2 and MASD (moisture-associated skin damage) to sacrum 11x5x0.1 ... . Treatments applied". Surveyor was unable to locate a treatment order for the Stage II pressure area. A physician's order dated 3/15/21 stated "Greers Goo apply 2 grams transdermally every 24 hours as needed for redness apply to buttocks". According to the resident's March 2021 MAR (medication administration record) and March 2021 TAR (treatment administration record), Greers Goo was never initialed by a nurse as being applied.

Resident #108 was assessed by the wound physician on 3/18/21 and the sacral wound had progressed from a Stage II to an unstageable area. The progress note states in part unstageable sacral pressure ulcer measuring 6 cm x 5.8 cm x 0.8 cm with small serosanguineous exudate, 60% slough, and 40% dermis. Treatment recommendations to the sacral pressure ulcer stated clean wound with wound cleaning spray daily and apply santyl to deeper slough area with foam cover every day and hydrocolloid to macerated periwound.

A "Weekly Pressure Wound Observation Tool"

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dated 3/19/21 described the sacral would as a stage "X" with slough tissue present and moist with scant amount of serosanguineous drainage. Wound measurement documented as 6 mm x 58 mm x 08 mm with periwound tissue described as macerated/denuded. The current treatment plan stated "clean with wound cleaner, apply santyl to wound bed, cover with foam. Hydrocolloid to macerated/denuded areas".

The first order for treatment to the sacral pressure ulcer was not until 3/19/21 with treatment to begin on 3/22/21. The physician's order dated 3/19/21 stated "Unstageable to sacrum: clean with wound cleaner, apply santyl, cover with foam/hydrocolloid to macerated area on buttocks every day shift for wound care". A review of Resident #108's March 2021 TAR (treatment administration record) revealed the first documented treatment to the unstageable area to the sacrum was recorded on 3/22/21. The treatment due to be completed on 3/23/21 was not initialed by the nurse as being completed. The treatment was initialed as being completed on 3/24/21.

On 8/04/21 at 1:45 pm, surveyor spoke with the wound nurse who stated Resident #108 was readmitted on 3/15/21 or 3/16/21 and the sacrum and buttocks were red to deep purple with a shallow open area, the treatment was hydrocolloid to the open area and Greer's Goo to the red area. The treatment nurse stated they wrote the treatment order down but failed to enter the order. The wound nurse further stated it was a "disconnect on my part" and they had just stepped into the position of wound nurse. The wound nurse stated they were the one addressing the sacral area and the treatment was done on

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F 686	Continued From page 72 3/18/21 and 3/19/21 but did not do the treatment on 3/20/21 or 3/21/21. Resident #108 was again seen by the wound physician on 3/25/21, the progress note describes the sacral pressure ulcer as unstageable, measuring 6.5 cm x 8 cm x 0.8 cm with small serosanguineous exudate, 20% slough and 80% necrotic. The wound progress was documented as "deteriorating". The treatment recommendation stated in part "needs ER evaluation for sacral wound infection for IV antibiotics cover loosely with DSD. Will follow up with additional wound care after patient returns from the hospital". A skin/wound progress note by the wound nurse dated 3/25/21 12:15 pm states in part "Wounds assessed and measured by (wound physician). Unstageable pressure ulcer to sacrum: 6.5x8x0.8 - Upon entering room odor noted coming from wound. (Wound physician) cleaned wound with wound cleaner and Dakin's to assess for need of debridement, when doctor wiping cleaning solution from wound black colored drainage noted. 80% necrotic, 20% slough, redness and edema note around wound. Infection suspected. (Wound physician) suggested for resident to be sent to ED for further evaluation and IV ABX (antibiotics)". Resident #108 was also seen by the facility physician on 3/25/21, progress notes states in part, "This (gentleman/lady) has sacral decubitus. Being followed by wound care nurse and wound care consultant, (name omitted). Wound care nurse asked me to evaluate the wound today. It has developed malodorous character. Also there has been rapid evolution of an eschar with some	F 686		

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F 686	Continued From page 73 erythema and induration. (He/she) has been afebrile. (He/she) has been having pain". "Sacral decubitus ulcer rapidly worsening. Necrotic tissue. Eschar. Likely infected. The rapid evolution raises concerns about possible necrotizing fasciitis. Cellulitis involving tissues about the sacral decubitus. Rapidly evolving. Concern regarding possible necrotizing fasciitis. Plan: Emergency transport to the emergency room. (He/she) is going to need stat labs. Likely needs IV antibiotics. Discussed the situation with director of nursing. EMS contacted." A subsequent nursing progress noted dated 3/25/21 12:22 pm states in part, "Resident is being sent out due to significant change in wound on sacrum. 911 was called". On 8/04/21 at 1:45 pm, the surveyor spoke with the Wound Nurse who stated they contacted the wound physician the day prior to their onsite visit concerning and wound appearance and the wound physician wanted to visualize the wound themselves. The Wound Nurse stated after assessing the sacral area on 3/25/21, the wound physician was concerned that the area was a Kennedy Ulcer or necrotizing fasciitis. On 8/05/21 at 11:53 am, surveyor met with the Resident #108's primary care physician while a resident at the facility and the wound physician concerning the resident's care. The wound physician stated the first time they saw Resident #108 the sacral wound had "a little slough" and when they saw the resident a week later the sacral wound was a little bigger with redness around the area and it looked like IV antibiotics were needed. Surveyor informed the physicians of Resident #108 not receiving treatment to the	F 686		

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sacral pressure wound from discovery on readmission on 3/16/21 until 3/22/21. The primary care physician stated the care was being provided, this was a process issue as they enter their own orders but the wound physician does not. The wound physician stated that the missing treatment of santyl to the sacral wound would not have changed a systemic infection and the resident's skin was very fragile.

On 8/02/21, Surveyor requested hospital records from (hospital name omitted) for the dates of 3/25/21 through 3/30/21 for Resident #108, the complete requested records were received on 8/30/21. The Hospitalist History and Physical dated 3/25/21 states in part "Upon presentation, found to be febrile with leukocytosis and suspected source of infection being sacral ulcer along with possibility of pneumonia based on CXR (chest x-ray)".

The Discharge Summary from (hospital name omitted) dated 3/30/21 10:57 am documents in part, Resident #108 was admitted on 3/25/21 and discharged on 3/30/21 with discharge diagnoses including, but not limited to sepsis 2/2 (secondary to) sacral ulcer, and sacral wound ulcer s/p (status post) debridement. The admission diagnosis was documented as pneumonia. The discharge summary states under the section "Hospital course", "Sepsis likely 2/2 sacral ulcer along with possible gram negative etiology pneumonia. Presented with fever, leukocytosis with neutrophil predominance, very elevated CRP/ESR with suspected sources including sacral ulcer (pictures in media section), as well as recurrent pneumonia". A CT of the abdomen and pelvis showed "bilateral peripheral infiltrates in the lower lungs" and "posterior sacral ulcer and

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subcutaneous edema without subcutaneous air. No bony erosion or osteomyelitis". "Surgery consulted for sacral ulcer; underwent debridement 3/26 surgical path and culture sent; no growth from culture; surgical path still pending" with "blood cultures x 2 NGTD (no growth to date)". Discharge wound care included "sacral wound: cleanse with saline moist saline gauze on top and a dry cover dressing".

Resident #108 was readmitted to the facility from the hospital on 3/30/21. A skin/wound progress note dated 3/31/21 8:34 am by the Wound Nurse states in part "Admission skin assessment complete: Unstageable to coccyx: 10x7x1.5, Right heel blister: 4x2x0, left heel stage I pressure: 4.2x2.8x0 .... Right lateral leg pressure: 10x1.5x0 .. ..Unstageable: Santyl, cover with bordered gauze, abrasions and stage 1 pressure, blisters: skin prep, cover with hydrocolloid for protection."

The previous physician's order dated 3/19/21 for the "unstageable to sacrum: clean with wound cleaner, apply santyl, cover with foam/hydrocolloid to macerated area on buttocks every day shift" was continued with readmission. This treatment order remained in effect until it was discontinued on 4/07/21. The treatment was not initialed by the nurse as being completed on 4/01/21.

On 8/04/21 at 1:45 pm, surveyor met with the wound nurse who stated on 3/31/21 following Resident #108's readmission from the hospital the sacral pressure had been debrided and the treatment was kept as Dakin's wet to dry. Surveyor asked the wound nurse if they could locate that treatment on the March 2021 or April

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2021 TAR and they stated "I could not".

Surveyor reviewed Resident #108's clinical record and was unable to locate treatment orders for the following areas noted on 3/31/21: right heel blister, left heel stage I, and right lateral leg pressure area. When speaking with the wound nurse on 8/04/21 at 1:45 pm, the wound nurse stated they "skin prepped" the areas to the left heel, right heel, and right malleolus because they were not open. The wound nurse stated they would check on the orders for these areas. The wound nurse returned to the surveyor at 2:25 pm and stated "I didn't put orders in for the other areas".

