STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING _____ B. WING _____	C 01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION & HEALTH CARE CENTER	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/11/22 through 1/13/22. The facility was in compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/11/22 through 1/13/22. One complaint was investigated during the survey (VA00054015 - substantiated). Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care - Requirements. The Life Safety Code survey/report will follow. The census in this 190 bed facility was 177 at the time of the survey. The survey sample consisted of 55 current resident reviews and seven closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	**F 550 SS=D Resident Rights/Exercise of Rights** **CFR(s): 483.10(a)(1)(2)(b)(1)(2)** Resident #327 Foley Catheter was covered by staff members on 1/12/2022 to maintain the resident in a dignified manner. Certified Nursing assistant #2 was educated on the importance of closing the restroom door while toileting residents to ensure the provision of privacy.	**2/8/2022**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Nicholle Williams

TITLE

Nursing Home Administrator

(X6) DATE

2/4/2022

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 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to provide dignity for two of 62 residents in the survey sample, Residents #327 and #171. 1. The facility staff failed to maintain Resident #327's urinary catheter in a dignified manner. Urine in the catheter bag was observed from the hall while Resident #327 was lying in bed. 2. CNA (certified nursing assistant) #2 failed to close the door to Resident #171's room and	F 550	Residents who reside at Canterbury Rehab & Healthcare have the risk of being affected by this practice. A 100% random audit was accomplished of all residents to ensure that they are being maintained in a dignified manner, and provision of privacy is also maintained. Urinary Catheter Care policy was reviewed, no revisions needed. The Staff Development Coordinator/Designee educated the Licensed Nursing staff, Certified Nursing Assistants, and TNA staff on the Urinary Catheter Care Policy and need for provision of dignity with resident care needs. Dignity policy reviewed no revisions needed. The Staff Development Coordinator/Designee educated the Licensed Nursing staff, Certified Nursing and TNA staff on the provision of privacy during resident care needs. Unit Managers/designee will complete a random audit of residents weekly x 4 weeks and then monthly x 2 months to ensure that residents needs are met with dignity and the provision of privacy. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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F 550	Continued From page 2	F 550		

bathroom while toileting and providing Resident #171 personal care. Resident #171 was observed exposed to the open doorways unclothed from the wait up.

The findings include:

1. Resident #327 was admitted to the facility on 12/29/21. Resident #327's diagnoses included but were not limited to multiple sclerosis, paralysis and high blood pressure. Resident #327's admission minimum data set assessment with an assessment reference date of 1/5/22, coded the resident as being cognitively intact.

Review of Resident #327's clinical record revealed a physician's order dated 12/30/21 for a urinary catheter.

On 1/11/22 at 1:49 p.m., Resident #327 was observed lying in bed. The resident's urinary catheter bag was observed attached to the bed frame and was located on the side of the bed that was facing the door. The catheter bag was not covered and urine in the catheter bag was visible from the hall. At this time, another resident was observed in the hall outside of the room door.

On 1/12/22 at 9:54 a.m., Resident #327 was observed lying in bed. The resident's urinary catheter bag was observed attached to the bed frame and was located on the side of the bed that was facing the door. The catheter bag was not covered and urine in the catheter bag was visible from the hall. At this time, Resident #327 was asked how she felt about this. The resident stated, "I don't feel good if people can see it."

Resident #327's comprehensive care plan dated

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F 550	Continued From page 3 12/31/21 failed to document information regarding dignity for the resident's urinary catheter bag. On 1/12/22 at 2:09 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated urinary catheter bags should have a cover over them. RN #3 stated, "You don't want to expose to the world the patient has a Foley (urinary catheter). It's personalized. They should have dignity at all times as much as possible." On 1/12/22 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Catheter Care, Urinary" failed to document information regarding dignity and urinary catheter bags. No further information was presented prior to exit. 2. Resident #171 was admitted to the facility on 4/27/21, with the diagnoses of but not limited to dementia, diabetes, high blood pressure, and depression. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/6/22. Resident #171 was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, and toileting; extensive assistance for transfers, bed mobility and dressing; supervision for eating; and was coded as incontinent of bowel and bladder. On 1/12/22 at 9:13 AM, CNA #2 was observed assisting Resident #171 to the bathroom. CNA #2	F 550		

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F 550	Continued From page 4 left the bathroom door and the door to the room open. Resident #171's wheelchair was placed in the doorway of the bathroom. After assisting the resident in the bathroom, CNA #2 assisted Resident #171 into the wheelchair. Observation revealed Resident #171 was undressed from the waist up, and was exposed to the open doorway of the room. At this time, CNA #2 was then observed putting a shirt on Resident #171. On 1/12/22 at 9:42 AM an interview was conducted with CNA #2. When asked about providing privacy during care, she stated that curtains and doors should be closed. When asked if the door to the room for Resident #171 was closed when she was providing her assistance to the bathroom and then dressing her, CNA #2 stated no. When asked if the resident's dignity was maintained, she stated that it was not. On 1/13/22 at 1:10 PM ASM #1 (Administrative Staff Member, the Administrator) stated they do not have a policy on the provision of privacy and dignity during care. On 1/12/22 at approximately 5:30 PM at the end of day meeting, ASM #1 and ASM #2 (Administrative Staff Members) the Administrator and Director of Nursing, respectively, were made aware of the findings. No further information was provided by the end of the survey.	F 550		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination	F 561	F561 SS=E Self-Determination CFR(s: 483.10(f)(1)-(3)(8)	2/8/2022

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F 561	Continued From page 5 through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review it was determined that the facility staff failed to honor the preference for showers twice a week for one of 62 residents in the survey sample, Resident # 162. The facility staff failed to honor Resident #162 preference for a shower on multiple dates in September 2021, October 2021 and November 2021.	F 561	Resident # 162 was provided a shower after resident was post Covid status and moved from the COVID Unit. Residents who reside in Canterbury Rehab and Health Care have the potential to be affected by this practice. Shower Schedules will be reviewed to ensure scheduled per resident preference. Accommodation of Needs Policy reviewed, no revisions necessary. Education was provided by the Staff Development Coordinator/Designee for the Licensed Nursing staff, Certified Nursing and TNA staff on honoring resident preference for showers twice per week. Showers will be reviewed by the Unit Manager to ensure residents are showered per preference weekly x 4 weeks and then Monthly x 2 months to ensure ongoing compliance with this process. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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F 561	Continued From page 6 The findings include: Resident #162 was admitted to the facility with diagnoses that included but were not limited to: hemiplegia [1], muscle weakness and high blood pressure Resident # 162's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/29/2021, coded Resident # 162 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 162 was coded as requiring extensive assistance of two staff members for activities of daily living and being totally dependent of one staff member for bathing. On 01/112022 at approximately 1:56 p.m., an interview was conducted with Resident # 162. When asked if staff assist with showers, Resident # 162 stated that they are scheduled for showers on Wednesdays and Saturdays. Resident #162 stated, "I am supposed to get them twice a week but I'm not getting them." She stated it was her preference to take showers twice a week but stated that staff were not getting it done. She stated staff did give her sponge baths. When asked how not getting showers as scheduled made her feel Resident # 162 stated that they didn't feel clean. The comprehensive care plan for Resident # 162 dated 07/08/2021 documented in part, "Focus. I have an ADL [activities of daily living] Self Care Performance Deficit. Date Initiated: 07/08/2021." Under "Interventions" it documented in part, "BATHING: total of one. Date Initiated: 07/08/2021."	F 561		

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F 561	Continued From page 7 The facility's "Kardex" for Resident # 162 dated 01/22/2022 documented in part, "Personal Hygiene. I require total assistance with personal hygiene care." Under "BATHING" it documented, "BATHING: total care." A review of Resident # 162's shower sheets dated September 1, 2021 through December 31, 2021 revealed that Resident # 162 did receive a shower on 09/04/2021, 09/08/2021, 09/15/2021, 09/22/2021, 10/27/2021, 11/10/2021 and on 11/27/2021. On 01/12/2022 at approximately 11:01 a.m. an interview was conducted with LPN [licensed practical nurse] # 5, unit manager. When asked to describe the procedure for resident showers LPN # 5 stated, "Residents get a bed bath every day and we use a dry shampoo for their hair." When asked about Resident # 162's shower schedule and receiving showers LPN # 5 stated, "[Resident # 162] was scheduled for showers every Wednesday and Saturday on the 3:00 p.m. to 11:00 p.m. shift." When asked about Resident # 162 receiving showers as scheduled LPN # 5 stated that there were times when Resident # 162 refused a shower. When asked if they were aware of any concerns expressed by Resident # 162's family LPN # 5 stated, "Yes, because they missed one shower day and it was given the following day." When asked if they recalled the date LPN # 5 stated no. On 01/12/2022 at approximately 2:44 p.m. an interview was conducted with CNA [certified nursing assistant] # 1. When asked about Resident # 162 receiving showers, CNA # 1 stated that they did not regularly assist with	F 561		

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F 561	Continued From page 8 Resident # 162's showers because they didn't always work the 3:00 p.m. to 11:00 p.m. shift. When asked about Resident # 162 not receiving a shower CNA # 1 stated, "One day we couldn't give [Resident # 162] a shower on her shower day because another staff member had called out and we were short staffed and [Resident # 162] requires two staff for transfers. I told her we would give her a shower the following day and we did. He wasn't happy about it but said it was okay." On 01/13/2022 at approximately 8:15 a.m. an interview was conducted with LPN [licensed practical nurse] # 5, unit manager. After reviewing Resident # 162's shower sheets dated September 2021 through December 2021, LPN # 5 was asked why Resident # 162 did not receive showers on the dates listed above. LPN # 5 stated, "I can't answer why." On 01/13/2022 at approximately 11:22 a.m. an interview was conducted with CNA [certified nursing assistant] # 3. When asked to describe the procedure for resident showers CNA # 3 stated, "Residents get a bed bath every day." When asked why a resident would not receive a shower on their scheduled shower day CNA # 3 stated, "We can't always give showers because we don't have enough staff." On 01/13/2022 at approximately 12:30 p.m. an interview was conducted with ASM [administrative staff member] # 2, director of nursing. After review of the bathing sheets for Resident # 162 dated September 2021 through December 2021, ASM # 2 was inform that Resident # 162 did not receive a shower or tub bath on the dates listed above. When asked if it was the resident's right	F 561		

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F 561	Continued From page 9 to receive showers or tub baths twice a week ASM # 2 stated yes. On 01/13/2022 at approximately 2:15 p.m., ASM (administrative staff member) #1, administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. Complaint deficiency Reference: [1] Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread This information was obtained from the website: https://medlineplus.gov/paralysis.html.	F 561		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584	**F584 SS=D Safe/Clean/Comfortable/Homelike Environment** **CFR (s): 483.10(i)(1)-(7)** The dry tan substance underneath the stainless-steel tube feeding pump pole in resident #426's room was cleaned at the time of the survey. Residents who reside at Canterbury Rehab and Health have the potential of being affected by this practice. Administrator/Designee completed rounds in each resident's room to ensure that A safe, clean, comfortable, homelike environment. Home Environment Policy reviewed no revisions necessary.	**2/8/2022**

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F 584	Continued From page 10 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to maintain a clean and homelike environment for one of 62 residents in the survey sample, Resident #426. The facility staff failed to clean a spill off of the floor in Resident #426's room in a timely manner. The findings include:	F 584	Canterbury staff were educated on the importance of keeping the resident room floors clean and providing a Safe/Clean/Comfortable/Homelike Environment. Director of Housekeeping/designee will randomly select 15 rooms a week x 4 week and then monthly x 2 months to monitor for a safe, clean, comfortable, homelike environment. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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F 584	Continued From page 11	F 584		

Resident #426 was admitted to the facility with diagnoses that included but were not limited to anoxic brain damage (1) and congestive heart failure (2). Resident #426's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/21/2021, coded the resident as being severely impaired for making daily decisions. Section G coded Resident #426 as requiring total assistance of two or more staff with bed mobility and total assistance of one staff member for personal hygiene, toileting, dressing and eating.

On 1/11/2022 at approximately 12:30 p.m., an observation was made of Resident #426 in their room. Resident #426 was observed lying in bed receiving a tube feeding attached to a feeding pump. Resident #426 was alert with their eyes open and non-verbal. The area located beside Resident #426's bed near the window was observed to contain an area of dried tan-colored material located on the floor underneath the stainless steel tube feeding pump pole. The area was observed to be approximately six by six inches, was dry and stuck to the floor.

Additional observations conducted on 1/11/2022 at 2:45 p.m., 4:30 p.m. and 1/12/2022 at 8:30 a.m. and 1:45 p.m., revealed the same findings as described above.

On 1/12/2022, at 2:00 p.m. an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 stated that housekeeping cleaned up large spills but any smaller spills were cleaned up by the nursing staff at the time of the incident. LPN #6 observed the areas of dried, tan colored substance on the floor and stated that nursing should have cleaned up the area when it

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F 584	Continued From page 12	F 584		

happened. LPN #6 stated that the substance appeared to be tube feeding that had spilled on the floor and dried up. LPN #6 stated that it should not have been there and the floor was not clean and did not appear homelike. LPN #6 stated that they would take care it at that time.

On 1/12/2022 at approximately 5:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy regarding maintaining a clean, comfortable, homelike environment.

On 1/13/2022 at 1:10 p.m., ASM #1 stated that the facility did not have a policy regarding a clean, comfortable, homelike environment.

On 1/12/2022 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concern.

No further information was presented prior to exit.