Resident #108 was seen by the NP (nurse practitioner) on 3/31/21, progress note states in part "seen toady following readmission to facility due to sepsis secondary to sacral wound with weakness ....During hospital stay, pts (patient's) sacral wound was debrided and (he/she) was on IV abx (antibiotic) therapy, converted to antibiotic via peg until 4/04 for 10 day course/also tx (treated) for aspiration PNA (pneumonia)".

Resident #108 was assessed by the wound physician on 4/01/21. The sacral pressure ulcer was described as unsteageable measuring 7.5 cm x 8.5 cm x 2.5 cm with undermining at 9-12 o'c: 1.5 cm. The wound bed was described as 60% granulation, 30% bone, and 10% subcutaneous with progress noted as "improving". The right lateral malleolus DTI was documented as 2.3 cm x 1 cm x 0 cm, closed with ecchymosis and erythema of the periwound. The right lateral heel DTI was documented as 0.9 cm x 0.9 cm x 0 cm, closed with ecchymosis and erythema of the periwound. The left medial heel DTI was

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F 686	Continued From page 77 documented as 3.5 cm x 1.6 cm x 0, closed with ecchymosis and erythema of the periwound. Treatment recommendations included: Sacral pressure ulcer - clean with wound cleaning spray, recommend NWPT (negative pressure wound therapy) 150mmHg, white foam on bone and undermined areas, black foam on rest, change Monday, Wednesday, and Friday; right lateral malleolus, right lateral heel, and left medial heel - cleanse, apply skin prep, honey hydrogel or hydrocolloid and heel boots daily. Surveyor reviewed Resident #108's clinical record and was unable to locate physician orders for the above recommendations from the wound physician on 4/01/21. The treatment to the sacrum continued as previously ordered on 3/19/21 that stated "unstageable to sacrum: clean with wound cleaner, apply santyl, cover with foam/hydrocolloid to macerated area on buttocks every day shift". This treatment order remained in effect until it was discontinued on 4/07/21. A physician's order dated 4/07/21 with a start date of 4/09/21 stated "Stage 4 Sacrum: NWPT 150 mmhg, continuous. Change M/W/F every day shift every Mon, Wed, Fri for wound care". According to the April 2021 TAR, this order was only initialed as being performed on 4/09/21. Surveyor was unable to locate treatment orders per the wound physician's recommendations for the areas to the right lateral malleolus, right lateral heel, or the left medial heel. While speaking with the wound nurse on 8/04/21 at 1:45 pm, they stated the wound vac was implemented on 4/01/21 and they changed the wound vac every Monday, Wednesday, and Friday. The wound nurse also stated honey hydrogel was being used on the right lateral	F 686		

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F 686	Continued From page 78 malleolus, right lateral heel, and the left medial heel. Resident #108 was reassessed by the wound physician on 4/08/21. The progress note states in part, stage 4 sacral pressure ulcer 7.5 cm x 8.5 cm x 3 cm with undermining 12-11 o'c 3 cm, with light serosanguineous exudate, 60 % granulation and 40% soft tissue, moderate odor and erythema of the periwound. Progress noted as "no change". DTIs to the right lateral heel and right lateral malleolus were noted as "improving". DTI to the left medial heel progress noted as "no change". During the visit, negative pressure Devon-extriCARE 3600 was applied to the sacral pressure ulcer. Treatment recommendations included: DTIs: cleanse, apply skin prep, hydrocolloid and heel boots daily; sacral pressure ulcer: cleanse with Dakin Solution 0.25% mmHg 150, black foam, white foam to undermined areas three times weekly Monday/Wednesday/Friday. A "Weekly Wound Pressure Wound Observation" dated 4/08/21 documents the current treatment plan to the sacral area as "NWPT 150mmhg. Change m/w/f - white foam covering bone and undermined areas, black foam on rest of wound. Again, the order for NWPT was not written until 4/07/21 with a start date of 4/09/21. A skin/wound progress note dated 4/09/21 10:46 am states in part "Unstageable: NWPT, abrasions and DTI: skin prep, cover with honey hydrogel for protection". Surveyor was unable to locate any treatment orders for the DTIs as documented in the progress note until 4/10/21. Treatment orders for the DTIs to the right malleolus, right heel, and left heel were not	F 686		

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F 686	Continued From page 79 ordered until 4/10/21. A physician's order dated 4/10/21 with a start date of 4/12/21 stated "DTI on Right malleolus, right heel, left heel, abrasion right elbow: Clean with wound cleaner, apply skin prep, hydrocolloid, cover with ABD and wrap every day shift every Mon, Wed, Fri for wound care". These treatments were scheduled to begin on 4/12/21 however, Resident #108 was sent out to the ER on 4/12/21. Therefore the TAR does not include documentation that treatments were ever administered to these areas since first noted on 3/31/21. A NP progress note dated 4/12/21 states in part "upon exam however pt is noted to be lethargic, diaphoretic, tachypnea present with respirations at 34. Pt is to be sent to ED for possible sepsis." A nursing progress note dated 4/12/21 12:12 pm states in part "Resident was observed by NP (name omitted). (He/she) suggested to send (him/her) out due to very lethargic, diaphoresis, and thought maybe septic. Nurse took vitals BP 187/120, HR 87, 02 (oxygen) 70-80s, Res (respirations) 22 temp 100.5". Resident #108 did not return to the facility. On 8/02/21, surveyor requested the resident's clinical records from (hospital name omitted), the complete requested records were received on 8/30/21. The "Emergency Department Note" dated 4/12/21 states in part "...numerous wounds found on skin check after initial assessment that all seem related to pressure wounds as they are located on the heels, elbows, cheek (noticeable indent with wound under nasal cannula), sacral. Patient also has had numerous bandages with underlying skin changes suggesting that they have been there for several days ... ...Social work	F 686		

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F 686	Continued From page 80 consulted for referral to APS (adult protective services) due to both provider and nursing concern that patient was not having adequate care (especially with inadequate turning to prevent pressure ulcers), social work reports that (adult child) is also concerned". Resident #108 ' s discharge diagnoses documented on the "Physician Discharge Summary" dated 4/22/21 included, but are not limited to Acute Hypoxic Respiratory Failure, Acute Right Lower Extremity DVT (deep vein thrombosis), Acute Subsegmental Pulmonary Embolism, Sepsis, Healthcare Associated Pneumonia, and Sacral Decubitus Ulcers Infection". Also included in the Discharge Summary was a clinical consult note dated 4/12/21 2140 (9:40 pm) which states in part "Sacral decubitus ulcer with pressure necrosis along the edges, fibrinous tissue in the base, no tracking, no evidence of necrotizing soft tissue infection, no purulent drainage. Wound vac removed to evaluate. There is some maceration of skin from vac and odor consistent with vac that has been in place over non-viable issue [sp] for 2-3 days. Would avoid vac when there is non-viable tissue present in the wound base. Sacral wound is not a source of sepsis, but could stand some debridement to aid with wound care". On 8/05/21 at 11:53 am, while meeting with Resident #108's primary care physician at the facility and the wound physician, surveyor also informed the physicians of Resident #108's DTIs noted on 3/31/21 with treatment not being ordered until 4/10/21, the primary care physician again stated this is not a care issue, it is a process issue. Surveyor informed the physicians that the order for the wound vac was not dated until 4/07/21 and was only initialed as being changed one time on 4/09/21. The wound	F 686		

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F 686	Continued From page 81 physician stated the wound nurse did a great job changing the wound vac. Resident #108's comprehensive person-centered care plan included a focus area created on 3/22/21 and revised on 4/09/21 stating "The resident has pressure ulcer to sacrum and has the potential for further pressure ulcer development r/t poor mobility, incontinence" with an intervention to "administer treatments as ordered and monitor for effectiveness", and the intervention of "wound vac to area per MD orders" was dated 4/09/21. Surveyor was unable to locate documentation on the resident's care plan related to the DTIs to the resident's right malleolus, right heel, or the left heel. Surveyor requested and received the facility policy entitled, "Wound Treatment Management" which states in part: 1. Wound treatments will be provided in accordance with physician's orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in absence of the treatment nurse. 7. Treatments will be documented on the Treatment Administration Record. Surveyor requested and received the facility policy entitled, "Pressure Injury Prevention and Management" which states in part:	F 686		

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F 686	Continued From page 82	F 686		

2. The facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate.

4. Interventions for Prevention and to Promote Healing

a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant

care plan that includes measurable goals for prevention and management of pressure injuries with

appropriate interventions.

d. Evidence-based treatments in accordance with current standards of practice will be provided for all

residents who have a pressure injury present.

f. Interventions will be documented in the care plan and communicated to all relevant staff.