References:

1. Anoxic brain damage
Not enough oxygen getting to the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001435.htm

2. Congestive heart failure
A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This

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F 584	Continued From page 13 information was obtained from the website: https://medlineplus.gov/heartfailure.html	F 584		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge,	F 623	**F623 Notice Requirements Before Transfer/Discharge** **CFR(s): 483.15(c)(3)-(6)(8)** Written notification of hospital transfer was provided to the Resident Representative for resident #97. Written notification of hospital transfer was provided to the Resident Representative and Ombudsman for resident #149. Written notification of hospital transfer was provided to the Resident Representative for resident #15. Written notification of hospital transfer was provided to the Resident Representative for resident #13. Written notification of hospital transfer was provided to the Resident Representative for resident #177.	**2/8/2022**

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F 623	Continued From page 14 under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder	F 623	Residents who resident at Canterbury Rehab and Healthcare who are transferred to the hospital have the potential to be affected by this practice. An audit was completed of the last 30 days of resident transfers to the hospital to ensure a written notification was provided to the Resident Representative and/or Ombudsman. Resident Representative and/or Ombudsman who did not receive the letter of these transfers will be sent the information accordingly. Trans/Discharge Policy reviewed no revisions necessary. Education was provided by the Administrator/Designee to the Social Service Department on the requirements for Notice of Requirements Before Transfer/Discharge. Interdisciplinary Team members will review as part of Morning Clinical residents who transfer to the hospital and if written notification was provided to the Resident Representative and/or Ombudsman. An audit will be completed by the Social Service Director/Designee weekly x 4 weeks and then monthly x 2 months of all residents who were transferred to the hospital and that a written notification was provided to the Resident Representative and/or Ombudsman. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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F 623	Continued From page 15 established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence a written notification was provided to the Resident Representative and/or Ombudsman for a hospital transfer for five of 62 residents in the survey sample; Residents #97, #149, #15, #13, and #177. The findings include: 1. The facility staff failed to evidence that a written notification was provided to the Resident Representative for Resident #97's hospital transfer on 11/17/21. Resident #97 was admitted to the facility on	F 623		

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F 623	Continued From page 16 11/11/21 and had the diagnoses of but not limited to fall with fractures of the tibia and ribs, dysphagia, depression, insomnia and dementia. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 11/29/21. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for bed mobility, dressing, toileting, and hygiene; limited assistance for transfers; supervision for eating; and was incontinent of bowel and bladder. A review of the clinical record revealed a nurse's note dated 11/17/21 at 4:37 PM that documented, "Received order to send resident to ER (emergency room) due to elevated WBC (white blood cells) and Redness to incision site. Writer attempted to reach Surgeon office. Message left. Seen by NP (nurse practitioner) resident will be sent out." A review of the "SNF/NF to Hospital Transfer Form" dated 11/17/21 and the nurses notes in the clinical record failed to reveal any evidence that a written notification of the hospital transfer was provided to the resident representative. On 1/12/22 at 2:59 PM, an interview was conducted with OSM #3 (Other Staff Member) the Social Services Director. She stated that she has been at the facility since 12/8/21 but has not been sending written notifications to the resident representative at this or any facility she has ever been at. On 1/12/22 at 3:19 PM OSM #3 followed up after checking with other staff regarding notifications that were sent before she started. OSM #3 stated that the facility had not been	F 623		

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F 623	Continued From page 17 doing written notifications to the Resident Representatives. On 1/13/22 at 1:10 PM ASM #1 (Administrative Staff Member, the Administrator) stated they did not have a policy on hospital transfer requirements. On 1/12/22 at approximately 5:30 PM at the end of day meeting, ASM #1 and ASM #2 (Administrative Staff Members) the Administrator and Director of Nursing, respectively, were made aware of the findings. No further information was provided by the end of the survey. 2. The facility staff failed to evidence that written notification was provided to the Ombudsman and Resident #149's resident representative for the Resident #149's hospital transfer on 12/9/21. Resident #149 was admitted on 10/27/20 and had the diagnoses of but not limited to stroke, chronic obstructive pulmonary disease, depression, obsessive compulsive disorder, pressure injury, left femur necrosis, high blood pressure, and alcohol abuse. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 12/21/21. The resident was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, bed mobility, dressing, hygiene and toileting; supervision for eating; and was coded as incontinent of bowel and bladder. A nurse's note dated 12/9/21 at 12:30 PM documented, "....Nurse reported small amount of	F 623		

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blood in stool last night. Unwitnessed fall out of bed a short time ago, very large hematoma to right forehead and top of head. Neurocheck [neurological check] normal but due to size will send to ED (emergency department) for evaluation, to rule out subdural hematoma, and for rectal bleeding...."

A nurse's note dated 12/9//21 at 1:44 PM documented, "Resident being sent to (name of emergency room) ER for eval (evaluation). RR (resident representative) made aware."

A review of the "SNF/NF [skilled nursing facility/nursing facility] to Hospital Transfer Form" dated 12/9/21 and the nurses notes in the clinical record failed to reveal any evidence that a written notification of the hospital transfer was provided to the resident representative and Ombudsman.

On 1/12/22 at 2:59 PM, an interview was conducted with OSM #3 (Other Staff Member) the Social Services Director. She stated that she has been at the facility since 12/8/21 but has not been sending written notifications to the resident representative at this or any facility she has ever been at. OSM #3 stated that normally the discharge list is printed and emailed to the Ombudsman. On 1/12/22 at 3:19 PM OSM #3 followed up after checking with other staff regarding notifications that were sent before she started. She stated that the facility had not been doing written notifications to the Resident Representatives. A list of resident discharges dated 9/1/21 through 1/12/22 was provided that was faxed to the Ombudsman on 1/11/12. Resident #149's transfer on 12/9/21 was not listed. OSM #3 stated that it was because he was not discharged. The facility was not tracking

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F 623	Continued From page 19 and reporting to the Ombudsman hospital transfers that went to the emergency room and back to the facility without a hospital admission or facility discharge. On 1/13/22 at 1:10 PM ASM #1 (Administrative Staff Member, the Administrator) stated they did not have a policy on hospital transfer requirements. On 1/12/22 at approximately 5:30 PM at the end of day meeting, ASM #1 and ASM #2 (Administrative Staff Members) the Administrator and Director of Nursing, respectively, were made aware of the findings. No further information was provided by the end of the survey. 3. The facility staff failed to provide written notification of transfer to the Resident/RP (responsible party) for Resident #13. Resident #13 was admitted to the facility on 4/2/21 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease [COPD] (chronic non-reversible lung disease) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and chronic kidney disease (decreased function of the kidneys frequently as a complication of diabetes) (3). Resident #13's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/17/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, bathing, toileting and	F 623		

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F 623	Continued From page 20 personal hygiene; supervision in eating. A review of the nursing progress note dated 10/27/21 at 8:00, documented in part, "Resident has been admitted to the hospital for treatment of foot ulcer." On 1/11/22 at 5:00 PM, a request was made for written RP notification for Resident #13. An interview was conducted on 1/12/22 at 3:20 PM with OSM (other staff member) #3, the social services director. When asked who provides the written RP notification, OSM #3 stated, "We have not been doing the written notification to the RP due to not having consistent social services staff. We were calling the RP and documenting that in the progress note." An interview was conducted on 1/13/22 at 8:15 AM with ASM #2, the director of nursing, who stated, "We do not do anything with written RP notification or bed hold." On 1/12/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. On 1/13/22 at 1:10 PM, ASM #1, the administrator, stated, "We do not have any policy regarding transfer requirements." No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120.	F 623		

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F 623	Continued From page 21 (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 119. 4. The facility staff failed to provide written notification of transfer to the Resident/RP (responsible party) for Resident #15. Resident #15 was admitted to the facility on 8/5/20 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease [COPD] (chronic non-reversible lung disease) (1), asthma (recurrent episodes of difficulty in breathing) (2) and osteoarthritis (degenerative changes in the joints) (3). Resident #15's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/12/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, toileting and personal hygiene; supervision in eating/total dependence in bathing. A review of the (interventions to reduce acute care transfers) Transfer Form V5 dated 11/27/21, documented in part, "Transfer to hospital." A review of the nursing progress note dated 11/27/21 at 4:43 PM, documented in part, "Patient noted incoherent, checked vitals, several	F 623		

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F 623	Continued From page 22 attempts to get off bed, combative, called 911, sent patient to the hospital. Called family member and notified of patient's status and reason for sending the resident out." On 1/11/22 at 5:00 PM, a request was made for written RP notification for Resident #15. An interview was conducted on 1/12/22 at 3:20 PM with OSM (other staff member) #3, the social services director. When asked who provides the written RP notification, OSM #3 stated, "We have not been doing the written notification to the RP due to not having consistent social services staff. We were calling the RP and documenting that in the progress note." An interview was conducted on 1/13/22 at 8:15 AM with ASM #2, the director of nursing, who stated, "We do not do anything with written RP notification or bed hold." On 1/13/22 at 2:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 50. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 420.	F 623		

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F 623	Continued From page 23 5. The facility staff failed to provide written notification of transfer to the Resident/RP (responsible party) for Resident #177. Resident #177 was admitted to the facility on 10/26/20 with diagnoses that included but were not limited to: cerebrovascular accident (hemorrhage or blockage of the blood vessels of the brain leads to a lack of oxygen) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and congestive heart failure (circulatory congestion and retention of salt and water by the kidneys) (3). Resident #177's most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 9/26/21, coded the resident as scoring 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, toileting and personal hygiene; supervision in eating/total dependence in bathing. A review of the nursing progress note dated 10/19/21 at 11:17 AM, documented in part, "Resident noted to have scrotal edema, increased edema in lower extremities. No [Sic.] shortness of breath or other respiratory distress noted. up in wheelchair per normal self. daughter in facility and insisting resident be sent to hospital, does not want him seen here by one of our physicians. Resident is alert and oriented per normal self. No [Sic.] complaint of pain voiced." A review of the nursing progress noted dated	F 623		

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F 623	Continued From page 24 10/19/21 at 12:06 PM, documented in part, "Resident transferred to hospital via stretcher non-emergent." On 1/12/22 at 5:00 PM, a request was made for written RP notification for Resident #177. An interview was conducted on 1/12/22 at 3:20 PM with OSM (other staff member) #3, the social services director. When asked who provides the written RP notification, OSM #3 stated, "We have not been doing the written notification to the RP due to not having consistent social services staff. We were calling the RP and documenting that in the progress note." An interview was conducted on 1/13/22 at 8:15 AM with ASM #2, the director of nursing, who stated, "We do not do anything with written RP notification or bed hold." On 1/13/22 at 2:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 111. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 133.	F 623		

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F 625	Continued From page 25	F 625		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to evidence a bed hold notice was provided upon transfer for three of 62 residents in the survey sample, Resident #13, Resident #15 and Resident #177.	F 625	**F625 SS=D Notice of Bed Hold Policy Before/Upon Transfer** **CFR(s): 15(d)(1)(2)** The Bed Hold Notice was provided to resident/resident representative #13, and #15. Resident #177 was discharged from Canterbury Rehab and Healthcare on 10/19/2021. Residents who reside at Canterbury Rehab and Healthcare who are transferred to the hospital have the potential to be affected by this practice. An audit was conducted of current residents who transferred to the hospital in the last 30 days to ensure the bed hold notice was provided upon transfer. Those residents who did not have bed hold notice provided were given this notice. Bed Hold Policy reviewed no revisions necessary. Education was provided by the Administrator/Designee to the Licensed Nursing Staff, Admissions and Social Service Department on the requirement for Notice of Bed Hold Before/Upon Transfer from the facility. Interdisciplinary Team members will review as part of Morning Clinical residents who transfer to the hospital that the Notice of Bed Hold Policy	: 2/8/2022

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F 625	Continued From page 26 The facility staff failed to provide a bed hold notice to Resident #13 upon transfer and admission to the hospital on 10/27/21, and failed to provide a bed hold notice to the resident or resident responsible party (RP), at the time of Resident #15's transfer to the hospital on 11/27/21, and at the time of Resident #177's transfer to the hospital on 10/19/21. The findings include: 1. Resident #13 was admitted to the facility on 4/2/21 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease [COPD] (chronic non-reversible lung disease) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and chronic kidney disease (decreased function of the kidneys frequently as a complication of diabetes) (3). Resident #13's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/17/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, bathing, toileting and personal hygiene; supervision in eating. A review of the nursing progress note dated 10/27/21 at 8:00, documented in part, "Resident has been admitted to the hospital for treatment of foot ulcer." On 1/11/22 at 5:00 PM, a request was made for the bed hold notice for Resident #13.	F 625	Before/Upon Transfer was accomplished. An audit will be completed by the Administrator/Designee weekly x 4 weeks and then monthly x 2 months on the Bed Hold policy being provided upon resident transfer. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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F 625	Continued From page 27 An interview was conducted on 1/12/22 at 3:48 PM with OSM (other staff member) #7, the admissions director. When asked who provides the bed hold notice, OSM #7 stated, "Admissions provides the bed hold notice. We do not have a bed hold for this resident." An interview was conducted on 1/13/22 at 8:15 AM with ASM #2, the director of nursing, who stated, "We do not do anything with written RP (responsible party) notification or bed hold." On 1/12/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. According to the facility's policy on bed hold, which documents in part, "Notice of Bed-Hold policy at time of transfer. At the time of transfer a resident to a hospital, a nursing facility shall provide a written notice to the resident, or when applicable, the residents representative, which specifies the duration of the bed hold policy." No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 119.	F 625		

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F 625	Continued From page 28 2. Resident #15 was admitted to the facility on 8/5/20 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease [COPD] (chronic non-reversible lung disease) (1), asthma (recurrent episodes of difficulty in breathing) (2) and osteoarthritis (degenerative changes in the joints) (3). Resident #15's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/12/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, toileting and personal hygiene; supervision in eating/total dependence in bathing. A review of the (interventions to reduce acute care transfers) Transfer Form V5 dated 11/27/21, documented in part, "Transfer to hospital." A review of the nursing progress note dated 11/27/21 at 4:43 PM, documented in part, "Patient noted incoherent, checked vitals, several attempts to get off bed, combative, called 911, sent patient to the hospital. Called family member and notified of patient's status and reason for sending the resident out." On 1/11/22 at 5:00 PM, a request was made for the bed hold notice for Resident #15. An interview was conducted on 1/12/22 at 3:48 PM with OSM (other staff member) #7, the admissions director. When asked who provides	F 625		

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F 625	Continued From page 29 the bed hold notice, OSM #7 stated, "Admissions provides the bed hold notice. We do not have a bed hold for this resident." An interview was conducted on 1/13/22 at 8:15 AM with ASM #2, the director of nursing, who stated, "We do not do anything with written RP notification or bed hold." On 1/13/22 at 2:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 50. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 420. 3. Resident #177 was admitted to the facility on 10/26/20 with diagnoses that included but were not limited to: cerebrovascular accident (hemorrhage or blockage of the blood vessels of the brain leads to a lack of oxygen) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and congestive heart failure (circulatory congestion and retention of salt and water by the kidneys) (3). Resident #177's most recent MDS (minimum data set) assessment, an annual assessment,	F 625		

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with an assessment reference date of 9/26/21, coded the resident as scoring 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, toileting and personal hygiene; supervision in eating/total dependence in bathing.

A review of the nursing progress note dated 10/19/21 at 11:17 AM, documented in part, "Resident noted to have scrotal edema, increased edema in lower extremities. no [Sic.] shortness of breath or other respiratory distress noted. up in wheelchair per normal self. daughter in facility and insisting resident be sent to hospital, does not want him seen here by one of our physicians. Resident is alert and oriented per normal self. No [Sic.] complaint of pain voiced."

A review of the nursing progress noted dated 10/19/21 at 12:06 PM, documented in part, "Resident transferred to hospital via stretcher non-emergent."

On 1/12/22 at 5:00 PM, a request was made for the bed hold notice for Resident #177.

An interview was conducted on 1/12/22 at 3:48 PM with OSM (other staff member) #7, the admissions director. When asked who provides the bed hold notice, OSM #7 stated, "Admissions provides the bed hold notice. We do not have a bed hold for this resident."

An interview was conducted on 1/13/22 at 8:15 AM with ASM #2, the director of nursing, who stated, "We do not do anything with written RP

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F 625	Continued From page 31 notification or bed hold." On 1/13/22 at 2:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 111. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 133.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to correctly code MDS (minimum data set) resident assessments for two of 62 residents in the survey sample, Resident #94 and #89. 1. The facility staff failed to code the quarterly MDS (minimum data set) for Resident #94 with the ARD (assessment reference date) of 12/3/2021 for falls sustained since the previous quarterly assessment on 9/14/2021.	F 641		

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F 625	Continued From page 31 notification or bed hold." On 1/13/22 at 2:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 111. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 133.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to correctly code MDS (minimum data set) resident assessments for two of 62 residents in the survey sample, Resident #94 and #89. 1. The facility staff failed to code the quarterly MDS (minimum data set) for Resident #94 with the ARD (assessment reference date) of 12/3/2021 for falls sustained since the previous quarterly assessment on 9/14/2021.	F 641	**F641 SS=D Accuracy of Assessments** **CFR(s): 483.20(g)** A Modification Minimum Data Set for Resident #94 was completed on 1/13/2022. A Modification Minimum Data Set for Resident #89 was completed on 1/12/2022.	2/8/2022

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F 641	Continued From page 32 2. The facility staff failed to code the quarterly MDS (minimum data set) for Resident #89 with the ARD (assessment reference date) of 11/27/2021 for restraint usage. The findings include: 1. Resident #94 was admitted to the facility with diagnoses that included but were not limited to dementia (1) and schizoaffective disorder (2). Resident #94's most recent MDS, a quarterly assessment with an ARD of 12/3/2021, coded Resident #94 as scoring a three (3) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 - being severely impaired for making daily decisions. Section J documented no falls since the prior assessment. The progress notes for Resident #94 documented in part the following: - "10/29/2021 15:43 (3:43 p.m.) Resident had a witnessed fall. RP (responsible party) [Name of responsible party] notified via voicemail and MD (medical doctor) aware. No injuries noted v/s (vital signs) 98.0 (temperature), 63 (pulse), 18 (respirations), 111/61 (blood pressure), 95% RA (oxygen saturation) (room air). Resident resting in wheelchair with neck collar intact." - "11/10/2021 14:18 (2:18 p.m.) Resident had a witnessed fall with no injuries. RP [Name of responsible party) notified, via cellphone. Awaiting return phone call. 97.8 (temperature), 69 (pulse), 18 (respirations), 104/79 (blood pressure)." The comprehensive care plan for Resident #94 dated 5/17/2021 documented in part, "I am at risk	F 641	Residents who reside at Canterbury Rehab and Healthcare who have had an MDS completed during the lookback period have the potential to be affected by this practice. MDS coordinator/designee reviewed the last 30 days of MDS's for accuracy and upon completion of upcoming assessments the MDS Coordinator/Designee will audit the prior MDS for accuracy of coding. Modifications completed for residents identified with discrepancies. Comprehensive Assessment Policy reviewed no revisions necessary. Regional MDS/Designee will educate MDS Nursing Department on Accuracy of Assessments, and the accuracy of coding assessments. MDS Director/Designee will audit coding/accuracy of 10 residents weekly x 4 weeks and then monthly x 2 months to ensure ongoing compliance with this practice. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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for falls r/t (related to) Dementia, poor safety judgment due to the same, poor neck control, incontinence, use of psychoactive medications and recent mobility decline. Observed on floor 7/11/21, Witnessed fall on 10/29/2021, Witnessed fall on 11/10/2021, Unwitnessed fall on 12/9/2021. Date Initiated: 05/17/2021."

On 01/13/2022 at 8:51 a.m., an interview was conducted OSM (other staff member) #4, the regional director of case management. OSM #4 stated that they reviewed the progress notes and the risk portal system to search for any falls during the assessment time frame when completing the MDS. OSM #4 stated that any falls that occurred between 9/14/2021 and 12/3/2021 would be documented on the quarterly MDS with the ARD of 12/3/2021. OSM #4 stated that they would review Resident #94's MDS to see if any falls should have been coded.

On 1/13/2022 at 9:07 a.m., OSM #4 stated that they had reviewed the clinical record, progress notes and risk portal system and the falls on 10/29/2021 and 11/10/2021 were documented and should have been coded on the MDS with the ARD of 12/3/2021. OSM #4 stated that they had missed documenting them and they would correct this. At that time, OSM #4 stated that they did not have a policy specific to completion of the MDS and followed the RAI manual.

According to the RAI Manual, Version 1.16, dated October 2018, Chapter 1, Section 1.3 Completion of the RAI documented in part, "The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that 1. the assessment accurately reflects the resident's status..." Chapter 1,

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F 641	Continued From page 34 Section 1.4 Problem Identification Using the RAI documented in part, "In essence, with an accurate RAI completed periodically, caregivers have a genuine and consistent recorded "look" at the resident and can attend to that resident's needs with realistic goals in hand..." On 1/12/2022 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. References: 1. Dementia: A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. 2. Schizoaffective disorder: "Schizoaffective disorder is a mental condition that causes both a loss of contact with reality (psychosis) and mood problems (depression or mania)." This information is taken from the website https://medlineplus.gov/ency/article/000930.htm. 2. Resident #89 was admitted to the facility with diagnoses that included but were not limited to dementia (1) and Alzheimer's disease (2). Resident #89's most recent MDS, a quarterly assessment with an ARD of 11/27/2021, coded Resident #89 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired for making daily decisions. Section P documented "other"	F 641		

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F 641	Continued From page 35 physical restraints being used less than daily for Resident #89. The clinical record for Resident #89 failed to evidence documentation of or for the use of restraints. On 1/12/2022 at approximately 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 stated that they were not aware of Resident #89 ever requiring the use of restraints when working with them. On 1/12/2022 at 1:00 p.m., an interview was conducted with RN (registered nurse) #1, the MDS director and OSM (other staff member) #4, the regional director of case management. RN #1 stated that they reviewed the clinical record, made observations and spoke with the nursing staff when completing the MDS assessment. RN #1 stated that they were new to the facility and were not familiar with Resident #89. RN #1 and OSM #4 stated that they would review the MDS with the ARD of 11/27/2021 and determine if restraints were used during the assessment period. On 1/12/2022 at 2:26 p.m., OSM #4 stated that they had reviewed the MDS for Resident #89 with the ARD of 11/27/2021 and the clinical record and it was a human error by clicking the box by mistake. OSM #4 stated that there were no restraints used for Resident #89. OSM #4 stated that they would modify the MDS to correct the mistake. On 1/12/2022 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing	F 641		

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F 641	Continued From page 36 were made aware of the findings. No further information was provided prior to exit. References: 1. Dementia: A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. 2. Alzheimer's disease: "Alzheimer's disease is an irreversible, progressive brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks. It is the most common cause of dementia in older adults." This information is taken from the website https://www.nia.nih.gov/health/alzheimers/basics.	F 641		
F 645 SS=E	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;	F 645	**F645 SS=E PASARR Screening for MD & ID** **CFR(s): 483.20(k)(1)-(3)** PASARR for resident #103 was completed on 1/12/2022. PASARR for resident #32 was completed on 1/12/2022. PASARR for resident #94 was completed on 1/12/2022. PASARR for resident #146 was completed on 1/12/2022.	**2/8/2022**

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F 645	Continued From page 37 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 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.	F 645	PASARR for resident #22 was completed on 1/12/2022. PASARR for resident #56 was completed on 1/12/2022. Residents who require Preadmission Screening for individuals with mental disorders and individuals with intellectual disabilities and reside at Canterbury Rehab and Healthcare have the potential to be affected by this practice. An audit was accomplished by the Social Service Director/Designee of current residents with need for Preadmission Screening of mental disorders and individuals with intellectual disabilities and completion of PASRR Level I and II. Preadmission Screening will be completed for residents identified that do not have PASRR Level I and II. Admission Criteria Policy reviewed no revisions necessary. Education was provided by the Administrator/Designee for the Social Service staff on the timely completion of PASARR Level I and II. Social Service Director/Designee will accomplish a weekly audit x 4 and monthly x 2 months of all new admissions for need for PASARR and their timely completion. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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F 645	Continued From page 38 §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 described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to evidence completion of a level 1 PASRR (preadmission screening and resident review) for six of 62 residents in the survey sample, Residents #103, #32, #94, #146, #22 and #56. The findings include: 1. The facility staff failed to complete a PASRR in a timely manner for Resident #103 who was admitted to the facility on 5/26/2021 with a readmission on 6/18/2021. Resident #103's PASRR was not completed until 1/12/2022. Resident #103 was admitted to the facility with diagnoses that included but were not limited to cerebral infarction (1) and post-traumatic stress disorder (2). Resident #103's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/9/2021, coded Resident #103 as scoring a 7 on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 - being severely impaired for making daily decisions.	F 645		

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F 645	Continued From page 39 Review of Resident #103's clinical record failed to evidence a level 1 PASRR. On 1/11/2022 at approximately 4:30 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the Level 1 PASRR for Resident #103. On 1/12/2022 at approximately 9:30 a.m., ASM #2, the director of nursing provided a Level 1 PASRR for Resident #103 with a completion date of 1/12/2022. On 1/12/2022 at 1:15 p.m., an interview was conducted with OSM (other staff member) #3, the director of social services and ASM #1, the administrator. OSM #3 stated that they were new to the facility and were unable to find the Level 1 PASRR for Resident #103. OSM #3 stated that they had completed a new PASRR on 1/12/2022 for Resident #103 that morning. OSM #3 stated that prior to the COVID-19 (3) pandemic the PASRR was completed prior to admission, however there were waivers in place that allowed them to admit residents without the assessment. OSM #3 stated that they were supposed to complete the PASRR after admission in a timely manner but was not sure of the exact timeframe allowed. OSM #3 stated that when they realized Resident #103 did not have one [PASRR] they completed it then. ASM #1 stated that they made all attempts to get the PASRR prior to admission and if the resident were admitted without it they completed it within 24-48 hours. ASM #1 stated that the waivers had caused confusion for staff regarding completion of them [PASRR]. ASM #1 stated that they had a QAPI (quality assurance and performance improvement) plan on completing the PASRR. At this time a request	F 645		

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F 645	Continued From page 40	F 645		

was made for the improvement plan that was put into place.

On 1/13/2022 at approximately 10:30 a.m., ASM #1 and OSM #3 provided the QAPI (quality assurance and performance improvement) meeting dated 12/22/2021 which documented in part, "QAPI Action Plan. Issue/Concern: PASSR [sic]/Preadmission Screening and Resident Review. Goals/Objective/Expected Outcome: Complete all PASSR's [sic] upon admission of residents admission...Audit the charts to ensure that all PASSR's [sic] are completed if needed including level 2 PASSR's [sic]...Projected Completed Date: 1/10/2022..." When asked the date of compliance for the QAPI plan, ASM #1 stated that it was 1/10/2022.

On 1/13/2022 at approximately 9:30 a.m., a request was made to ASM #1, the administrator for the facility policy regarding completion of the PASRR.

On 1/13/2022 at 1:10 p.m., ASM #1 stated that the facility did not have a policy regarding completion of the PASRR.

According to the CMS document, "COVID-19 Emergency Declaration Waivers" updated 11/29/2021, documented in part on page 16, "Waive Pre-Admission Screening and Annual Resident Review (PASARR). CMS (Centers for Medicare and Medicaid Services) is waiving 42CFR 483.20(k), allowing nursing homes to admit new residents who have not received Level 1 or Level 2 Preadmission Screening. Level 1 assessments may be performed post-admission. On or before the 30th day of admission, new patients admitted to nursing homes with a mental

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illness (MI) or intellectual disability (ID) should be referred promptly by the nursing home to State PASARR program for Level 2 Resident Review..." This information was obtained from the website: https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

On 1/13/2022 at 12:15 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

1. Cerebrovascular disease, infarction or accident: A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.

2. Post-traumatic stress disorder (PTSD): A disorder that develops in some people who have experienced a shocking, scary, or dangerous event. This information was obtained from the website: http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml.

3. COVID-19: COVID-19 is caused by a coronavirus called SARS-CoV-2. Coronaviruses are a large family of viruses that are common in people and may different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then

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F 645	Continued From page 42 spread between people. This occurred with MERS-CoV and SARS-CoV, and now with the virus that causes COVID-19. The SARS-CoV-2 virus is a betacoronavirus, like MERS-CoV and SARS-CoV. All three of these viruses have their origins in bats. The sequences from U.S. patients are similar to the one that China initially posted, suggesting a likely single, recent emergence of this virus from an animal reservoir. However, the exact source of this virus is unknown. This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/faq.html#How-COVID-19-Spreads. 2. The facility staff failed to complete a PASRR for Resident #32 who was admitted to the facility on 7/7/2021. Resident #32 was admitted to the facility with diagnoses that included but were not limited to Parkinson's disease (1) and schizophrenia (2). Resident #32's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/30/2021, coded Resident #32 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Review of Resident #32's clinical record failed to evidence a level 1 PASRR. On 1/11/2022 at approximately 4:30 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the Level 1 PASRR for Resident #32. On 1/12/2022 at 1:15 p.m., an interview was	F 645		

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F 645	Continued From page 43 conducted with OSM (other staff member) #3, the director of social services and ASM #1, the administrator. OSM #3 stated that prior to the COVID-19 (3) pandemic the PASRR was completed prior to admission, however there were waivers in place that allowed them to admit residents without the assessment. OSM #3 stated that they were supposed to complete the PASRR after admission in a timely manner but was not sure of the exact timeframe allowed. OSM #3 stated that when they realize they did not have one [PASRR] they completed it then. ASM #1 stated that they made all attempts to get the PASRR prior to admission and if the resident were admitted without it they completed it within 24-48 hours. ASM #1 stated that the waivers had caused confusion for staff regarding completion of them [PASRR]. ASM #1 stated that they had a QAPI (quality assurance and performance improvement) plan on completing the PASRR. At this time a request was made for the improvement plan that was put into place. On 1/13/2022 at approximately 10:30 a.m., ASM #1 and OSM #3 provided the QAPI (quality assurance and performance improvement) meeting dated 12/22/2021 which documented in part, "QAPI Action Plan. Issue/Concern: PASSR [sic]/Preadmission Screening and Resident Review. Goals/Objective/Expected Outcome: Complete all PASSR's [sic] upon admission of residents admission...Audit the charts to ensure that all PASSR's [sic] are completed if needed including level 2 PASSR's [sic]...Projected Completed Date: 1/10/2022..." When asked the date of compliance for the QAPI plan, ASM #1 stated that it was 1/10/2022. On 1/13/2022 at 12:15 p.m., ASM #2, the director	F 645		

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of nursing stated that the facility did not have a PASRR for Resident #32.

On 1/13/2022 at 12:15 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

1. Parkinson's disease: A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

2. Schizophrenia: "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information is taken from the website https://medlineplus.gov/schizophrenia.html

3. COVID-19: COVID-19 is caused by a coronavirus called SARS-CoV-2. This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/faq.html#How-COVID-19-Spreads.

3. The facility staff failed to complete a PASRR in a timely manner for Resident #94 who was admitted to the facility on 5/17/2021 with a readmission on 7/30/2021. Resident #94's PASRR was not completed until 1/12/2022.

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Resident #94 was admitted to the facility with diagnoses that included but were not limited to schizophrenia (1) and dementia (2). Resident #94's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/3/2021, coded Resident #94 as scoring a 3 on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 - being severely impaired for making daily decisions.