On 8/04/21 at 5:20 pm, surveyor met with the administrator, director of nursing, Regional Vice President of Clinical Services, and the Regional Director of Operations and discussed the concern of Resident #108 not receiving treatments as ordered to an unstageable pressure area to the sacrum and deep tissue injuries to the right malleolus, right heel, and left heel. The Regional

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F 686	Continued From page 83 Vice President of Clinical Services stated they would review the documentation. The following morning at 8:51 am, surveyor met with the Regional Vice President of Clinical Services and who stated they were unable to find any additional documentation. They further stated that the wound nurse had started the job a week prior and thought the doctor put the orders in. According to the CMS-671 form completed by the facility staff at the time of the survey, the facility reported six (6) current residents with pressure ulcers at a stage II or greater. During the course of the survey, the survey team investigated three current residents and one discharged resident with pressure ulcers. No additional concerns were identified with pressure ulcers. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/05/21. This is a complaint deficiency.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		

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F 690	Continued From page 84 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review the facility staff failed to provide catheter services for 3 of 30 residents, Resident #32, Resident #48 and Resident #14. The findings included: 1. For Resident #32 the facility staff failed to anchor the catheter tubing Resident #32's face sheet listed diagnoses which included but not limited to hemiplegia, type II diabetes mellitus, acute kidney failure, aphasia, anxiety, depression, retention of urine, anemia,	F 690	**F690** 1. **Resident #32: catheter discontinued 08/12/2021.** **Resident # 48: Catheter anchor to resident** **and catheter care provided.** **Resident # 14: Catheter anchor to resident.** 2. **Audit of current residents with foley catheters to ensure orders for catheter care and anchoring of tubing.** 3. **Education of Licensed Nursing staff on catheter care including anchoring of tubing to resident.** 4. **DON and/or designee will conduct weekly audits of residents with indwelling catheter x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.** 5. **Date of Compliance:** September 19, 2021.	

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F 690	Continued From page 85 dysphagia and adult failure to thrive. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) 06/17/21 failed to assign the resident a BIMS (brief interview for mental status) score, in section C, cognitive patterns. The quarterly MDS with an ARD date of 03/31/21 assigned the resident a BIMS score of 8 out of 15 in section C. This indicates that the resident is moderately cognitively impaired. Resident #32's clinical record was reviewed on 08/01/21. It contained a physician's order summary for the month of August, which read in part "Check placement of catheter strap every shift every shift for catheter care" Resident #32's eTAR (electronic treatment administration record) for the month of August 2021 was reviewed and contained an entry as above. This entry was initialed as completed. Surveyor observed Resident #32 on 08/01/21 at 12:40 pm, along with LPN (licensed practical nurse) #1. Surveyor asked LPN #1 if Resident #32's catheter tubing was anchored and LPN #1 stated that it was not. Surveyor asked LPN #1 if catheter tubing should be anchored, and LPN #1 stated that it should be. Surveyor requested and was provided with a facility policy entitled "Catheter Care, Urinary" which read in part, "2. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.)"	F 690		

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The concern of the resident's catheter tubing not being anchored was discussed with the administrative team (administrator, director of nursing, regional vice-president of clinical services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm.

No further information was provided prior to exit.

2. For Resident #48 the facility failed to anchor the catheter tubing and failed to ensure catheter care was completed.

Resident #48's face sheet listed diagnoses which included but not limited to mechanical complication of indwelling urethral catheter, obstructive and reflux uropathy, history of urinary tract infections, dementia, congestive heart failure, dysphagia, hypertension and retention of urine.

The most recent comprehensive MDS (minimum data set) with an ARD (assessment reference date) of 06/21/21 assigned the resident a BIMS (brief interview for mental status) score of 0 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired.

Resident #48's comprehensive care plan was reviewed and contained a care plan for "...has a long hx (history) of bladder kidney related issues, including kidney stones, infections requiring foley catheter to be replaced..."

Resident #48's clinical record was reviewed and contained a physician's order summary for the month of August 2021, which read in part "Check placement of catheter strap every shift every shift for placement", Change catheter drainage bag

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F 690	Continued From page 87 every 30 days and as needed. Label with date changed, every day shift every 30 day(s) for infection control", "Indwelling urinary (Foley) catheter is in privacy bag and catheter leg strap on at all times" and "Indwelling Urinary Catheter Care: cleanse with soap and water every shift every shift for infection control". Resident #48's eTAR (electronic treatment administration record for the month of August 2021 was reviewed and contained entries as above. The entries had been initialed as having been completed on 08/01/21. Surveyor observed Resident #48 on 08/01/21 at 10:05 am. Surveyor noted a large puddle of liquid under resident's bed that appeared to originate from the area under the catheter drainage bag. Surveyor again observed Resident #48 on 08/01/21 at 12:55 pm, along with LPN (licensed practical nurse) #1. Surveyor asked LPN #1 if resident's catheter tubing was anchored, and LPN #1 stated that is was not. Surveyor asked LPN #1 if tubing should be anchored, and LPN #1 stated that it should be. On the morning of 08/02/21 at approximately 8:20 am, surveyor asked LPN #2 who is responsible for completing catheter care on residents and LPN #2 stated "The nurse's, I guess?". Surveyor then asked LPN #2 how often catheter care was to be done, and LPN #2 stated "I'm not sure, it's in the computer". Surveyor requested to observe catheter care on Resident #48. At approximately 10:00 am, surveyor reminded LPN #2 that they wished to observe catheter care on Resident #48, and LPN #2 stated, "I won't forget". Surveyor observed Resident #48 on 08/02/21 at 11:30 am, along with DON (director of nursing). Resident	F 690		

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F 690	Continued From page 88	F 690		

was resting in bed, fully dressed in street clothes. Surveyor informed DON that they had requested to observe catheter care this AM.

On 08/03/21 at 9:15 am, surveyor observed LPN #3 and CNA (certified nurse's aide) #1 while performing catheter care on Resident #48. While performing catheter care, LPN #1 laid the catheter drainage bag on the bed beside resident. While turning the resident, the catheter bag fell to the floor. LPN #3 then picked the bag up from the floor and placed it back on the bed. Surveyor asked LPN #3 how often catheter care was performed and LPN #3 stated, "It's done daily and as needed".

Surveyor observed Resident #48 on 08/04/21 at 10:40 am along with DON. Surveyor pointed out a large puddle of liquid under resident's bed to DON and DON stated "Again", and then stated to surveyor that resident's catheter bag is leaking. DON also stated that the bag had been leaking earlier in the week and just been changed on Sunday (08/01/21).

Surveyor requested and was provided with a facility policy entitled "Catheter Care, Urinary", which read in part "Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Maintaining Unobstructed Urine Flow: 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Infection Control: B. Be sure catheter tubing and drainage bag are kept off the floor. Changing Catheters: 2. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note:

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F 690	Continued From page 89 Catheter tubing should be strapped to the resident's inner thigh". The concern of not providing catheter care was discussed with the administrative team (administrator, director of nursing, regional vice-president of clinical services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm. No further information was provided prior to exit. 3. For Resident #14 the facility staff failed to anchor the catheter tubing. Resident #14's face sheet listed diagnoses which included but not limited to Huntington's Disease, obstructive and reflux uropathy, anxiety, depression, dysphagia, hypertension, and history of urinary tract infections. Resident #14's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/26/21 assigned the resident a BIMS (brief interview for mental status) score of 99. This indicates that the resident was unable to complete the interview due to being severely cognitively impaired. Resident #14's comprehensive care plan was reviewed and contained a care plan for "At risk for Urinary Tract infection due to hx (history) of chronic indwelling foley catheter". Interventions for this care plan includes "Provide foley catheter care and keep skin clean and dry". Resident #14's clinical record was reviewed and contained a physician's order summary, which read in part "Check placement of catheter strap	F 690		

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F 690	Continued From page 90 every shift every shift for monitoring". Resident #14's eTAR (electronic treatment administration record) for the month of August 2021 was reviewed and contained an entry as above. This entry was initialed as completed. Surveyor observed Resident #14 on 08/01/21 at 10:05 am. Resident was resting in bed, catheter drainage bag was observed hanging from side of bed, and only partially covered. Surveyor again observed Resident #14 on 08/01/21 at 12:55 pm, along with LPN (licensed practical nurse) #1. Surveyor asked LPN #1 if resident's catheter tubing was anchored, and LPN #1 stated that is was not. Surveyor asked LPN #1 if tubing should be anchored, and LPN #1 stated that it should be. Surveyor requested and was provided with a facility policy entitled "Catheter Care, Urinary", which read in part "Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Maintaining Unobstructed Urine Flow: 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Infection Control: B. Be sure catheter tubing and drainage bag are kept off the floor. Changing Catheters: 2. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh". The concern of the resident's catheter tubing not being anchored was discussed with the administrative team (administrator, director of nursing, regional vice-president of clinical	F 690		