Review of Resident #94's clinical record failed to evidence a level 1 PASRR.

On 1/11/2022 at approximately 4:30 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the Level 1 PASRR for Resident #94.

On 1/12/2022 at approximately 9:30 a.m., ASM #2, the director of nursing provided a Level 1 PASRR for Resident #94 with a completion date of 1/12/2022.

On 1/12/2022 at 1:15 p.m., an interview was conducted with OSM (other staff member) #3, the director of social services and ASM #1, the administrator. OSM #3 stated that they were new to the facility and were unable to find the Level 1 PASRR for Resident #94. OSM #3 stated that they had completed a new PASRR on 1/12/2022 for Resident #94 that morning. OSM #3 stated that prior to the COVID-19 (3) pandemic the PASRR was completed prior to admission, however there were waivers in place that allowed them to admit residents without the assessment. OSM #3 stated that they were supposed to complete the PASRR after admission in a timely manner but was not sure of the exact timeframe

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F 645	Continued From page 46 allowed. OSM #3 stated that when they realize Resident #94 did not have one [PASRR] they completed it then. ASM #1 stated that they made all attempts to get the PASRR prior to admission and if the resident were admitted without it they completed it within 24-48 hours. ASM #1 stated that the waivers had caused confusion for staff regarding completion of them [PASRR]. ASM #1 stated that they had a QAPI (quality assurance and performance improvement) plan on completing the PASRR. At this time a request was made for the improvement plan that was put into place. On 1/13/2022 at approximately 10:30 a.m., ASM #1 and OSM #3 provided the QAPI (quality assurance and performance improvement) meeting dated 12/22/2021 which documented in part, "QAPI Action Plan. Issue/Concern: PASSR [sic]/Preadmission Screening and Resident Review. Goals/Objective/Expected Outcome: Complete all PASSR's [sic] upon admission of residents admission...Audit the charts to ensure that all PASSR's [sic] are completed if needed including level 2 PASSR's [sic]...Projected Completed Date: 1/10/2022..." When asked the date of compliance for completion of the QAPI plan, ASM #1 stated that it was 1/10/2022. On 1/13/2022 at 12:15 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings above. No further information was provided prior to exit. References: 1. Schizophrenia: "Schizophrenia is a serious brain illness. People who have it may hear voices	F 645		

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that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information is taken from the website https://medlineplus.gov/schizophrenia.html

2. Dementia: A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

3. COVID-19: COVID-19 is caused by a coronavirus called SARS-CoV-2. This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/faq.html#How-COVID-19-Spreads.

4. The facility staff failed to complete a PASRR (preadmission screening and resident review) in a timely manner for Resident #146 who was admitted to the facility on 9/17/2020. Resident #146's PASRR was not completed until 1/12/2022.

Resident #146 was admitted to the facility on 9/17/20 with diagnoses that included but were not limited to: non-traumatic intracerebral hemorrhage (bleeding within the brain) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and chronic kidney disease (decreased function of the kidneys frequently as a complication of diabetes) (3).

Resident #146's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/17/21,

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coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, bathing, toileting and personal hygiene; supervision in eating.

A review of Resident #146's clinical record failed to reveal evidence of completion of a PASRR either prior to or on admission on 9/17/20.

A PASRR for Resident #146 dated 1/12/22 was provided on 1/12/22 at 11:00 AM.

An interview was conducted on 1/12/22 at 1:15 PM, with OSM (other staff member) #3, the social services director. When asked about the PASRR for Resident #146 being completed on 1/12/22, OSM #3 stated, "No I could not find the PASRR's, so I did them today. Prior to COVID (coronavirus), they were done before admission, then after COVID, they could be done after the resident was in the building. We will go ahead and complete them and if needed refer to a level II. Normally they would be completed within 24-48 hours of admission."

An interview was conducted on 1/12/22 at 1:20 PM, with ASM (administrative staff member) #1, the administrator, who stated, "There are CMS guideline to do this. There is a waiver for PASRR's for a particular period of time."

According to a CMS waiver "CMS is waiving 42CFR 483.20(k), allowing nursing homes to admit new residents who have not received Level 1 or Level 2 Preadmission Screening. Level 1 assessments may be performed post-admission.

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F 645	Continued From page 49 On or before the 30th day of admission, new patients admitted to nursing homes with a mental illness (MI) or intellectual disability (ID) should be referred promptly by the nursing home to State PASARR program for Level 2 Resident Review." On 1/12/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. On 1/13/22 at 1:10 PM, ASM #1 stated, "We do not have a policy for PASRR". No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 304. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 119. 5. The facility staff failed to complete a PASRR (preadmission screening and resident review) in a timely manner for Resident #22 who was admitted to the facility on 11/14/2020. Resident #22's PASRR was not completed until 1/12/2022. Resident #22 was admitted to the facility on 11/14/20 with diagnoses that included but were not limited to: cerebrovascular accident (hemorrhage of blockage of the vessels of the brain leading to a lack of oxygen) (1), diabetes	F 645		

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F 645	Continued From page 50 mellitus (inability of insulin to function normally in the body) (2) and post-traumatic stress disorder (mood disorder occurring after a traumatic event) (3). Resident #22's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/20/21, coded the resident as scoring 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of Resident #22's clinical record failed to reveal evidence of completion of a PASRR either prior to or on admission on 11/14/20. A PASRR for Resident #22 dated 1/12/22 was provided on 1/12/22 at 11:00 AM. An interview was conducted on 1/12/22 at 1:15 PM, with OSM (other staff member) #3, the social services director. When asked about the PASRR for Resident #22 being completed on 1/12/22, OSM #3 stated, "No I could not find the PASRR's, so I did them today. Prior to COVID (coronavirus), they done before admission, then after COVID, they could be done after the resident was in the building. We will go ahead and complete them and if needed refer to a level II. Normally they would be completed within 24-48 hours of admission." An interview was conducted on 1/12/22 at 1:20 PM, with ASM (administrative staff member) #1, the administrator, who stated, "There are CMS guideline to do this. There is a waiver for PASRR's for a particular period of time." According to a CMS waiver "CMS is waiving	F 645		

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F 645	Continued From page 51 42CFR 483.20(k), allowing nursing homes to admit new residents who have not received Level 1 or Level 2 Preadmission Screening. Level 1 assessments may be performed post-admission. On or before the 30th day of admission, new patients admitted to nursing homes with a mental illness (MI) or intellectual disability (ID) should be referred promptly by the nursing home to State PASARR program for Level 2 Resident Review." On 1/12/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. On 1/13/22 at 1:10 PM, ASM #1 stated, "We do not have a policy for PASRR". No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 111. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 467.. 6. The facility staff failed to complete a level I PASRR (preadmission screening and resident review) for Resident #56. Resident #56 was admitted to the facility on 11/10/21. Resident #56's diagnoses included but were not limited to diabetes, high blood pressure and schizophrenia. Resident #56's admission minimum data set assessment with an	F 645		

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F 645	Continued From page 52 assessment reference date of 11/11/21 coded the resident's cognition as moderately impaired. Review of Resident #56's clinical record failed to reveal a level I PASRR was completed prior to or after admission to the facility. On 1/12/22 at 1:16 p.m., an interview was conducted with OSM (other staff member) #3 (the social services director) and ASM (administrative staff member) #1 (the administrator). OSM #3 stated she completed Resident #56's PASRR on this day (1/12/2022) because she could not find that one had been completed. OSM #3 stated that prior to COVID, PASRRs were supposed to be done prior to admission but after COVID, Medicaid and the Department of Health said PASRRs could be done after admission. ASM #1 stated PASRRs should be done within 24 to 48 hours of admission. OSM #3 stated there had been a waiver in place but she was not sure if that had changed. On 1/12/22 at 5:15 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 645		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident	F 655	**F655 SS=D Baseline Care Plan** **CFR(s): 483.21(a)(1)-(3)**	2/8/2022

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F 655	Continued From page 53 that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it	F 655	The Care Plan was updated to include Colostomy care for resident #326. The Care Plan was updated to include Oxygen usage on resident #328. Residents who were admitted to Canterbury Rehab and Healthcare requiring baseline care plans completion have the potential to be affected by this practice. Baseline Care Plans were audited for all residents who were admitted to the facility in the last 30 days to ensure baseline care plans were initiated. The facility audit included development and implementation of a Baseline Care Plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality of care. Baseline Care Plan Policy reviewed no revisions necessary. Education provided by the Staff Development Coordinator/Designee for the Interdisciplinary team and Licensed Nursing staff on the development and implementation of a Baseline Care Plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality of care, and the timeliness of 48 hours of resident admission.	

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F 655	Continued From page 54 was determined that the facility staff failed to develop a complete baseline care plan for two of 62 residents in the survey sample, Residents #326 and #328. The facility staff failed to develop a complete baseline care plan to address colostomy care for Resident #326 and failed to develop a baseline care plan to address and include Resident #328's oxygen use. The findings include: 1. Resident #326 was admitted to the facility on 1/4/22. Resident #326's diagnoses included but were not limited to chronic kidney disease, history of breast cancer and an underactive thyroid. Resident #326's admission minimum data set assessment was not completed. An admission nursing evaluation dated 1/4/22 documented Resident #326 was alert and oriented to person, place and time. Review of Resident #326's clinical record revealed physician's orders dated 1/10/22 and 1/11/22 for the resident's colostomy care. Resident #326's baseline care plan dated 1/5/22 only included a section for nutrition. The care plan did not include any other information regarding the resident's colostomy or other care that was needed. On 1/12/22 at 12:56 p.m., an interview was conducted with RN (registered nurse) #1 (the minimum data set coordinator), ASM (administrative staff member) #1 (the administrator) and OSM #4 (the regional director of case management). RN #1 stated the care	F 655	Interdisciplinary Team members will review as part of Morning Clinical the development and implementation of a Baseline Care Plan for each newly admitted resident. An audit will be accomplished by the Director of MDS/Designee weekly x 4 weeks and then monthly x 2 months on the development and implementation of a Baseline Care Plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality of care, and the timeliness of 48 hours of resident admission. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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plan is a holistic approach in caring for the resident, taking in all disciplines and identifying an approach in caring for the patient. RN #1 stated the facility staff try to establish a baseline care plan within 48 hours of admission and the baseline care plan should include basic need items including activities of daily living, skin, pain, nutritional status and significant medication or care areas.

On 1/12/22 at 2:09 p.m., an interview was conducted with RN #3. RN #3 stated the purpose of the care plan is that it is individualized to meet the needs of the patient. RN #3 stated a resident's baseline care plan is created on admission and should include all basic care plans such as pain, falls and skin. RN #3 stated a baseline care plan should include colostomy care because the resident is at risk for skin breakdown and electrolyte dysfunction.

On 1/12/22 at 2:28 p.m., OSM (other staff member) #4 stated it is the facility staff's best practice that they would include colostomy care on a resident's baseline care plan.

On 1/12/22 at 5:15 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Care Plans- Baseline" documented, "1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. 2. The interdisciplinary team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the

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F 655	Continued From page 56 resident's immediate care needs including, but not limited to the following: a. Initial goals based on admission orders; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services; and f. PASARR recommendation, if applicable." No further information was presented prior to exit. Reference: (1) "Colostomy is a surgical procedure that brings one end of the large intestine out through an opening (stoma) made in the abdominal wall. Stools moving through the intestine drain through the stoma into a bag attached to the abdomen." This information was obtained from the website: https://medlineplus.gov/ency/article/002942.htm 2. Resident #328 was admitted to the facility on 1/5/22. Resident #328's diagnoses included but were not limited to diabetes, acute kidney failure and pneumonia secondary COVID-19. Resident #328's admission minimum data set assessment was not completed. An admission nursing evaluation dated 1/5/22 documented Resident #328 was alert and oriented to person and place. On 1/12/22 at 8:13 a.m. Resident #328 was observed lying in bed receiving oxygen at two and a half liters per minute via nasal cannula. Review of Resident #328's January 2022 physician's orders failed to reveal a physician order for oxygen. Resident #328's baseline care plan dated 1/6/22 failed to reveal documentation regarding oxygen.	F 655		

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F 655	Continued From page 57 On 1/12/22 at 12:56 p.m., an interview was conducted with RN (registered nurse) #1 (the minimum data set coordinator), ASM (administrative staff member) #1 (the administrator) and OSM #4 (the regional director of case management). RN #1 stated the care plan is a holistic approach in caring for the resident, taking in all disciplines and identifying an approach in caring for the patient. RN #1 stated the facility staff try to establish a baseline care plan within 48 hours of admission and the baseline care plan should include basic need items including activities of daily living, skin, pain, nutritional status and significant medication or care areas. On 1/12/22 at 2:09 p.m., an interview was conducted with RN #3. RN #3 stated the purpose of the care plan is that it is individualized to meet the needs of the patient. RN #3 stated a resident's baseline care plan is created on admission and should include all basic care plans such as pain, falls and skin. RN #3 stated oxygen use should absolutely be included on a baseline care plan because oxygen use is part of safety and breathing. On 1/12/22 at 2:28 p.m., OSM #4 stated it is the facility staff's best practice that they would include oxygen use on a resident's baseline care plan. On 1/12/22 at 5:15 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 655		

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F 656 F 656 SS=D	Continued From page 58 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 local contact agencies and/or other appropriate	F 656 F 656	**F656 SS=D Develop/Implement Comprehensive Care Plan** **CFR(s): 483.21(b)(1)** Resident #131's Orthotic/Splint was assessed by therapy and a new splint was applied 1/12/2022. Resident #426's Television was assessed by the maintenance department to be functioning properly and was turned on per resident channel preference at the time of survey. Resident #117's oxygen was applied per physician order at the time of survey. Residents that reside at Canterbury Rehab and Healthcare that meet the guidelines for Comprehensive Care Plan Development have the potential to be affected by this practice. An audit was completed by the IDT Team/Designee on current residents who reside at Canterbury Rehab and Healthcare for the development and implementation of a Comprehensive person-centered Care Plan. Identified discrepancies adjusted to reflect residents' current status. Comprehensive Person-Centered Care policy reviewed no revisions necessary.	**2/8/2022**

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F 656	Continued From page 59 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 staff interview, facility document review and clinical record review, it was determined the facility staff failed to develop/implement the comprehensive care plan for three of 62 residents in the survey sample, Resident #131, Resident #426 and Resident #117. The facility staff failed to implement Resident #131's comprehensive care plan for a left hand splint, failed to implement Resident #426's comprehensive care plan for preferred activities and failed to implement Resident #117's comprehensive care plan for the administration of oxygen. The findings include: 1. Resident #131 was admitted to the facility on 9/12/20 with diagnoses that included but were not limited to: cerebral infarction [CVA] (hemorrhage or blockage of blood vessels of the brain leading to a lack of oxygen) (1) hemiplegia (paralysis affecting one side of the body) (2) and atherosclerotic cardiovascular disease (plaque consisting of lipids and cholesterol building up in arterial walls) (3). Resident #131's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/18/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score,	F 656	Education was provided to the IDT Team and the licensed nursing staff by the Director of Nursing/Designee on the Comprehensive Person-Centered Care plan policy. Interdisciplinary Team members will review as part of Quarterly Care Conferences the development and implementation of a Comprehensive person-centered Care Plan. A random audit of 5 resident will be completed as part of the Care Planning process weekly x 4 weeks and then monthly x 2 months to ensure ongoing compliance with the development and implementation of a Comprehensive person-centered Care Plan process. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, toileting and personal hygiene; independent in eating and total dependence in bathing.