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F 690	Continued From page 91 services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm. No further information was provided prior to exit.	F 690	**F691** 1. **Resident #30: colostomy supplies were ordered and are on site.** 2. **Audit of current ostomy resident's supplies to ensure adequate stock.** 3. **Education of Central Supply clerk on timely ordering of adequate supplies to ensure resident do not go without.** 4. **Central Supply Clerk will conduct weekly audits of ostomy supplies x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.** 5. **Date of Compliance: September 19, 2021.**	
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and in the course of a complaint investigation the facility staff failed to ensure 1 of 30 residents received the necessary care and treatment in regards to a colostomy. Resident #30 The findings included: The facility staff failed to ensure Resident #30 had colostomy supplies. The clinical record included the diagnoses, quadriplegia, chronic pain syndrome, personality disorder, antisocial personality disorder, major depressive disorder, and insomnia. Section C (cognitive patterns) of Resident #30's significant change (MDS) minimum data set assessment with an (ARD) assessment reference date of 06/09/2021 included a (BIMS) brief	F 691		

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F 691	Continued From page 92 interview for mental status summary score of 15 out of a possible 15 points. Section G (functional status) was coded to indicate the resident was totally dependent on two persons for bed mobility, transfers, dressing, toilet use, and personal hygiene. Section H (bladder and bowel) was coded to indicate the resident had a colostomy. Resident #30's comprehensive care plan included the focus area has a colostomy. Activity of daily living self-care performance deficit related to quadriplegia. 08/01/21 10:57 a.m., Resident #30 stated the facility had run out of their colostomy supplies and they had called the hospital where they had previously been admitted and asked an agency nurse (no name given) to go to the hospital to pick up the supplies. 08/03/21 2:45 p.m., (CNA) certified nursing assistant #1 stated there was one occurrence where they were unable to find colostomy supplies for this resident. They had to wait until someone found colostomy supplies and until they did, they had to leave this resident in the bed. A plastic bag was placed under the resident until they obtained the colostomy supplies. 08/04/21 5:14 p.m., during an end of the day meeting with the Administrator, (DON) director of nursing, Regional Vice President of Clinical Services, and the Regional Director of Operations the Administrator stated they were not aware the resident had run out of colostomy supplies. This is a complaint deficiency.	F 691		
F 692 SS=D	Nutrition/Hydration Status Maintenance	F 692		

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F 692

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CFR(s): 483.25(g)(1)-(3)

§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on interviews and the review of documents, it was determined the facility staff failed to address a weight loss for one (1) of 30 sampled residents (Resident #33).

The findings include:

The facility staff failed to address Resident #33's weight loss when the resident's weight dropped below the care planned goal to keep weight greater than 113 pounds.

Resident #33's minimum data set (MDS) assessment, with an assessment reference date

F 692

F692

1. **Resident #33 reweighed and weight loss addressed by MD.**
2. **Audit of past 30 days of current residents' weight for MD and family notification of changes.**
3. **Education of Licensed Nursing and Certified Nurses Assistants on obtaining, entering, and monitoring daily, weekly, and monthly weights.**
4. **Weekly audits of weights x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.**
5. **Date of Compliance: September 19, 2021.**

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(ARD) of 6/17/21, was signed as completed on 6/24/21. Resident #33 was assessed as sometimes able to make self understood and as sometimes able to understand others. The resident was assessed as having problems with short-term and long-term memory. Resident #33 was assessed as requiring extensive assistance with bed mobility, transfers, dressing, and personal hygiene. Resident #33 was assessed as being dependent on staff for toilet use and bathing. Resident #33's diagnoses included, but were not limited to: high blood pressure, Alzheimer's disease, dementia, depression, anxiety, and vision problems.

Resident #33's clinical record included the following weights:
- On 1/7/21, the resident's weight was 113 pounds.
- On 4/12/21, the resident's weight was 114 pounds.
- On 5/5/21, the resident's weight was 116 pounds.
- On 6/4/21, the resident's weight was 112.8 pounds.
- On 7/7/21, the resident's weight was 107.6 pounds.

Review of Resident #33's clinical record failed to reveal a provider notification of the resident's weight decreasing to 107.6 pounds. On 8/4/21 at 1:51, the facility's MDS Nurse was asked about the facility staff's response to the resident's weight decreasing to 107.6 pounds. The MDS nurse reported action was not taken on the weight loss due it not meeting the criteria for a significant weight loss. The weight loss was not greater than 5% during a one (1) month period or 7.5% in a three (3) month period.

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Resident #33 was weighed on 8/4/21 at 2:46 p.m. The resident's weight was 106.4 pounds. The following progress notes were documented:
- On 8/4/21 at 3:49 p.m., "Care plan updated for (Resident #33). Weight loss notification was sent to Registered Dietitian. Waiting on recommendations ..."
- On 8/4/21 at 4:04 p.m., "(resident) has a weight loss of 7.5% (provider's name omitted) has been notified with no new orders (registered dietitian) has been notified (resident's responsible party) aware".

The following information was found in a facility policy titled "Weight Monitoring" (with a revised/reviewed date of 10/28/20):
- "Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preference indicate otherwise."
- "Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem."
- "Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status."

Resident #33's care plan included a focus that addressed the resident's nutritional needs. This

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F 692	Continued From page 96 focus included the goal of "(the resident) will not have a decrease in (oral) intake, maintain weight (greater than) 113 pounds." The care planned focus included the following intervention: "Weigh per facility protocol/MD orders and monitor for any significant weight changes." On 8/5/21 at 9:18 a.m., the failure of the facility staff to address Resident #33's weight loss, when the resident's weight dropped below the care planned goal to keeping their weight greater than 113 pounds, was discussed during a survey team meeting with the facility's Administrator, Director of Nursing (DON), Regional Vice-President of Clinical Services, and Regional Director of Operations.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding	F 693		

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including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility staff failed to follow physician orders in regards to tube feedings for 2 of 30 residents, Residents #40 and #32.

The findings included:

1. For Resident #40, the facility staff failed to ensure the residents tube feeding was set at the prescribed physician ordered rate of 75cc/hour.

Resident #40's (EHR) electronic health record included the diagnoses, chronic respiratory failure, diabetes, dysphagia, and epilepsy.

Section C (cognitive patterns) of Resident #40's admission (MDS) minimum data set assessment with an (ARD) assessment reference date of 06/21/21 had been coded (0/1/1) to indicate the resident had problems with long term memory and had modified independence in cognitive skills for daily decision making. Section K (swallowing/nutritional status) was coded to indicate Resident #40 had a feeding tube.

The Residents comprehensive care plan included the focus area requires tube feeding for 100% nutrition.

The (EHR) electronic health record included a physician order to administer promote per peg via pump at 75cc/hour continuous.

08/01/21 12:51 p.m., observed resident resting on

F 693

F693

1. **Resident #40: discharged from the facility on 08/16/2021.**
   Resident #32: Enteral feed order was clarified with MD and tube feeding adjusted to comply with order.
2. **Audit of current resident on enteral feed to ensure accurate orders.**
3. **Education of Licensed Nursing staff on continuous vs intermittent feed orders.**
4. **Monday – Friday audits of enteral feed orders x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.**

5. **Date of Compliance: September 19, 2021.**

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bed, tube feeding running at 65cc/ hour.

08/01/21 3:10 p.m., observed tube feeding running at 65cc/hour. Checked by (LPN) licensed practical nurse #4 who stated it should be at 75cc and adjusted the rate.

08/04/21 05:14 p.m., the Administrator, (DON) director of nursing, Regional Vice President of Clinical Services, and the Regional Director of Operations were made aware of the issue regarding Resident #40's tube feeding rate.

No further information regarding the residents tube feeding was provided to the survey team prior to the exit conference.

2. For Resident #32 the facility staff failed to follow tube feeding orders.

Resident #32's face sheet listed diagnoses which included but not limited to hemiplegia, type II diabetes mellitus, acute kidney failure, aphasia, anxiety, depression, retention of urine, anemia, dysphagia and adult failure to thrive.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) 06/17/21 failed to assign the resident a BIMS (brief interview for mental status) score, in section C, cognitive patterns. The quarterly MDS with an ARD date of 03/31/21 assigned the resident a BIMS score of 8 out of 15 in section C. This indicates that the resident is moderately cognitively impaired.