During the initial facility tour on 1/11/22 at 12:30 PM, Resident #131 was observed sitting on the side of the bed with his left arm in his lap and hand curled up. At this time when interviewed, Resident #131 stated, "I have a splint but it is in the top drawer." When asked who helps him put the splint on, Resident #131 stated, "I cannot do it myself, and the staff usually does not put it on. I used to be in therapy but not anymore."

On 1/12/22 at 9:30 AM, observed Resident #131 without splint on hand, as he was sitting on the side of the bed.

A review of Resident #131's comprehensive care plan dated 9/21/20, documented in part, "FOCUS-I have limited physical mobility related to left hemiplegia status/post CVA. INTERVENTIONS-Grab bars when in bed to aide in positioning and mobility. One-person physical assist for bathing and showers, one person assist with toileting. I require set up help for eating. Neutral left hand splint to be worn as ordered."

A review of the physician orders, dated 8/31/21, documented in part, "Neutral resting splint for left hand and wrist."

An interview was conducted on 1/11/22 at 12:45 PM, with OSM (other staff member) #14, the physical therapist. When asked who was responsible to assist Resident #131 with placing

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his splint, OSM #14 stated, "He used to be in therapy, and we would work with him. The nurses put it on now."

An interview was conducted on 1/12/22 at 9:10 AM with CNA (certified nursing assistant) #1. When asked who was responsible to assist Resident #131 with placing his splint, CNA #1 stated, "He usually doesn't wake up in the mornings. So I do not put the splint on till about noon. Sometimes therapy puts the splint on."

An interview was conducted on 1/12/22 at 12:56 PM with RN (registered nurse) #1, the MDS director and OSM (other staff member) #4, the regional director of care management. When asked her start date, RN #1 stated, "I started 1/10/22." When asked the purpose of the care plan, RN #1 stated, "The purpose of the care plan is to provide a holistic approach in caring for the resident and to inform all disciplines. It includes head to toe and psychosocial care for them in all aspects." When asked if splints included as an intervention on the comprehensive care plan should be applied, OSM #4 stated yes, of course, splints should be applied.

On 1/12/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above findings.

A review of the facility's "Comprehensive, person-centered care plan" policy, version 1.3, documented in part, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each

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F 656	Continued From page 62 resident. The comprehensive, person-centered care plan will: include measurable objectives and timeframes; describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Aid in preventing or reducing decline in the resident's functional status and/or functional levels" No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 111. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 264. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 52. 2. Resident #426 was admitted to the facility with diagnoses that included but were not limited to anoxic brain damage (1) and congestive heart failure (2). Resident #426's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/21/2021, coded the resident as being severely impaired for making daily decisions. Section G coded Resident #426 as requiring total assistance of two or more staff with bed mobility and total assistance of one staff member for personal hygiene, toileting, dressing and eating. On 1/11/2022 at approximately 12:30 p.m., an observation was made of Resident #426 in their room. Resident #426 was observed lying in bed receiving a tube feeding attached to a feeding pump. Resident #426 was alert with their eyes	F 656		

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open and non-verbal. A television was located on top of the dresser at the foot of Resident #426's bed. A note on the television documented preferred television channels, the television was observed to be off.

Additional observations conducted on 1/11/2022 at 2:45 p.m., 4:30 p.m. and 1/12/2022 at 8:30 a.m. and 1:45 p.m., revealed the findings as described above.

On 1/11/2022 at approximately 2:15 p.m., an interview was conducted with Resident #426's responsible party. Resident #426's responsible party voiced concerns regarding the facility staff not following their requests to turn the television on the sports channels for Resident #426. Resident #426's responsible party stated that he enjoyed listening to anything related to sports because of his previous career and it was one of the only things that he really showed a response to.

The comprehensive care plan for Resident #426 dated 12/01/2020 documented in part, "[Resident #426] requires assistance to structures [sic] his leisure time r/t (related to) his physical and cognitive deficits. Date Initiated: 12/01/2020." Under "Interventions" it documented in part, "Assist resident with TV. Date Initiated: 12/01/2020. I enjoy music R&B and oldies, I also enjoy church and socials. I enjoy watching TV and sports. Date Initiated: 12/01/2020..." The care plan further documented "I am dependent on staff for activities, cognitive stimulation, social interaction r/t cognitive deficits, physical limitations. Date Initiated: 12/14/2020." Under "Interventions" it documented in part, "My preferred cavities are music, sensory stimulation,

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and watching TV. Date Initiated: 12/14/2020."

The "Activities-Quarterly/Annual Participation Review" dated 4/22/2021 documented in part, "... [Resident #426] watches sports and ESPN broadcast, the recreation team facilitates facetime calls for [Resident #426] and his family weekly..."

On 1/12/2022 at 9:39 a.m., an interview was conducted with OSM (other staff member) #10, activities. OSM #10 stated that they worked on Resident #426's unit. OSM #10 stated that they personalized activities for the residents based on their preferences and personal choices. OSM #10 stated that they relied on the care plan using the resident's personal experiences to provide activities.

On 1/12/2022 at 1:45 p.m., an interview was conducted with CNA (certified nursing assistant) #8. CNA #8 stated that Resident #426 was non-verbal and stayed in the bed most days. CNA #8 stated that Resident #426 required total care from staff for all activities of daily living and did not attend activities outside of the room. CNA #8 stated that Resident #426 liked sports and enjoyed listening to football and sports on the television.

On 1/12/2022 at 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 stated that Resident #426 did not participate in activities and stayed in their room in bed most days. LPN #6 stated that Resident #426 was nonverbal and followed objects with his eyes. LPN #6 stated that Resident #426 used to watch sports on television prior to it breaking. LPN #6 stated that the television had been

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F 656	Continued From page 65 broken since November of 2021 and they were not sure if the family was aware that it was broken or if maintenance was aware of this. LPN #6 stated whoever discovered the television was broken should have reported it to the family and maintenance for repairs. On 1/12/2022 at approximately 2:15 p.m., a request was made to OSM #6, maintenance director for any work order requests for repairs to Resident #426's television. On 1/12/2022 at 2:49 p.m., an interview was conducted with OSM #10, activities. OSM #10 stated that Resident #426 was mostly bed ridden and non-responsive. OSM #10 stated that they had scheduled weekly virtual calls scheduled with Resident #426's responsible party. OSM #10 stated that Resident #426 previously worked as a football coach and enjoyed watching sports channels on the television. OSM #10 stated that they were not aware that Resident #426's television was not working or they would have provided an alternate activity for him, possibly a streaming device or radio to listen to sports. OSM #10 stated that the activities department had radios, speakers and ipads available for resident use. OSM #10 stated that if they had been aware the television was not working they would have had maintenance check it. On 1/12/2022 at approximately 3:30 p.m., OSM #5, the regional director of plant operations stated that they did not have any work order requests for Resident #426's television. On 1/12/2022 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator stated that maintenance had	F 656		

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F 656	Continued From page 66 checked Resident #426's television and that it was not broken but had to have the channel settings adjusting. ASM #1 stated that the television was working at that time. On 1/12/2022 at approximately 5:00 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concern. No further information was presented prior to exit. References: 1. Anoxic brain damage: Not enough oxygen getting to the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001435.htm 2. Congestive heart failure: A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html 3. Resident #117 was admitted to the facility on 12/6/21. Resident #117's diagnoses included but were not limited to heart failure, respiratory failure and acute kidney failure. Resident #117's admission minimum data set with an assessment reference date of 12/10/21, coded the resident as being cognitively intact. Section O coded Resident #117 as having received oxygen. Review of Resident #117's clinical record	F 656		

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F 656	Continued From page 67 revealed a physician's order dated 12/8/21 for oxygen at two liters per minute continuously via nasal cannula. Resident #117's comprehensive care plan dated 12/15/21 documented, "I have altered respiratory status/Difficulty Breathing. Provide oxygen as ordered." On 1/11/22 at 1:29 p.m. and 1/12/22 at 8:21 a.m., Resident #117 was observed lying in bed and was not receiving oxygen. On 1/12/22 at 2:09 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated the purpose of the care plan is that it is individualized to meet the needs of the patient. RN #3 stated nurses implement the care plan by reviewing the care plan in the computer system and aides implement the care plan by reviewing a kardex. On 1/12/22 at 2:43 p.m. an interview was conducted with RN #2. RN #2 stated Resident #117's tracheostomy was recently removed and the resident uses oxygen sometimes. When asked what a physician's order for continuous oxygen meant, RN #2 stated, "They should have oxygen all the time." On 1/12/22 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657	**F657 SS=D Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)**	

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F 657	Continued From page 68 §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 clinical record review, staff interview, resident family interview and facility document review, it was determined that facility staff failed to review or revise the comprehensive care plan for two of 62 residents in the survey sample, Resident #426 and Resident # 148. The facility staff failed to include the resident representative in reviewing and revising the comprehensive care plan for Resident #426 and failed to review and revise Resident #148's	F 657	A Comprehensive Care Plan was held for Resident #426 with Resident Representative on 1/31/2022. Resident 148 was assessed for continued use of side rails and was found to not have need for their usage at this time. Comprehensive Care Plan was reviewed with requirement for bed rail update not needed. Orders for side rails were not required due to the discontinuation of side rail usage. Residents who reside at Canterbury Rehab and Healthcare who meet the requirement for a Comprehensive Care plan have the potential to be affected by this practice. An audit was completed by the MDS Coordinator/Designee for current residents in the last quarter who meet the criteria for Comprehensive Care Plan meetings to ensure documentation supports Resident/Resident Representative were invited to attend the Care Plan meeting. Those found to have not had invitation/attendance to the Comprehensive Care Plan meeting in the last quarter were contacted for opportunity for meeting to discuss the Comprehensive Care Plan. Residents who reside at Canterbury Rehab and Healthcare who require update/revision their care plan have the potential to be affected by this documentation practice. An audit was completed for residents requiring update/revision to the Care Plan. Modifications were made for residents identified with discrepancies.	2/8/2022

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F 657	Continued From page 69 comprehensive care plan for the use of bed rails. The findings include: 1. The facility staff failed to include the resident representative in reviewing and revising the comprehensive care plan for Resident #426. Resident #426 was admitted to the facility with diagnoses that included but were not limited to anoxic brain damage (1) and congestive heart failure (2). Resident #426's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/21/2021, coded the resident as being severely impaired for making daily decisions. Section G coded Resident #426 as requiring total assistance of two or more staff with bed mobility and total assistance of one staff member for personal hygiene, toileting, dressing and eating. On 1/11/2022 at approximately 12:30 p.m., an observation was made of Resident #426 in their room. Resident #426 was observed lying in bed receiving a tube feeding attached to a feeding pump. Resident #426 was alert with their eyes open and non-verbal. On 1/11/2022 at approximately 2:15 p.m., an interview was conducted with Resident #426's responsible party. Resident #426's responsible party voiced concerns regarding the facility staff not informing them of the care plan meetings. Resident #426's responsible party stated that they advocated for Resident #426 because they were non-verbal and could not speak for themselves and had weekly facetime calls scheduled with the resident. Resident #426's responsible party	F 657	Care Planning Policy reviewed no revisions necessary. Education was completed by the Administrator/Designee on the inclusion of resident representative in the review and revision of the comprehensive care plan. An audit will be completed by the Social Service Director weekly x 4 weeks and then monthly x 2 months of resident/resident representative invitations to the Care Plan meetings. Education was completed by the Staff Development Coordinator/Designee to the Interdisciplinary team and Licensed nursing staff on the updating/revision of the Comprehensive Care plan to meet current resident needs. Interdisciplinary Team members will review in Morning Clinical the updating/revision of the Comprehensive Care plan. An random audit of 5 residents will be completed by the Director of Nursing/Designee weekly x 4 weeks and then monthly x 2 months to ensure the updating/revision of the Comprehensive Care Plan occurs timely and reflect the current resident needs. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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F 657	Continued From page 70	F 657		

stated that they previously received invitations to attend the care plan meetings and was willing to attend by facetime but never knew when they were to occur because no one let them know. Resident #426's responsible party stated that they had voiced this concern to the social worker previously but had never heard any updates.

Review of Resident #426's clinical record failed to evidence documentation of an interdisciplinary care plan meeting to review/revise the care plan or notification of the responsible party of a care plan meeting.

On 1/11/2022 at approximately 4:30 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of an interdisciplinary care plan meeting and invitation to the responsible party.

On 1/12/2022 at approximately 9:30 a.m., ASM #2, the director of nursing provided a progress note dated 9/17/2020 which documented, "SW (social worker) held an open discussion with this resident's wife regarding scheduling a Care Plan. SW on this day was receptive to the SW and relayed her availability is better on Fridays. SW has established a Care plan for Friday September 25th at 2pm." ASM #2 also provided a care plan meeting review note dated 9/25/2020 which documented family attendance.