Resident #32's comprehensive care plan was reviewed and contained a care plan for "...requires tube feeding due to CVA

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F 693	Continued From page 99 (cerebrovascular accident) with dysphagia and aphasia". Surveyor observed Resident #32 on 08/01/21 at 10:10 am. Resident was resting in bed. Surveyor observed tube feeding of Osmolite 1.5 running via infusion pump at a rate of 65 cc/hour. Resident #32's clinical record was reviewed and contained a physician's order summary, which read in part "Enteral Feed Order every evening and night shift for nutrition needs Enteral 1 - Feeding: Administer Osmolite 1.5 per PEG (percutaneous endoscopic gastrostomy) via Pump, Rate 65 mLs/hour". Resident #32's eMAR (electronic medication administration record)/eTAR (electronic treatment administration record) for the month of August 2021 were reviewed. Surveyor could not located an enteral feed order on the August eMAR/eTAR. Resident #32's eMAR for the month of July 2021 were reviewed and contained an entry, which read in part "Enteral Feed Order every shift OSMOLITE 1.5 50 cc hour -Start date-07/30/20211900 -D/C (discontinue) Date-07/30/2021 1041". This entry was not initialed as having been done. Surveyor spoke with the regional vice-president of clinical services (RVPCS) on 08/03/21 regarding Resident #32's tube feeding orders. RVPCS stated that resident's original enteral feed order was Glucerna 1.5 at 65 cc/hour x 16 hours/day. This order started on 02/24/21 and ended on 07/20/21, when the resident was hospitalized. RVPCS stated when resident returned from the hospital, there was no evidence that the enteral feed order was re-instated. RVPCS stated the	F 693		

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enteral feed order for Osmolite 1.5 at 65 cc/hour was written on 07/30/21, "but for some reason did not populate to the MAR". This order was discontinued on 08/02/21 and the current order of Glucerna 1.5 at 65 cc/hour x 16 hours/day entered.

RVPCS provided the surveyor with a copy of an "Order Recap Report" for Resident #32, which read in part "Commercial Supplement every shift for supplement Glucerna 1.5 @ 65 ml/hr for 16 hrs (3p-7a) with 150 ml flush q (every) 4 hr Start Date 02/2420/21 End Date of 02/20/2021", "Enteral Feed Order every evening and nigh shift for nutrition needs Enteral 1-Feeding: Administer osmolite 1.5 per PEG via pump. Rate 65 mLs/hour Start Date 07/30/2021 End Date 08/02/2021" and "Enteral Feed Order two times a day for nutrition Enteral-1-Feeding: Administer Glucerna 1.5 per (Specify: PEG via Pump. Rate: 65 mLs/hour, up at 3 pm down at 7 a Start Date 08/03/2021".

Surveyor observed Resident #32 on 08/04/21 at 8:45 am. Resident was resting in bed, enteral tube feeding of Glucerna 1.5 running via pump at 65 cc/ hour. Surveyor, along with DON (director of nursing) again observed Resident #32 on 08/04/21 at 10:45 am. Resident was resting in bed with enteral feeding of Glucerna 1.5 running via pump at 65 cc/hour. Surveyor asked DON to confirm resident tube feeding order. After confirming order, DON stated the feeding should not be running and stated they would take it down "right now".

The concern of the facility staff not follow physician's orders in regards to Resident #32's tube feedings was discussed with the

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F 693	Continued From page 101 administrative team (administrator, director of nursing, regional vice-president of clinical services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm. No further information was provided prior to exit.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review the facility staff failed to maintain respiratory equipment for 1 of 30 residents, Resident #19. The findings included: For Resident #19 the facility staff failed to store the resident's respiratory equipment in a manner to prevent contamination. Resident #19's face sheet listed diagnoses which included but not limited to acute and chronic respiratory failure, congestive heart failure, chronic obstructive pulmonary disease, chronic kidney disease, atrial fibrillation, gastroesophageal reflux disease and depression.	F 695	**F695** 1. **Resident #19: Nebulizer mask and tubing disposed of and new set provided with plastic bag provided for storage.** 2. **Audit of current residents with nebulizer and O_2 treatments to ensure proper storage and labeling of equipment.** 3. **Education of Licensed Nursing staff on policy and procedure for storage of nebulizer equipment.** 4. **Weekly audits of new orders x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.** 5. **Date of Compliance: September 19, 2021.**	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROANOKE	324 KING GEORGE AVE SW ROANOKE, VA 24016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 102 Resident #19's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 06/02/21 assigned the resident a BIMS (brief interview for mental status) score of 11 out of 15. This indicates that the resident is cognitively intact. Resident #19's clinical record was reviewed and contained a physician's order summary which read in part "Ipratropium-Albuterol Solution 0.5-2/5 (3) MG/ML 1 application inhale orally every 4 hours as needed for sob/wheezing". Surveyor observed Resident #19 on 08/01/21 at 12:50 pm. Resident was resting in bed. Surveyor observed nebulizer machine, mask and tubing resting on resident's overbed table. Surveyor again observed Resident #19 on 08/01/21 at 2:50 pm and 4:40 pm. Both times, surveyor observed resident's nebulizer mask and tubing lying uncovered on the overbed table. On 08/02/21 at 8:05 am, surveyor, along with DON observed Resident #19's nebulizer mask lying uncovered on the overbed table. Surveyor asked the DON if the mask should be stored in this manner, and DON stated that it should not. DON also stated that they would replace the mask and tubing and provide a bag for it to be placed in. Surveyor requested and was provided with a copy of a facility policy entitled "Administering Medications through a Small Volume (Handheld) Nebulizer" which read in part, "29. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it." The concern of maintaining the resident's	F 695		

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F 695	Continued From page 103 respiratory equipment was discussed with the administrative team (administrator, director of nursing, regional vice-president of clinical services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm. No further information was provided prior to exit.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews and the review of documents, it was determined the facility staff failed to provide a pain medication as ordered by the provider for one (1) of 30 sampled residents (Resident #34). The findings include: The facility staff failed to administer Resident #34's medication, to address pain, as ordered by the provider. Resident #34's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 5/21/21, was signed as completed on 6/11/21. Resident #34 was assessed as able to make self understood and as able to understand others. Resident #34's Brief Interview for Mental Status (BIMS) summary score was documented as 15 out of 15. Resident #34 was assessed as	F 697	**F697** 1. **Resident #34: Order was clarified for administration.** 2. **Audit of current residents MARs / TARS for missed pain medication administration.** 3. **Education of Licensed Nursing staff on pain management and professional standards of practice.** 4. **Monday - Friday audits of MARS x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.** 5. **Date of Compliance: September 19, 2021.**	

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F 697	Continued From page 104	F 697		

requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #34's diagnoses included, but were not limited to: high blood pressure, seizures, anxiety, depression, and lung disease.

During an interview on 8/1/21 at 11:00 a.m., Resident #34 reported that approximately a month ago, a medication (gabapentin) was not provided as ordered. Resident #34 reported this medication was used to treat their pain.

Resident #34's clinical record included a provider order, dated 2/17/21, for gabapentin 300mg one (1) capsule a day; this was scheduled for 2:00 p.m. This medication was documented as being ordered for "POLYNEUROPATHY". (Polyneuropathy is a condition affecting an individual's nerves that can result in numbness, weakness, and/or pain.)

Resident #34's clinical record included a provider order, dated 2/17/21, for gabapentin 300mg two (2) capsules twice a day; this was scheduled for 8:00 a.m. and 9:00 p.m. This medication was documented as being ordered for "seizures/pain".

Review of Resident #34's medication administration records (MARs), clinical documentation, and medication count records indicated the resident's gabapentin was not administered as ordered/scheduled on:
- 5/1/21 at 8:00 a.m.; this was a 600mg dose,
- 5/1/21 at 2:00 p.m.; this was a 300mg dose,
- 5/1/21 at 9:00 p.m.; this was a 600mg dose,
- 5/31/21 at 9:00 p.m.; this was a 600mg dose,
- 6/1/21 at 8:00 a.m.; this was a 600mg dose, and
- 6/1/21 at 2:00 p.m.; this was a 300mg dose.