On 1/12/2022 at 1:00 p.m., an interview was conducted with RN (registered nurse) #1, MDS director and OSM (other staff member) #4, the regional director of case management. RN #1 stated that they were new to the facility but thought that the care plan meetings were arranged by the social worker. RN #1 stated that

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F 657	Continued From page 71 the care plan was a holistic approach used to care for the total resident and covered all disciplines. On 1/13/2022 at 9:30 a.m., an interview was conducted with OSM #3, the director of social services. OSM #3 stated that they were new to the facility and were working on a process to improve care planning. OSM #3 stated that they had started doing care navigation meetings as a team in the resident's room and calling the responsible party to include them. OSM #3 stated that they began the process after starting at the facility in early December of 2021. OSM #3 stated that they had a roster of care plan meetings that were behind schedule and were working to get them back on the quarterly schedule. OSM #3 stated that Resident #426 was a long term care resident and the pandemic and staffing issues had delayed the meetings being set up. OSM #3 reviewed Resident #426's clinical record and stated that there was no documentation of a care plan meeting held in 2021. On 1/13/2022 at approximately 10:30 a.m., ASM #1 and OSM #3 provided the QAPI (quality assurance and performance improvement) meeting dated 12/22/2021 which documented in part, "...Data: Care Plans not completed... Analysis (Root Cause Analysis): Meetings not scheduled due to staffing issues. Families unable to attend due to COVID (3). Residents not attending due to COVID...Plan: Social Services will schedule, create letters and mail to residents and their families. Staff and family members will be notified in a timely manner. Required staff will include, the facility will follow CDC (centers for disease control) guidelines to ensure safety for	F 657		

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F 657	Continued From page 72 participants during the meetings..." When asked the date of compliance for the QAPI plan, ASM #1 stated that it was 1/10/2022. At this time, a second request was made for evidence of the scheduled care plan meeting and letter mailed to Resident #426's responsible party as documented in the QAPI plan. OSM #3 stated that they had started the process with the short term residents and had not finished the long-term residents at that time. On 1/12/2022 at approximately 5:00 p.m., a request was made to ASM #1, the administrator for the facility policy regarding reviewing and/or revising the care plan. The facility policy, "Care Plans, Comprehensive Person-Centered" documented in part, "...The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representatives, develops and implements a comprehensive, person-centered care plan for each resident...The care planning process will: a. facilitate resident and/or representative involvement; b. include an assessment of the resident's strengths and needs; and c. incorporate the resident's personal and cultural preferences in developing the goals of care..." The policy further documented, "14. The interdisciplinary team must review and update the care plan: ...at least quarterly, in conjunction with the required quarterly MDS assessment..." On 1/13/2022 at approximately 12:15 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concern. No further information was presented prior to exit.	F 657		

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F 657	Continued From page 73 References: 1. Anoxic brain damage: Not enough oxygen getting to the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001435.htm 2. Congestive heart failure: A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html 3. COVID-19: COVID-19 is caused by a coronavirus called SARS-CoV-2. Coronaviruses are a large family of viruses that are common in people and may different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people. This occurred with MERS-CoV and SARS-CoV, and now with the virus that causes COVID-19. The SARS-CoV-2 virus is a betacoronavirus, like MERS-CoV and SARS-CoV. All three of these viruses have their origins in bats. The sequences from U.S. patients are similar to the one that China initially posted, suggesting a likely single, recent emergence of this virus from an animal reservoir. However, the exact source of this virus is unknown. This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/faq.html#How-COVID-19-Spreads 2. The facility staff failed to review and revise Resident #148's comprehensive care plan for the	F 657		

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F 657	Continued From page 74 use of bed rails. Resident #148 was admitted to the facility on 6/19/20. Resident #148's diagnoses included but were not limited to diabetes, chronic kidney disease and COVID-19. Resident #148's quarterly minimum data set assessment with an assessment reference date of 12/20/21, coded the resident's cognition as severely impaired. On 1/11/22 at 2:16 p.m., Resident #148 was observed lying in bed with bilateral grab bar bed rails in the upright position. Resident #148's comprehensive care plan dated 9/22/20 failed to reveal documentation regarding bed rails. Review of Resident #148's clinical record on 1/11/22 failed to reveal a physician's order for bed rails. On 1/12/22 at 12:56 p.m., an interview was conducted with RN (registered nurse) #1 (the minimum data set coordinator), ASM (administrative staff member) #1 (the administrator) and OSM #4 (the regional director of case management). RN #1 stated the care plan is a holistic approach in caring for the resident, taking in all disciplines and identifying an approach in caring for the patient. On 1/12/22 at 2:09 p.m., an interview was conducted with RN #3. RN #3 stated the purpose of the care plan is that it is individualized to meet the needs of the patient. RN #3 stated the use of bed rails should be included on a resident's comprehensive care plan.	F 657		

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F 657	Continued From page 75 On 1/12/22 at 2:28 p.m., OSM #4 stated the use of bed rails should be included on a resident's comprehensive care plan. On 1/12/22 at 5:15 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, family interview, staff interviews and facility document review it was determined that the facility staff failed to provide preferred activities to meet the needs of one of 62 residents in the survey sample, Resident #426. The findings include: Resident #426 was admitted to the facility with diagnoses that included but were not limited to anoxic brain damage (1) and congestive heart failure (2). Resident #426's most recent MDS	F 679	**F679 SS=D Activities to Meet Interests/Needs Each Resident** **CFR(s): 483.24©(1)** Resident #426 Television / preferred activity was provided. The Television was assessed by the Maintenance Director to be working properly during the survey process. Residents who reside at Canterbury Rehab and Healthcare and have activities of choice have the potential to be affected by this practice. An audit was completed by the Activities Director/Designee of current residents to ensure their preferred activities meet their current needs. Activities Policy reviewed no revisions necessary.	**2/8/2022**

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F 679	Continued From page 76 (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/21/2021, coded the resident as being severely impaired for making daily decisions. Section G coded Resident #426 as requiring total assistance of two or more staff with bed mobility and total assistance of one staff member for personal hygiene, toileting, dressing and eating. On 1/11/2022 at approximately 12:30 p.m., an observation was made of Resident #426 in their room. Resident #426 was observed lying in bed receiving a tube feeding attached to a feeding pump. Resident #426 was alert with their eyes open and non-verbal. A television was located on top of the dresser at the foot of Resident #426's bed. A note on the television documented preferred television channels, the television was observed to be off. The privacy curtain was observed to be pulled halfway between Resident #426 and their roommate. Additional observations conducted on 1/11/2022 at 2:45 p.m., 4:30 p.m. and 1/12/2022 at 8:30 a.m. and 1:45 p.m., revealed the findings as described above. On 1/11/2022 at approximately 2:15 p.m., an interview was conducted with Resident #426's responsible party. Resident #426's responsible party voiced concerns regarding the facility staff not following their requests to turn the television on the sports channels for Resident #426. Resident #426's responsible party stated that he enjoyed listening to anything related to sports because of his previous career and it was one of the only things that he really showed a response to.	F 679	Education was provided by the Administrator/Designee for the Activities Department staff on the provision of activities to meet the resident needs. A random audit of 15 residents will be completed weekly x 4 weeks and then monthly x 2 months by the Activities Director/Designee to ensure that the staff are providing residents with the preferred activities. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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F 679	Continued From page 77 The comprehensive care plan for Resident #426 dated 12/01/2020 documented in part, "[Resident #426] requires assistance to structures [sic] his leisure time r/t (related to) his physical and cognitive deficits. Date Initiated: 12/01/2020." Under "Interventions" it documented in part, "Assist resident with TV. Date Initiated: 12/01/2020. I enjoy music R&B and oldies, I also enjoy church and socials. I enjoy watching TV and sports. Date Initiated: 12/01/2020..." The care plan further documented "I am dependent on staff for activities, cognitive stimulation, social interaction r/t cognitive deficits, physical limitations. Date Initiated: 12/14/2020." Under "Interventions" it documented in part, "My preferred cavities are music, sensory stimulation, and watching TV. Date Initiated: 12/14/2020." The "Activities-Quarterly/Annual Participation Review" dated 4/22/2021 documented in part, "... [Resident #426] watches sports and ESPN broadcast, the recreation team facilitates facetime calls for [Resident #426] and his family weekly..." On 1/12/2022 at 9:39 a.m., an interview was conducted with OSM (other staff member) #10, activities. OSM #10 stated that they worked on Resident #426's unit. OSM #10 stated that they personalized activities for the residents based on their preferences and personal choices. OSM #10 stated that they relied on the care plan using the resident's personal experiences to provide activities. On 1/12/2022 at 1:45 p.m., an interview was conducted with CNA (certified nursing assistant) #8. CNA #8 stated that Resident #426 was non-verbal and stayed in the bed most days.	F 679		

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CNA #8 stated that Resident #426 required total care from staff for all activities of daily living and did not attend activities outside of the room. CNA #8 stated that Resident #426 liked sports and enjoyed listening to football and sports on the television.

On 1/12/2022 at 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 stated that Resident #426 did not participate in activities and stayed in their room in bed most days. LPN #6 stated that Resident #426 was nonverbal and followed objects with his eyes. LPN #6 stated that Resident #426 used to watch sports on television prior to it breaking. LPN #6 stated that the television had been broken since November of 2021 and they were not sure if the family was aware that it was broken or if maintenance was aware of this. LPN #6 stated whoever discovered the television was broken should have reported it to the family and maintenance for repairs.

On 1/12/2022 at approximately 2:15 p.m., a request was made to OSM #6, maintenance director for any work order requests for repairs to Resident #426's television.

On 1/12/2022 at 2:49 p.m., an interview was conducted with OSM #10, activities. OSM #10 stated that Resident #426 was mostly bed ridden and non-responsive. OSM #10 stated that they had scheduled weekly virtual calls scheduled with Resident #426's responsible party. OSM #10 stated that Resident #426 previously worked as a football coach and enjoyed watching sports channels on the television. OSM #10 stated that they were not aware that Resident #426's television was not working or they would have

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provided an alternate activity for him, possibly a streaming device or radio to listen to sports. OSM #10 stated that the activities department had radios, speakers and ipads available for resident use. OSM #10 stated that if they had been aware the television was not working they would have had maintenance check it.

On 1/12/2022 at approximately 3:30 p.m., OSM #5, the regional director of plant operations stated that they did not have any work order requests for Resident #426's television.

On 1/12/2022 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator stated that maintenance had checked Resident #426's television and that it was not broken but had to have the channel settings adjusted. ASM #1 stated that the television was working at that time.

On 1/12/2022 at approximately 5:00 p.m., a request was made to ASM #1, the administrator for the facility policy regarding providing activities to residents.

The facility policy, "Activity Programs" documented in part, "Activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident...Activities are not necessarily limited to formal activities being provided only by activities staff. Other facility staff, volunteers, visitors, residents and family members may also provide the activities...Individualized and group activities are provided that: reflect the schedules, choices and rights of the residents..."

On 1/12/2022 at approximately 5:00 p.m., ASM

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F 679	Continued From page 80 #1, the administrator and ASM #2, the director of nursing were made aware of the above concern. No further information was presented prior to exit. References: 1. Anoxic brain damage: Not enough oxygen getting to the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001435.htm 2. Congestive heart failure: A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it	F 684	**F684 SS=E Quality of Care** **CFR(s): 483.25** Lidocaine patch was removed at time of survey. Physician and family were notified of Lidocaine patch 5% being applied instead of Lidocaine cream 4% topically. Education was provided by the Director of Nursing/Designee to LPN #3 on following physician orders and Comprehensive Care plan. Residents who reside at Canterbury Rehab and Healthcare who receive medications have the potential to be affected by this practice.	2/8/2022

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F 684	Continued From page 81 was determined that the facility staff failed to administer medication per physician's order and comprehensive plan of care for one of 6 residents in the Medication Administration task, Resident #14. The facility staff administered a Lidocaine patch 5% to Resident #14 instead of Lidocaine cream 4% to neck, shoulder topically four times a day for pain as ordered by the physician, the incorrect type (patch vs cream) and dose 5% vs 4% and location knee vs neck/shoulder of this medication. The findings include: Resident #14 was admitted on 6/28/2 and had the diagnoses of but not limited to dementia, traumatic brain injury, depression, chronic migraine, overactive bladder, high blood pressure, and dysphagia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/12/21. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for hygiene; limited assistance for transfers, bed mobility, dressing, and toileting; independent for eating; and was occasionally to frequently incontinent of bowel and bladder. On 1/12/22 at 8:25 AM, LPN #3 (Licensed Practical Nurse) was observed to preparing and administering the following medications for Resident #14: (1) Tramadol 50 mg (milligrams) 1 tab (2) Oxybutynin 5 mg 1 tab (3) Topiramate 50 mg 1 tab	F 684	Medication Administration Policy reviewed no revisions necessary. Education provided by the Staff Development Coordinator/Designee for the licensed nursing staff on the administration of medication per physician order and following of the Comprehensive Care plan. An audit will be completed by the Staff Development Coordinator/Designee weekly x 4 weeks and then monthly x 2 months of residents who receive medications to ensure medication are given per physician order and following of the Comprehensive Care Plan. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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F 684	Continued From page 82 (4) Ezetimibe 10 mg 1 tab (5) Zoloft 50 mg 1 tab (6) Omeprazole 20 mg 1 tab (7) Lidocaine 5% patch applied to knee. The pharmacy label on the box for the Lidocaine patch was observed to have another resident's name on it. LPN #3 verbally gave Resident #14 options of where to put the patch, asking her if she wanted the patch on her knee or on her back and the resident chose to have it put on her knee. A review of the clinical record revealed a nurse's note dated 1/12/22 at 2:14 PM written by LPN #3 that documented, "resident asked nurse to remove lidocaine patch on her knee." On 1/12/22 at 4:37 PM, during reconciliation of the above medication administration with Resident #14's physician's orders, it was noted that there was no order for a Lidocaine patch 5% to either a knee or back for Resident #14. The review of Resident #14's physician's orders revealed one dated 6/28/21 for "Lidocaine Cream 4 % Apply to neck, shoulder topically four times a day for pain." This was not what was observed being administered. LPN #3 administered the incorrect type (patch vs cream) and dose (5% vs 4%) and location (knee vs neck/shoulder) of this medication. On 1/13/22 at 7:45 AM, an interview was conducted with LPN #4, the unit manager. He stated that LPN #3 was not on the schedule for this date and that LPN #3 was a "PRN" (as needed) nurse, not a regular facility nurse. When informed that Resident #14 was administered a Lidocaine patch on 1/12/22, LPN #4 immediately stated, "She isn't on a patch." When informed of	F 684		

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F 684	Continued From page 83	F 684		

the above observation, LPN #4 stated that the rights of medication administration were not followed and that the medication was not administered as ordered. When asked if the comprehensive care plan documenting, "Administer analgesia as per orders" was followed, LPN #4 stated it was not.

A review of the facility policy "Administering Medications" documented, "4. Medications are administered in accordance with prescriber orders, including any required time frame....10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication....25. Medications ordered for a particular resident may not be administered to another resident, unless permitted by state law and facility policy, and approved by the director of nursing services."

On 1/12/22 at approximately 5:30 PM at the end of day meeting, ASM #1 and ASM #2 (Administrative Staff Members) the Administrator and Director of Nursing, respectively, were made aware of the findings. No further information was provided by the end of the survey.