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F 697	Continued From page 105 Resident #34's care plan included the following focus: "(resident) is at risk for alteration in comfort (related to) migraine headache, neuropathic pain." This care planned focus included 'medicate as ordered' as an intervention. On 8/3/21 at 11:05 a.m., the failure of the facility staff to administer the aforementioned doses of gabapentin was discussed with the Regional Vice-President of Clinical Services. The failure of the facility staff to provide Resident #34's medications as ordered/scheduled was discussed with the Administrator, Director of Nursing (DON), Regional Vice-President of Clinical Services, and the Regional Director of Operations on 8/5/21 at 9:18 a.m. Please see F842 for information related to medication count records and MAR documentation accuracy.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §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, clinical record review, and facility document review, the facility staff failed to coordinate care with the contracting dialysis center for 2 of 30 residents in the survey sample, Resident #46, and #49.	F 698		

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F 698	Continued From page 106 The findings included: 1. For Resident #46, the facility staff failed to complete dialysis communication forms prior to dialysis treatments. Resident #46's diagnosis list indicated diagnoses, which included, but not limited to Acute Systolic (Congestive) Heart Failure, Chronic Obstructive Pulmonary Disease Unspecified, End Stage Renal Disease, Dependence on Renal Dialysis, Chronic Respiratory Failure with Hypoxia, Anemia in Chronic Kidney Disease, and Paranoid Schizophrenia. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 6/29/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, Cognitive Patterns. A review of Resident #46's active physician's orders included an order dated 5/21/21 for outpatient hemodialysis on Tuesdays, Thursdays, and Saturdays. On 8/02/21, surveyor reviewed Resident #46's clinical record and the most recent Dialysis Communication form located in the clinical record was dated 12/24/20. Surveyor requested and was provided with copies of dialysis communication forms for Resident #46 dated 3/04/21 through 7/31/21. Of the 54 provided dialysis communication forms, 44 forms were blank in the section to be completed by facility staff prior to dialysis and sent with the resident to the dialysis center. This section on the communication forms dated 3/04/21 through 5/13/21 and 7/10/21 through 7/31/21 documents	F 698	**F698** 1. **Resident #46: Dialysis Communication Form completed. Resident #49: Dialysis Communication Form completed.** 2. **Audit of current dialysis residents to ensure Dialysis Communication Forms are in place and completed.** 3. **Education of Licensed Nursing staff completion of Dialysis Communication Form.** 4. **Weekly audits of Dialysis Communication Forms x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.** 5. **Date of Compliance: September 19, 2021.**	

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F 698	Continued From page 107 information on antibiotic use, isolation, pre-dialysis vital signs, medications, diabetic, and blood sugar. A different communication form entitled "Dialysis Communication Form" was used from 5/15/21 through 7/01/21, this section documents information on meal provided to take to dialysis, medications required before dialysis, change in condition before going to dialysis, and medications to be given during dialysis. In addition to the provided dialysis communication forms, the facility also provided an in-service sign-in sheet dated 8/03/21 for the subject of "Dialysis Communication" with a blank copy of a dialysis communication form stapled to the back and signed by eight nurses in attendance. Surveyor requested and received the facility policy entitled, "Care of a Resident with End-Stage Renal Disease" which states in part: 4. Agreements between this facility and the contracted ESRD (end-stage renal disease) facility include all aspects of how the resident's care will be managed, including: b. How information will be exchanged between the facilities The concern of the incomplete dialysis communication forms for Resident #46 was discussed with the administrator, director of nursing, Regional Vice President of Clinical Services, and the Regional Director of Operations on 8/04/21 at 5:20 pm. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/05/21. 2. The facility staff failed to complete Resident #49's dialysis communication forms prior to	F 698		

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F 698	Continued From page 108 dialysis treatments. Resident #49's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 7/13/21, was signed as completed on 7/16/21. Resident #49 was assessed as able to make self understood and as able to understand others. Resident #49's Brief Interview for Mental Status (BIMS) summary score was documented as 15 out of 15. Resident #49 was assessed as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #49's diagnoses included, but were limited to: anemia, heart disease, high blood pressure, kidney disease, diabetes, and lung disease. Resident #49's clinical record included a medical provider order for outpatient hemodialysis. Resident #49's clinical record included multiple "Dialysis Communication" forms. This form included an area for the facility to complete prior to the resident going to the dialysis provider and an area for the dialysis provider to complete prior to the resident returning to the facility. The section of the form to be completed by the facility included the following information: - antibiotic use, - isolation status, - pre-dialysis vital signs, - medications received during the day prior to dialysis, - whether or not the resident was diabetic (if diabetic what was the most recent finger stick blood sugar and how much insulin was provided), and - a "comments" area for any additional information.	F 698		

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F 698	Continued From page 109 Review of Resident #49's clinical record revealed the facility staff members failed to complete their section of this form prior to the resident going to dialysis on the following dates: 5/24/21; 5/26/21; 5/31/21; 6/2/21; 6/7/21; 6/21/21; 6/23/21; 6/25/21; and 7/19/21. The findings of the incomplete dialysis communication forms for Resident #49 was discussed with the Administrator, Director of Nursing (DON), Regional Vice-President of Clinical Services, and the Regional Director of Operations on 8/05/21 at 9:18 a.m.	F 698		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756	**F756** 1. **Resident # 13: Review of current MAR for duplication of medications with issues being corrected.** 2. **Audit of current resident's MRR to ensure all note medication irregularities are addressed in a timely manner.** 3. **Education of Licensed Nursing staff on order entry.** 4. **Weekly audits of MARS x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.** 5. **Date of Compliance: September 19, 2021.**	

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F 756	Continued From page 110	F 756		

(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review the facility staff failed to identify and report medication irregularities for 1 of 30 residents, Resident #13.

The findings included:

For Resident #13 the facility staff failed to identify multiple orders for the mediations aspirin and escitalopram on the physician's order summary and eMAR (electronic medication administration record).

Resident #13's face sheet listed diagnoses which included but not limited to urinary tract infection, cerebral infarction, hemiplegia, and hemiparesis, dysphagia, hypertension, and acute and chronic respiratory failure.

Resident #13's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 06/24/21 assigned the resident

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F 756	Continued From page 111	F 756		

a BIMS (brief interview for mental status) score of 15 of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.

Resident #13's clinical record was reviewed and contained a physician's order summary, which read in part "Aspirin Low Dose Tablet Chewable 81 mg (Aspirin). Give 1 tablet by mouth one time a day related to CEREBRAL INFARCTION DUE TO UNSPECIFIED OCCLUSION OR STENOSIS OF RIGHT MIDDLE CEREBRAL ARTERY", "Aspirin Tablet Chewable 81 mg. Give 1 tablet by mouth one time a day related to CEREBRAL INFARCTION, UNSPECIFIED", "Escitalopram Oxalate Tablet 10 mg. Give 1 tablet by mouth one time a day for depression", and Escitalopram Oxalate 10 mg. Give 1 tablet by mouth one time a day for depression".

Resident #13's eMAR for the month of May 2021 was reviewed and contained entries as above. Both entries for aspirin and both entries for escitalopram were initialed as being administered.

Resident #13's consultant pharmacist medication regimen review for the months of April and May 2021 were reviewed. The multiple entries for the medications was not identified by the consultant pharmacist during these medication reviews.

Surveyor spoke with the Director of Pharmacy Operations on 08/03/21 at 3:30 pm regarding Resident #13's medications. Director of Pharmacy Operations stated that there was no way to know if resident received multiple doses of aspirin, since it is a house stock medication. Director of Pharmacy Operations stated that the pharmacy had sent 30 day supply of escitalopram

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F 756	Continued From page 112 on 04/15/21, 05/10/21, 06/09/21 and 07/21/21. Director of Pharmacy Operations stated this indicated the resident was receiving the medication as ordered daily. Surveyor requested and was provided with a facility policy entitled "Medication Regimen Review" which read in part, "Policy Explanation and Compliance Guidelines: 1. Medication Regimen Review (MRR), or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes: a. Review of the medical record in order to prevent, identify, report, and resolve medication-related problems, errors, or other irregularities, 4. The pharmacist shall document, either manually or electronically, that each medication regimen review has been completed. a. The pharmacist shall document either that no irregularity was identified or the nature of any identified irregularities." The concern of failing to identify irregularities on the physician's order summary and eMAR was discussed with the administrative team (administrator, director of nursing, regional vice-president of clinical services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm. No further information was provided prior to exit.	F 756		
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	F 761		

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F 761	Continued From page 113 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 staff interview, clinical record review and in the course of a complaint investigation the facility staff failed to store and account for controlled medications for 1 of 30 residents, Resident #159. The findings included: For Resident #159 the facility staff failed to account for 36 hydrocodone tablets. Resident #159's face sheet listed diagnoses which included, but not limited to chronic kidney	F 761	**F761** 1. **Resident #159: Resident discharged from facility on 03/26/2020.** 2. **Audit of controlled substances to ensure correct count.** 3. **Education of Licensed Nursing staff on Policy/Procedure for Controlled Substance Administration and Accountability and Destruction of Unused Drugs. September 10 and 13, 2021** 4. **Weekly audits of Controlled Substance count sheets x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.** 5. **Date of Compliance: September 19, 2021.**	

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F 761	Continued From page 114 disease, anemia, anxiety, cirrhosis of liver, hypertension, and chronic viral hepatitis. Resident #159's admission MDS (minimum data set) with an ARD (assessment reference date) of 01/23/20 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C cognitive patterns. This indicates that the resident was cognitively intact. Resident #159's comprehensive care plan was reviewed and contained a care plan for " ... (name omitted) has chronic pain due to bursitis and CTS (carpal tunnel syndrome)". Resident #159's clinical record was reviewed and contained a physician's order summary for the months of January 2020 through March 2020, which read in part "oxycodone HCl tablet 5 mg Give 5 mg by mouth every 8 hours as needed for pain". This order has a start date of 01/14/2020. Resident #159's eMAR's (electronic medication administration record) for the months of January, February and March of 2020 were reviewed and contained entries as above. The eMAR indicated that the resident received the medication 14 times in January, 37 times in February and 3 times in March. Resident #159's clinical record contained a physician's progress note dated 03/02/2020, which read in part "Chief Complaint/Nature of Present Problem: Pain. Also seeing her because nursing staff requested a refill on her PRN (as needed) codon. She takes 5 mg every 8 hours as needed. Seems too soon for her refill, I called the pharmacy for information regarding her prior order, reviewed the MAR and examined the med	F 761		

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F 761	Continued From page 115 cart, and discovered a 36 pill variance. This was brought to the attention of the ADON (assistant director of nursing), pharmacy, and my attending. Plan: Will hold off on refilling oxycodone for now, consider changing prescription to ER (extended release) tablets, and also I think patient is appropriate for GDR (gradual dose reduction)". Surveyor requested Resident #159's "Medication Monitoring/Control Record" for oxycodone 5 mg for the above mentioned order. The facility could not provide the requested control record. The facility staff provided the surveyor with a letter written by the facility's previous director of nursing, which read in part "On March 3, 2020 Physician Assistant ... (name omitted), documented in History and Progress Note a 36-tablet variance of Oxycodone 5 mg tablets. January 16, 2020 the original order for ninety tablets of oxycodone 5 mg q (every) 8 hour PRN to be dispensed for resident. According to ... (name omitted) at ... (pharmacy name omitted), Oxycodone 5 mg was dispense on January 16, 2020 (21tablets), January 26, 2020 (21 tablets), February 5, 2020 (21 tablets), February 16, 2020 (21 tablets) and February 25, 2020 (4 tablets). It was calculated that eighty-eight (88) tablets of oxycodone was dispensed to this resident between January and March 2020. Review of the medication monitoring/control record reveals three (3) narcotic monitoring sheets are missing. No other narcotic monitoring sheet were located. It is unable to be determined if all medications were signed out on the narcotic monitoring form. Review of the MAR reveals (55) oxycodone 5 mg were administered to the resident" Surveyor spoke with the facility SW (social	F 761		

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F 761	Continued From page 116 worker) on 08/03/21 at approximately 1:45 pm regarding Resident #159's missing medications. SW stated since they have nothing to do with medications, they wouldn't even know if medications are missing. There were no other staff available for interview that were employed during the time frame of the missing medications. The concern of the facility not storing and accounting for medications was discussed with the administrative team (administrator, DON, regional vice-president of clinical services, regional director of operations) during a meeting on 08/04/21 at approximately 5:20 pm. No further information was provided prior to exit. THIS IS A COMPLAINT DEFICIENCY	F 761		
F 772 SS=D	Lab Services Not Provided On-Site CFR(s): 483.50(a)(1)(iv) §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician ordered laboratory test for 1 of 30 residents, Resident #40. The findings included:	F 772	**F772** **1. Resident # 40 discharged from facility on 08/13/2021.** **2. Audit of last 30 days current resident's labs for completion and results.** **3. Education of Licensed Nursing staff on Policy and Procedure for Laboratory Services and Reporting. September 10 and 13, 2021.** **4. Weekly audits of Lab Order Book x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.** **5. Date of Compliance: September 19, 2021.**	

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The facility failed to obtain the physician ordered laboratory test hemoccult of stools.

Resident #40's (EHR) electronic health record included the diagnoses, chronic respiratory failure, diabetes, dysphagia, anemia, and epilepsy.

Section C (cognitive patterns) of Resident #40's admission (MDS) minimum data set assessment with an (ARD) assessment reference date of 06/21/21 had been coded (0/1/1) to indicate the resident had problems with long term memory and had modified independence in cognitive skills for daily decision making.

The clinical record included a physicians order for a hemoccult X3.

A review of the (EMAR's) electronic medication administration records revealed that the facility nursing staff had signed the EMAR's with their initials beginning on 07/14/21 through 07/24/21. However, the surveyor was unable to find any results for the hemoccult test.

08/02/21 4:03 p.m., during a meeting with the Administrator, (DON) director of nursing, and Regional Vice President of Clinical Services the results of the hemoccult tests were requested.

08/04/21 5:14 p.m., the Administrator stated they did not have the results of the hemoccult lab tests.

No further information was provided to the survey team prior to the exit conference.

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F 842	Continued From page 118	F 842	**F842**	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842	**1. Resident #6: Pharmacy contacted to ensure no recommendations were made 02/01, 04/01, 05/01, and 06/01/2021.** **Resident #49: Pharmacy contacted to ensure no recommendations were made 02/01, 03/01, 04/01, 05/01, and 06/01/2021.** **Resident #34: Medication made available.** **2. Audit of current resident's and new admissions MRRs to ensure completion of Consultant Pharmacist's Medication Regimen Review.** **3. Education of DON and MD on Policy and Procedure for Medication Regimen Review. September 09,2021.** **4. Monthly audit of Medication Regimen Review monthly x 6 months, with audits being presented to QAPI for accountability.** **5. Date of Compliance: September192, 2021.**	

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medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

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

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on interviews and the review of documents, it was determined the facility staff failed to maintain complete and accurate clinical records for three (3) of 30 sampled residents (Resident #6, Resident #34, and Resident #49).

The findings include:

1. The facility staff failed to ensure the

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pharmacist completing Resident #6's monthly medication regimen review (MRR) documented in the resident's clinical records that no recommendations were made.

Resident #6's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 5/7/21, was signed as being completed on 5/25/21. Resident #6 was assessed as usually able to make self understood and as usually able to understand others. Resident #6 was assessed as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #6's diagnoses included, but were not limited to: heart disease, high blood pressure, seizure disorder, depression, and diabetes.

Review of Resident #6's clinical record included the phrase "MRR Completed" documented by a pharmacist for the following dates: 2/1/2021; 4/5/2021; 5/3/2021; and 6/8/21. These entries did not identify if the pharmacist made recommendations based on the MRR.

"Consultant Pharmacist's Medication Regimen Review: Listing of Resident Reviewed with No Recommendations" documents were provided to the survey team. Resident #6's name was one of the many resident names included on the same form for the following dates:
- "For Recommendation Created Between 2/1/2021 And [sic] 2/16/21"
- "For Recommendation Created Between 4/1/2021 And [sic] 4/30/21"
- "For Recommendation Created Between 5/1/2021 And [sic] 5/12/21"
- "For Recommendation Created Between 6/1/2021 And [sic] 6/17/21"

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F 842	Continued From page 121 These forms were not part of the resident's clinical records. The following information was found in a facility document titled "Medication Regimen Review" (with an implemented date of 11/1/2020): "Written communications from the pharmacist shall become a part of the resident's medical record." During an interview on 8/3/21 at 2:48 p.m., the Regional Vice-President of Clinical Services was asked about pharmacist documentation of the monthly MRRs; the Regional Vice-President of Clinical Services reported pharmacist documentation should include whether or not recommendations were made due to the MRR. The failure of the pharmacist to document, in Resident #6's clinical record, whether or not recommendations were made as a result of the monthly MRR was discussed with the facility's Administrator, Director of Nursing (DON), Regional Vice-President of Clinical Services, and Regional Director of Operationson on 8/5/21 at 9:18 a.m. 2. The facility staff failed to ensure the pharmacist completing Resident #49's monthly medication regimen review (MRR) documented in the resident's clinical records that no recommendations were made. Resident #49's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 7/13/21, was signed as completed on 7/16/21. Resident #49 was assessed as able to make self understood and as able to understand others. Resident #49's Brief Interview for Mental	F 842		

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Status (BIMS) summary score was documented as 15 out of 15. Resident #49 was assessed as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #49's diagnoses included, but were limited to: anemia, heart disease, high blood pressure, kidney disease, diabetes, and lung disease.

Review of Resident #49's clinical record included the phrase "MRR Completed" documented by a pharmacist for the following dates: 2/2/2021; 3/2/2021; 4/5/2021; 5/4/2021; and 6/8/21. These entries did not identify if the pharmacist made recommendations as part of the MRR.