References:

(1) Tramadol is used to relieve moderate to severe pain.
Information obtained from https://medlineplus.gov/druginfo/meds/a695011.html

(2) Oxybutynin is used to treat overactive bladder.
Information obtained from

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F 684	Continued From page 84 https://medlineplus.gov/druginfo/meds/a682141.html (3) Topiramate is used to treat seizures. Information obtained from https://medlineplus.gov/druginfo/meds/a697012.html (4) Ezetimibe is used to treat high cholesterol. Information obtained from https://medlineplus.gov/druginfo/meds/a603015.html (5) Zoloft is used to treat depression Information obtained from https://medlineplus.gov/druginfo/meds/a697048.html (6) Omeprazole is used to treat gastroesophageal reflux. Information obtained from https://medlineplus.gov/druginfo/meds/a693050.html (7) Lidocaine 5% patch is used to treat certain types of pain. Information obtained from https://medlineplus.gov/druginfo/meds/a603026.html	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		

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F 688	Continued From page 85 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review it was determined that the facility staff failed to provide treatment and services to maintain or improve mobility for one of 62 residents in the survey sample, Resident #131. Resident #131 was observed on separate occasions on 1/11/21 and 1/12/21 without the physician ordered neutral resting splint for the resident's left hand and wrist in place. The findings include: The facility staff failed to implement the splint for Resident #131. Resident #131 was admitted to the facility on 9/12/20 with diagnoses that included but were not limited to: cerebral infarction [CVA] (hemorrhage or blockage of blood vessels of the brain leading to a lack of oxygen) (1) hemiplegia (paralysis affecting one side of the body) (2) and atherosclerotic cardiovascular disease (plaque consisting of lipids and cholesterol building up in	F 688	**F688 SS=E Increase/Prevent Decrease ROM/Mobility** **CFR(s): 483.25©(1)-(3)** On 1/12/2022 the resident was assessed for a new splint and splint was obtained on 1/12/2022. Residents who resident at Canterbury Rehab and Healthcare and utilize orthotic/splints have the potential to be affected by this practice. An audit was completed by the Director of Rehabilitation/Designee of current residents with orders for splits to ensure appropriate application of splint. Education was completed by the Director of Rehabilitation/Designee for the Licensed nursing staff on the utilization of orthotic/splints for provision of treatment and services to maintain or improve mobility. An audit will be completed by the Director of Rehabilitation/Designee weekly x 4 weeks and then monthly x 2 months on current residents who utilize orthotics/splints, to ensure appropriate application of splint. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	2/8/2022

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F 688	Continued From page 86 arterial walls) (3). Resident #131's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/18/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, toileting and personal hygiene; independent in eating and total dependence in bathing. During the initial facility tour on 1/11/22 at 12:30 PM, Resident #131 was observed sitting on the side of the bed with his left arm in his lap and hand curled up. At this time when interviewed, Resident #131 stated, "I have a splint but it is in the top drawer." When asked who helps him put the splint on, Resident #131 stated, "I cannot do it myself, and the staff usually does not put it on. I used to be in therapy but not anymore." On 1/12/22 at 9:30 AM, observed Resident #131 without splint on hand, as he was sitting on the side of the bed. Resident #131's comprehensive care plan dated 9/21/20, documented in part, "FOCUS-I have limited physical mobility related to left hemiplegia status/post CVA. INTERVENTIONS-Grab bars when in bed to aide in positioning and mobility. One-person physical assist for bathing and showers, one person assist with toileting. I require set up help for eating. Neutral left hand splint to be worn as ordered."	F 688		

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F 688	Continued From page 87 A review of the physician orders, dated 8/31/21, documented in part, "Neutral resting splint for left hand and wrist." An interview was conducted on 1/11/22 at 12:45 PM, with OSM (other staff member) #14, the physical therapist. When asked who was responsible to assist Resident #131 with placing his splint, OSM #14 stated, "He used to be in therapy, and we would work with him. The nurses put it on now." An interview was conducted on 1/12/22 at 9:10 AM with CNA (certified nursing assistant) #1. When asked who was responsible to assist Resident #131 with placing his splint, CNA #1 stated, "He usually doesn't wake up in the mornings. So I do not put the splint on till about noon. Sometimes therapy puts the splint on." An interview was conducted on 1/12/22 at 9:40 AM with OSM #1, the director of rehab services. When asked about the splint for Resident #131, OSM #1 stated, "I just re-evaluated him and he will qualify for more therapy, so I have put him back on the caseload. I also looked at his splint and I am going to order another type of splint for him." On 1/12/222/1/21 at 5:00 PM, ASM #1, the administrator and ASM #2, the director of nursing informed of the findings. A request was made for policy regarding splints application. On 1/13/22 at 1:10 PM, ASM #1, the administrator, stated, "We do not have that policy." No further information was provided prior to exit.	F 688		

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F 688	Continued From page 88 References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 111. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 264. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 52.	F 688		
F 695 SS=E	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 and facility document review it was determined that the facility staff failed to provide respiratory services consistent with the comprehensive person-centered plan of care for four of 62 residents in the survey sample, Resident #15, Resident #73, Resident #117 and Resident #328. The facility staff failed to administer oxygen to Resident #15 at the flow rate ordered by the physician, failed store Resident # 73's nebulizer	F 695	**F695 SS=E Respiratory/Tracheostomy Care and Suctioning** **CFR(s): 483.25(i)** Resident #15 oxygen flow rate was set to the physician ordered rate at the time of the survey findings Resident #73's nebulizer set up was replaced with a new set at the time of survey findings. Resident # 117 oxygen flow rate was set to the physician ordered rate at the time of the survey findings. Obtained physician order for the usage of oxygen per ordered flow rate on resident #328. An audit was conducted by the DON/Designee on current residents with ordered oxygen therapy for accuracy of physician ordered flow rate.	2/8/2022

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F 695	Continued From page 89 mask in a sanitary manner when it was not in use, failed to administer oxygen to Resident #117 per physician's orders, and failed to obtain a physician's order for the administration of oxygen to Resident #328. The findings include: 1. Resident #15 was admitted to the facility on 8/5/20 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease [COPD] (chronic non-reversible lung disease) (1), asthma (recurrent episodes of difficulty in breathing) (2) and osteoarthritis (degenerative changes in the joints) (3). Resident #15's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/12/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, toileting and personal hygiene; supervision in eating/total dependence in bathing. A review of Resident #15's comprehensive care plan dated 10/4/20, documents in part, "FOCUS-I have Shortness of Breath related to COPD, respiratory failure and sleep apnea. INTERVENTIONS-Administer oxygen as ordered via the nasal cannula." A review of the physician orders dated 12/3/21, documented in part, "02 [oxygen] at 4 liters/minute via nasal cannula continuously to	F 695	An audit was conducted by the Respiratory Therapist/Designee on current residents with nebulizer treatments to ensure proper storage of nebulizer mask and tubing. Oxygen Therapy Policy reviewed no revisions necessary. Education provided by the Staff Development Coordinator/Designee for Licensed Nursing staff on administration of oxygen at flow rate ordered by the physician and obtaining physician orders for oxygen usage. Procedure for Administration of Nebulizer reviewed, no revisions necessary. Education provided by the Staff Development Coordinator/Designee for Licensed Nursing staff on proper storage of nebulizer mask and tubing when not in use. A weekly audit will be accomplished by the Respiratory Therapist/Designee weekly x 4 weeks and then monthly x 2 months on residents that require oxygen and nebulizer treatments to ensure order obtained, oxygen administered per order and nebulizer mask and tubing properly stored between usage. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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F 695	Continued From page 90 maintain 02 saturations above 90% every shift. During initial resident observation on 1/11/22 at 12:15 PM, observation of Resident #15 revealed the residents O2 (oxygen) setting was at 5.0 liters per minute. On 1/12/22 at 2:12 PM, Resident #15's oxygen setting on the oxygen concentrator was observed at 5.0 liters per minute. An interview was conducted on 1/12/22 at 2:20 PM with LPN (licensed practical nurse) #2. When asked what flow rate Resident #15's oxygen was set at, LPN #2 stated, ""The oxygen level is reading 5." LPN #2 stated, "The line should be in the middle of the ball and it is set on 5." When asked who checks the oxygen setting, LPN #2 stated, "We are to check the oxygen setting every shift." On 1/12/22 at 5:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. On 1/13/22 at 1:10 PM, ASM #1, the administrator stated, "We do not have a policy for oxygen therapy and storage." The "NIDEK-NUVO" oxygen concentrator user manual, documents in part, "Turn the flow adjustment know to the required value. The know may have already been locked in the medically prescribed position. View the flowmeter in the horizontal plan for the accurate settings." No further information was provided prior to exit.	F 695		

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F 695	Continued From page 91 References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 50. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 420. 2. Resident # 73 was admitted to the facility with diagnosis that included but was not limited to: respiratory failure [1]. Resident #73's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 11/14/2021, coded Resident # 73 as scoring a 0 [zero] on the brief interview for mental status (BIMS) of a score of 0 - 15, 0 [zero] - being severely impaired of cognition for making daily decisions. On 01/11/2022 at approximately 1:45 p.m., 01/12/2022 at approximately 9:45 a.m., and 01/12/2022 at approximately 12:45 p.m., observations of Resident # 73's room revealed a nebulizer mask lying on Resident # 73's bedside table uncovered. The POS [physician's order sheet] for Resident # 73 documented in part, "Albuterol Solution 0.5 - 2.5 (3) MG/3ML [milligram/milliliter] inhale orally every 6 [six] hours as needed for SOB [shortness of breath] or wheezing via [by] nebulizer. Order Date: 10/25/2021. Start Date: 10/26/2021." The comprehensive care plan for Resident # 73 dated 10/26/2021 documented in part, "Focus: I have altered respiratory status/Difficulty Breathing r/t [related/to] respiratory failure/ pneumonia s/p	F 695		

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F 695	Continued From page 92 [status/post] recent hospital readmit. Date Initiated: 10/26/2021. Under "Interventions" it documented in part, "Administer medication/puffers as ordered. Monitor for effectiveness and side effects. Date Initiated: 10/26/2021." On 01/12/2022 at approximately 1:15 p.m. an interview was conducted with LPN [licensed practical nurse] # 7 regarding the procedure staff follows for storing a nebulizer mask when it was not in use. LPN # 7 stated, "It should be placed in a plastic bag to keep it clean and free of germs." When LPN # 7 was asked to observe Resident # 73's nebulizer mask, LPN # 7 stated, "I believe you." On 01/12/2022 at approximately 4:10 p.m., ASM [administrative staff member] # 1, executive director, ASM # 2, director of clinical services, ASM # 3, regional vice president of operations, ASM # 4, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: [1] When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 3. Resident #117 was admitted to the facility on 12/6/21. Resident #117's diagnoses included but were not limited to heart failure, respiratory failure and acute kidney failure. Resident #117's admission minimum data set with an assessment reference date of 12/10/21, coded the resident as being cognitively intact. Section O coded	F 695		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 93 Resident #117 as having received oxygen. Review of Resident #117's clinical record revealed a physician's order dated 12/8/21 for oxygen at two liters per minute continuously via nasal cannula. Resident #117's comprehensive care plan dated 12/15/21 documented, "I have altered respiratory status/Difficulty Breathing. Provide oxygen as ordered." On 1/11/22 at 1:29 p.m. and 1/12/22 at 8:21 a.m., Resident #117 was observed lying in bed and was not receiving oxygen. On 1/12/22 at 2:43 p.m. an interview was conducted with RN (registered nurse) #2. RN #2 stated Resident #117's tracheostomy was recently removed and the resident uses oxygen sometimes. When asked what a physician's order for continuous oxygen meant, RN #2 stated, "They should have oxygen all the time." On 1/12/22 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 4. Resident #328 was admitted to the facility on 1/5/22. Resident #328's diagnoses included but were not limited to diabetes, acute kidney failure and pneumonia secondary COVID-19. Resident #328's admission minimum data set assessment was not completed. An admission nursing evaluation dated 1/5/22 documented Resident #328 was alert and oriented to person and place.	F 695		

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F 695	Continued From page 94 On 1/12/22 at 8:13 a.m. Resident #328 was observed lying in bed receiving oxygen at two and a half liters per minute via nasal cannula. Review of Resident #328's January 2022 physician's orders failed to reveal a physician order for oxygen. Resident #328's baseline care plan dated 1/6/22 failed to reveal documentation regarding oxygen. On 1/12/22 at 2:40 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated there should be a physician's order for a resident's oxygen use. RN #2 stated Resident #328 transferred from the facility COVID unit two days prior and was transferred with oxygen. On 1/12/22 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 700	**F700 SS=D Bed Rails** **CFR(s): 483.25(n)(1)-(4)** Resident #326 side rails were removed on 1/12/22. The maintenance director reviewed the manufacturer's recommendation and re-inspected residents' bed to ensure that the bed dimension is appropriate for the resident's size and weight.	**2/8/2022**

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F 700	Continued From page 95 §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to implement bed rail requirements for two of 62 residents in the survey sample, Residents #326 and #148. The facility staff implemented bed rails for Resident #326 without a documented clinical need and failed to obtain informed consent for the use of bed rails and the facility staff implemented bed rails for Resident #148 without a documented clinical need. The findings include: 1. Resident #326 was admitted to the facility on 1/4/22. Resident #326's diagnoses included but were not limited to chronic kidney disease, history of breast cancer and an underactive thyroid. Resident #326's admission minimum data set assessment was not completed. An admission nursing evaluation dated 1/4/22 documented Resident #326 was alert and oriented to person, place and time.	F 700	Resident #148 Side rails removed at the time of survey. The maintenance director reviewed the manufacturer's recommendation and re-inspected both residents' bed to ensure that the bed dimension are appropriate for the resident's size and weight. Residents residing in the facility with bed rails have the potential to be affected by this practice. Facility maintenance director/designee will perform 100% audit on all beds in the building to ensure the bed's dimensions are appropriate for the resident size and weight, and ensure facility is following the manufacturer's recommendation and specifications for installing and monitoring beds/bed rails. The Director of Nursing/designee will evaluate all residents with bed rails to ensure the resident/resident representative has been advised of the risks and benefits of bed rails and that informed consent obtained, and physician order obtained.	

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F 700	Continued From page 96 On 1/11/22 at 1:55 p.m., Resident #326 was observed lying in bed with bilateral grab bar bed rails in the upright position. A safety/assistive device evaluation dated 1/4/22 documented in part, "3. Does the resident use the side rail or grab bars to achieve independent bed mobility? No...5. Does the resident use a side rail or grab bar to get out of bed independently? No...9. Does the resident request that the side rails be raised? No. 10. Does the resident request a grab bar for mobility? No. B. Recommendations- 11. Safety/Assistive Device Needs (a check beside) None." Review of Resident #326's January 2022 physician's orders failed to reveal an order for bed rails. Resident #326's baseline care plan dated 1/5/22 failed to reveal documentation regarding bed rails. Further review of Resident #326's clinical record failed to reveal documentation that informed consent for the use of bed rails was obtained. On 1/12/22 at 2:09 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 was asked to describe what should be done in regards to a resident with bed rails on their bed. RN #3 stated a restraint device evaluation should be completed and the evaluation contains numerous questions that determine if the bed rails are considered a restraint. RN #3 stated that if an assessment documents bed rails are not needed and the resident is not using the bed rails for assistance then bed rails should not be used. On 1/12/22 at 3:19 p.m., Resident #326 was lying in bed and the grab bar bed rails were removed. An interview was conducted with Resident #326.	F 700	Care plans will be updated to reflect residents plan of care. Bed Safety Policy reviewed no revisions necessary. The Director of Education/designee will educate all unit managers on base line care planning, updating care plans and incorporating that the resident/resident representative our obtaining informed consent prior to the installation of side rails and that risk/benefits have been reviewed. The Administrator/Regional Director of Maintenance will educate the maintenance director/staff on conducting inspections on bed frames, bed dimensions, mattresses, bed rails to ensure safety and eliminate risk of entrapment for residents. The Director of Nursing/designee will perform weekly audit x 4 weeks and then monthly x 2 months for new admissions to ensure base line care plans have been completed appropriately with side rails and ensuring informed consent was established with review in risk/benefits. The Maintenance Director/designee will perform house audits every month for 4 months to ensure regulatory and manufacturer compliance on all beds. Any patterns or trends will be reported to the Quality Assurance and Performance Committee at least quarterly. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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F 700	Continued From page 97 The resident stated no facility staff had talked to her about the bed rails and did not request consent for the use of the bed rails. On 1/12/22 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 1/13/22 at 1:10 p.m., ASM #1 stated the facility did not have a policy regarding bed rails. No further information was presented prior to exit. 2. Resident #148 was admitted to the facility on 6/19/20. Resident #148's diagnoses included but were not limited to diabetes, chronic kidney disease and COVID-19. Resident #148's quarterly minimum data set assessment with an assessment reference date of 12/20/21, coded the resident's cognition as severely impaired. On 1/11/22 at 2:16 p.m., Resident #148 was observed lying in bed with bilateral grab bar bed rails in the upright position. Resident #148's comprehensive care plan dated 9/22/20 failed to reveal documentation regarding bed rails. A safety/assistive device evaluation dated 11/3/21 documented in part, "3. Does the resident use the side rail or grab bars to achieve independent bed mobility? No...5. Does the resident use a side rail or grab bar to get out of bed independently? No...9. Does the resident request that the side rails be raised? No. 10. Does the resident request a grab bar for mobility? No. B. Recommendations- 11. Safety/Assistive Device	F 700		