"Consultant Pharmacist's Medication Regimen Review: Listing of Resident Reviewed with No Recommendations" documents were provided to the survey team. Resident #49's name was one of the many resident names included on the same form for the following dates:
- "For Recommendation Created Between 2/1/2021 And [sic] 2/16/21"
- "For Recommendation Created Between 3/1/2021 And [sic] 3/29/21"
- "For Recommendation Created Between 4/1/2021 And [sic] 4/30/21"
- "For Recommendation Created Between 5/1/2021 And [sic] 5/12/21"
- "For Recommendation Created Between 6/1/2021 And [sic] 6/17/21"
These forms were not part of the resident's clinical record.

The following information was found in a facility document titled "Medication Regimen Review" (with an implemented date of 11/1/2020):
"Written communications from the pharmacist shall become a part of the resident's medical

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record."

During an interview on 8/3/21 at 2:48 p.m., the Regional Vice-President of Clinical Services was asked about pharmacist documentation of the monthly MRRs; the Regional Vice-President of Clinical Services reported the pharmacist documentation should include whether or not recommendations were made during the MRR.

The failure of the pharmacist to document, in Resident #49's clinical record, whether or not recommendations were made as a result of the monthly MRR was discussed with the facility's Administrator, Director of Nursing (DON), Regional Vice-President of Clinical Services, and Regional Director of Operationson on 8/5/21 at 9:18 a.m.

3. The facility staff failed to ensure Resident #34's medication administration records (MARs) were accurate and correct.

Resident #34's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 5/21/21, was signed as completed on 6/11/21. Resident #34 was assessed as able to make self understood and as able to understand others. Resident #34's Brief Interview for Mental Status (BIMS) summary score was documented as 15 out of 15. Resident #34 was assessed as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #34's diagnoses included, but were not limited to: high blood pressure, seizures, anxiety, depression, and lung disease.

During an interview on 8/1/21 at 11:00 a.m., Resident #34 reported that approximately a

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month ago a medication, gabapentin, had not been not provided as ordered. Resident #34 reported this medication was used to treat their pain.

Review of Resident #34's medication administration records (MARs) and clinical documentation indicated the resident's gabapentin was not administered as ordered and/or scheduled on:
- 5/1/21 at 8:00 a.m.; this was a 600mg dose and
- 5/1/21 at 2:00 p.m.; this was a 300mg dose.
The resident's MARs indicated the gabapentin 600mg dose due on 5/1/21 at 9:00 p.m. was documented as administered although Resident #34's "MEDICATION MONITORING/CONTROL RECORD" indicated the resident ran out of the medication on 4/30/21 at 9:00 p.m. and the medication was not restocked until 5/2/21 at 8:00 a.m.; no documentation was provided to the survey team to show this medication dose had been obtained for the resident.

Review of Resident #34's medication administration records (MARs) and clinical documentation indicated the resident's gabapentin was not administered as ordered and/or scheduled on:
- 5/31/21 at 9:00 p.m.; this was a 600mg dose, and
- 6/1/21 at 2:00 p.m.; this was a 300mg dose.
The resident's MARs indicated the gabapentin 600mg dose due on 6/1/21 at 8:00 a.m. was documented as administered although Resident #6's "MEDICATION MONITORING/CONTROL RECORD" indicated the resident ran out of the medication on 5/31/21 at 2:00 p.m. and the medication was not restocked until 6/1/21 at 9:00 p.m.; no documentation was provided to the

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F 842	Continued From page 125 survey team to show this medication dose had been obtained for the resident. On 8/3/21 at 11:05 a.m., the failure of the facility staff to administer the aforementioned doses of Gabapentin was discussed with the Regional Vice-President of Clinical Services. The following information was found in a facility document titled "Documentation in Medical Record" [sic] (with a reviewed/revised date of 10/28/2020): "Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation." The failure of the facility staff to ensure correct and accurate documentation, on Resident #34's MARs, was discussed with the Administrator, Director of Nursing (DON), Regional Vice-President of Clinical Services, and the Regional Director of Operations on 8/5/21 at 9:18 a.m.	F 842		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 883		

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	495156	A. BUILDING ______ B. WING ______	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROANOKE	324 KING GEORGE AVE SW ROANOKE, VA 24016

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F 883 Continued From page 126

annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

F883

1. **Resident #35: Pneumonia vaccine offer and given 09/09/2021. Flu vaccine was offered, accepted, and will be given during flu season.**
2. **Audit of current resident's flu and pneumonia vaccine status.**
3. **Education of Licensed Nursing staff on Policy and Procedure for Flu and Pneumonia Vaccine September 10 and 13, 2021.**
4. **Monthly audit of Newly Admitted and readmitted residents for vaccination status monthly x 6 months, with audits being presented to QAPI for accountability.**

5. **Date of Compliance: September 19, 2021.**

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F 883	Continued From page 127 (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to offer the flu and pneumonia vaccine to 1 of 30 Residents, Resident #35. The findings included: For Resident #35, the facility staff failed to offer a flu and pneumonia vaccine upon admit to the facility. The Residents face sheet revealed that Resident #35 had been admitted to the facility 12/28/20 and included the diagnoses anxiety disorder, bipolar disorder, depressive disorder, and paranoid schizophrenia. Section C (cognitive patterns) of Resident #35's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/23/21 included a BIMS (brief interview for mental status) summary score of 9 out of a possible 15 points. Section O (special treatments, procedures, and programs) had been coded to indicate the resident had not received the influenza vaccine and was not offered the flu or pneumonia vaccine. 08/04/21 the Vice President of Clinical Services provided the surveyor with a copy of their pneumococcal vaccine and influenza vaccine policies. These polices read in part, "...Each resident will be assessed for pneumococcal	F 883		

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F 883	Continued From page 128 immunization upon admission...Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized...Influenza vaccinations will be routinely offered annually from October 1st through May 31st unless immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine..." 08/04/21 10:00 a.m., the infection preventionist stated Resident #35 had not been offered the flu and pneumonia vaccine, it should have been offered, and encouraged. 08/04/21 5:14 p.m., the Administrator, (DON) director of nursing, Regional Director of Operations, and the Regional Vice President of Clinical Services were made aware of the issue regarding Resident #35 not being offered a flu and/or pneumonia vaccine. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 883		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 919		

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F 919	Continued From page 129 Based on observations, interviews, and the review of documents, it was determined the facility staff failed to ensure a properly working call system for parts of two (2) of two (2) open units. The findings include: On 8/3/21 at 8:28 a.m., the call light in the resident bathroom shared by Room 119 and Room 121 was noted to have been pulled but the light outside of the rooms in the hallway was not lit to indicate the bathroom call light had been activated. It was also noted that an alarm was not heard on either of the units to alert staff to the call light being activated. This observation was confirmed by the facility's Director of Maintenance (DoM) and Employee #31 (a respiratory therapist). Observations of the facility's call system identified the following additional concerns: 1. The call light in the resident bathroom shared by Room 102 and Room 104 was not working. 2. The call light for Room 104 Bed B was not working. 3. The call light in the resident bathroom shared by Room 105 and Room 107 did not have a "pull cord". The DoM was notified on 8/3/21 at 9:15 of the missing "pull cord". 4. The call light for Room 110 Bed A was not working. 5. The call light in Room 55's resident bathroom was not working. 6. The call light in Room 56's resident bathroom was not working. 7. The call light in Room 60's resident bathroom was not working. 8. The call light in the resident bathroom shared	F 919	**F919** **1. Malfunctioning call bell system has been repaired. Annunciator panels moved to nurse's stations.** **2. Audit of call bell system to ensure proper function.** **3. Education of Maintenance Director on Policy and Procedure for Call Light System. September 10,2021.** **4. Weekly audit of Call Light System weekly x 4 weeks then monthly x 6 months, with audits being presented to QAPI for accountability.** **5. Date of Compliance: September 19, 2021.**	

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F 919	Continued From page 130	F 919		

by Room 123 and Room 125 was not working.
9. The call light in the resident bathroom shared by Room 122 and Room 124 was not working.

On 8/3/21 at 9:06 a.m., it was noted that the annunciator panels, on one (1) of the facility's open units, that were to notify facility staff of call lights being activated were located in a respiratory therapy storage room; this storage room's door was closed and secured with a code pad.

The following information was found in a facility document titled "Answering the Call Light" (with a revised date of October 2010): " ... Be sure the call light is plugged in at all times ... Report all defective call lights to the nurse supervisor promptly ..."

On 8/3/21, the facility's Administrator provided the survey team with a document titled "Call Bell System Failure"; this document was dated 8/3/21. This document identified actions the facility was taking to repair the malfunctioning call system and actions the facility staff were taking to meet the needs of their residents (e.g., every 15 minute checks on the impacted residents, provide a manual call bell, one-on-one supervision when a resident is utilizing an affected bathroom).

During an interview on 8/3/21 at 5:14 p.m., the Administrator and the Regional Vice-President of Clinical Services reported that interventions detailed in the "Call System Failure" document was being kept in place until the facility's Call System was functioning correctly.