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F 700	Continued From page 98 Needs (a check beside) None." Review of Resident #148's clinical record on 1/11/22 failed to reveal a physician's order for bed rails. On 1/12/22 at 2:09 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 was asked to describe what should be done in regards to a resident with bed rails on their bed. RN #3 stated a restraint device evaluation should be completed and the evaluation contains numerous questions that determine if the bed rails are considered a restraint. RN #3 stated that if an assessment documents bed rails are not needed and the resident is not using the bed rails for assistance then bed rails should not be used. On 1/12/22 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 700		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 725		2/8/2022

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F 725	Continued From page 99 at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, it was determined that the facility staff failed to provide sufficient staffing to meet the needs for one of 62 residents in the survey sample, Resident # 162. The facility staff failed to provide Resident # 162 who is coded as dependant on one staff member for bathing, with a shower two times a week, Wednesdays and Saturdays, due to insufficient CNA (certified nursing assistant) staffing. The findings include: Resident #162 was admitted to the facility with diagnoses that included but were not limited to: hemiplegia [1], muscle weakness and high blood pressure Resident # 162's most recent MDS (minimum data set), a quarterly assessment with an ARD	F 725	**F725 SS=E Sufficient Nursing Staffing** **CFR(s): 483.35(a)(1)(2)** Resident # 162 was provided a shower after resident was post Covid status and moved from the COVID Unit. Residents who reside in Canterbury Rehab and Health Care have the potential to be affected by this practice. Shower Schedules will be reviewed to ensure scheduled per resident preference. Staffing Policy reviewed no revisions necessary. Labor Management meeting will be held Monday through Friday for the next three months and ongoing with continued need. Weekly calls on recruitment with the corporate recruitment team will continue for the next three months and ongoing with continued need. Daily Labor Meeting will review staffing needs for the week in advance to identify areas lacking staff and develop a plan to ensure the facility is able to meet the needs of the residents. Showers will be reviewed by the Unit Manager to ensure residents are showered per preference weekly x 4 weeks and then Monthly x 2 months to ensure ongoing compliance with this process. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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(assessment reference date) of 12/29/2021, coded Resident # 162 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 162 was coded as requiring extensive assistance of two staff members for activities of daily living and being totally dependent of one staff member for bathing.

On 01/112022 at approximately 1:56 p.m., an interview was conducted with Resident # 162. When asked if staff assist with showers, Resident # 162 stated that they are scheduled for showers on Wednesdays and Saturdays. Resident #162 stated, "I am supposed to get them twice a week but I'm not getting them." She stated it was her preference to take showers twice a week. Resident #162 stated that staff were not getting it done. She stated staff did give her sponge baths. When asked how not getting showers as scheduled made her feel Resident # 162 stated that she didn't feel clean.

The comprehensive care plan for Resident # 162 dated 07/08/2021 documented in part, "Focus. I have an ADL [activities of daily living] Self Care Performance Deficit. Date Initiated: 07/08/2021." Under "Interventions" it documented in part, "BATHING: total of one. Date Initiated: 07/08/2021."

The facility's "Kardex" for Resident # 162 dated 01/22/2022 documented in part, "Personal Hygiene. I require total assistance with personal hygiene care." Under "BATHING" it documented, "BATHING: total care."

On 01/12/2022 at approximately 11:01 a.m. an interview was conducted with LPN [licensed

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F 725	Continued From page 101	F 725		

practical nurse] # 5, unit manager. When asked to describe the procedure for resident showers LPN # 5 stated, "Residents get a bed bath every day and we use a dry shampoo for their hair." When asked about Resident # 162's shower schedule and receiving showers LPN # 5 stated, "[Resident # 162] was scheduled for showers every Wednesday and Saturday on the 3:00 p.m. to 11:00 p.m. shift."

Review of the facility staffing schedule for 09/15/2021 and the facility census revealed three CNAs were scheduled for Resident # 162's unit; on 09/22/2021 the facility census revealed three CNAs were scheduled for Resident # 162's unit, on 09/27/2021 the facility census revealed two CNAs were scheduled for Resident # 162's unit and on 10/10/2021 the facility census revealed three CNAs were scheduled for Resident # 162's unit.

On 01/13/2022 at approximately 12:50 p.m. an interview was conducted with OSM [other staff member] # 9, staffing coordinator. When asked to describe the minimal and full staffing requirements CNAs [certified nursing assistants] in order to provide adequate and consistent resident care OSM # 9 stated, "The minimal is four CNAs on the 7:00 a.m. to 3:00 p.m. shift; four CNAs on the 3:00 p.m. to 11:00 p.m. and three CNAs on the 11:00 p.m. to 7:00 a.m. shift. Full staffing is six CNAs on the 7:00 a.m. to 3:00 p.m. shift; six CNAs on the 3:00 p.m. to 11:00 p.m. and four CNAs on the 11:00 p.m. to 7:00 a.m. shift."

On 01/13/2022 at approximately 8:15 a.m. a second interview was conducted with LPN

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F 725	Continued From page 102 [licensed practical nurse] # 5, unit manager. After reviewing Resident # 162's shower sheets dated September 2021 through December 2021, LPN # 5 was asked why Resident # 162 did not receive showers on the dates listed above. LPN # 5 stated, "I can't answer why." On 01/13/2022 at approximately 11:22 a.m. an interview was conducted with CNA [certified nursing assistant] # 3. When asked to describe the procedure for resident showers CNA # 3 stated, "Residents get a bed bath every day." When asked why a resident would not receive a shower on their scheduled shower day CNA # 3 stated, "We can't always give showers because we don't have enough staff." On 01/13/2022 at approximately 12:30 p.m. an interview was conducted with ASM [administrative staff member] # 2, director of nursing. After review of the bathing sheets for Resident # 162 dated September 2021 through December 2021, ASM # 2 was inform that Resident # 162 did not receive a shower or tub bath on the dates listed above. When asked if it was the resident's right to receive showers or tub baths twice a week ASM # 2 stated yes. When asked if a shortage of staff was a reason for Resident # 162 not to receive showers or tub baths twice a week as scheduled ASM # 2 stated no. On 01/13/2022 at approximately 2:15 p.m., ASM (administrative staff member) #1, administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. Complaint deficiency	F 725		

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F 725	Continued From page 103 Reference: [1] Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread This information was obtained from the website: https://medlineplus.gov/paralysis.html.	F 725		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761	**F761 SS=D Label/Storage Drugs and Biologicals** **CFR(s): 483.45(g)(h)(1)(2)** Medications were returned to the cart and the medication cart was secured at time of the survey. LPN #3 received education on securing medications, locking the medication cart, and not leaving medication on the top of the cart while the cart was out of line of sight. Residents who reside at Canterbury Rehab and Healthcare have the potential to be affected by this practice. An audit was conducted by Staff Development Coordinator during random medication pass times to ensure medications were secure while not in line of sight, medication carts were locked appropriately, medications were not left on top of medication cart while nurse was not present.	**2/8/2022**

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F 761	Continued From page 104 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to store medications in a safe and secure manner on one of three nursing units, the Grove unit. The facility staff failed to secure medications and lock the medication cart and left unsecured medications on top of the cart while the cart was out of the line of sight when administering medications to residents on the Grove unit. The findings include: Resident #164 was admitted on 6/27/14 and had the diagnoses of but not limited to stroke, dysphagia, aphasia, dementia, diabetes, viral hepatitis, high blood pressure and gastrostomy. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 12/24/21. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for eating and toileting; total care for all other areas of activities of daily living; and was incontinent of bowel and bladder. Resident #23 was admitted on 5/14/21 and had the diagnosis of but not limited to dysphagia, stroke, dementia, chronic obstructive pulmonary disease, bilateral above knee amputations, depression, aphasia, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment	F 761	Administration of Medications policy reviewed no revisions necessary. Education was provided by the Staff Development Coordinator/Designee for the Licensed Nursing staff on securing medications, locking of the medication cart, not leaving medications unsecured on the top of the cart while the cart is not in line of sight, and the proper storage of drugs and biologicals. An audit will be conducted on each unit on random shifts weekly x 4 weeks and then monthly x 2 months by the Staff Development Coordinator/Designee on securing medications, locking of the medication cart, not leaving medications unsecured on the top of the cart while the cart is not in line of sight, and the proper storage of drugs and biologicals Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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Reference Date) of 10/21/21. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for dressing; total care for all other areas of activities of daily living; and was incontinent of bowel and bladder.

On 1/12/22 at 8:25 AM, LPN #3 (Licensed Practical Nurse) was observed during the Medication Administration task on the Grove unit for Resident #164. LPN #3 prepared and administered the following medications:

(1) Aspirin 81 mg (milligrams) 1 tab.
(2) Metoprolol 12.5 mg (1/2 of 25 mg tab).
(3) Senna syrup 176 mg / 5 ml (milliliters); give 10 ml.

On 1/12/22 at 8:48 AM, LPN #3 went into the room for Resident #164 to administer these medications via PEG tube. The resident was in the "B" (window) bed. LPN #3 pulled the curtain around the bed of Resident #164 to provide privacy when administering the above medications via PEG tube. LPN #3 had left the pill card of Metoprolol on top of the medication cart which was now unsupervised and out of line of sight while she was behind the curtain at the window bed. Two CNA's (Certified Nursing Assistant) that were in the hallway passing breakfast trays passed by the unattended medication cart 3 times. The "A" bed resident (door side) bed of Resident #164's room was up in her wheelchair approximately 6 feet from the unsupervised medication cart. LPN #4, passed the medication cart four times and even provided water to the "A" bed resident in Resident #164's

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room. He was noted to glance at the top of the medication cart.

On 1/12/22 at 8:57 AM, LPN #3 returned to the medication cart. The Metoprolol was unsupervised and out of LPN #3's line of sight for approximately 9 minutes.

LPN #3 then proceeded to prepare and administer the following medications to Resident #23:

(4) Norvasc 10 mg (milligrams) 1 tab.
(1) Aspirin 81 mg 1 tab.
(5) Baclofen 5 mg 1 tab.
(6) Hydralazine 25 mg 1 tab.
(7) Ondansetron 4 mg 1 tab.
(8) Pantoprazole 40 mg powder.
(9) Prednisone 2.5 mg 1 tab.
(10) Potassium chloride 20 meq (milliequivalents) per 15 ml (milliliters), poured 15 ml.
(11) Keppra 100 mg/ml, give 5 ml for 500 mg.

On 1/12/22 at 9:06 AM, after pulling Resident #23's medications, then putting away the Metoprolol from Resident #164, at 9:13 AM, LPN #3 then went into the room for Resident #23 to administer the above medications. Resident #23 was in the "B" (window) bed. LPN #3 pulled the curtain around the bed of Resident #23 to provide privacy when administering the above medications via PEG tube. LPN #3 had left the medication cart unlocked and the pill cards or bottles on top of cart. The medication cards and or bottles for Aspirin, Hydralazine, Prednisone, Norvasc, Ondansetron, and Baclofen were on top of the medication cart which was now unsupervised and out of line of sight of LPN #3 while she was behind the curtain at the window

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bed. A CNA that was attending to the "A" (door side) bed resident passed by the cart going in and out of the room to get supplies to tend to the "A" bed resident. A housekeeper that was in the hallway also passed by the medication cart.

On 1/12/22 at 9:25 AM, the CNA took the "A" bed resident out of the room in her wheelchair, and moved the medication cart out of the way. The cart was still unlocked with the pill cards and bottles still on top, unsupervised and out of the line of sight of LPN #3.

On 1/12/22 at 9:27 AM, LPN #3 returned to the cart. The medications were unsupervised and out of the line of sight of LPN #3 for approximately 14 minutes. She put all of the pills away except for the bottle of aspirin. She then emptied the trash can on the cart, then locked the cart with the Aspirin still on top. LPN #3 then moved the cart to the end of the hall to the nurse's station, which was in an open community area where several residents were seated in wheelchairs and at tables. She then went to the other end of the nurse's station to put away items in her personal bag. LPN #3 had her back to the cart which still had the bottle of unsecured aspirin on top.

On 1/12/22 at 9:31 AM LPN #3 returned to the medication cart, plugged in the computer that was on top of the cart, and then put the aspirin away in cart. The aspirin was left on top of the cart for an additional 4 minutes after the other medications were put away.

On 1/12/22 at 9:34 AM, an interview was conducted with LPN #3. When asked how the medication cart should be maintained when the

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nurse is not present at the cart, LPN #3 stated that it should be locked and minimize the computer screen. When asked if there was anything else, LPN #3 stated, "I can't think of anything else." When asked about leaving the medications unsupervised, LPN #3 stated that they should not be left on top of the cart.

On 1/12/22 at 9:45 AM an interview was conducted with LPN #4, who had been by the cart when it was in front of Resident #164's room with the Metoprolol on top. He stated that he did not notice the medication on top of the cart because his view was blocked by the computer. He stated that if he had, he would have secured the medication in the cart. LPN #4 stated that the cart not in line of sight of LPN #3 and that the medications should not have been left on top while unsupervised.

A review of the facility policy, "Administering Medications" documented, "19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by."

On 1/12/22 at approximately 5:30 PM at the end of day meeting, ASM #1 and ASM #2 (Administrative Staff Members) the Administrator and Director of Nursing, respectively, were made aware of the findings. No further information was provided by the end of the survey.

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F 761	Continued From page 109 References: (1) Aspirin is used to relieve some types of pain and prevent heart attacks and strokes. Information obtained from https://medlineplus.gov/druginfo/meds/a682878.html (2) Metoprolol is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682864.html (3) Senna is used to treat constipation. Information obtained from https://medlineplus.gov/druginfo/natural/652.html (4) Norvasc is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a692044.html (5) Baclofen is a muscle relaxant. Information obtained from https://medlineplus.gov/druginfo/meds/a682530.html (6) Hydralazine is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682246.html (7) Ondansetron is used to prevent nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a606022.h	F 761		

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F 761	Continued From page 110 tml (8) Pantoprazole is used to treat gastroesophageal reflux Information obtained from https://medlineplus.gov/druginfo/meds/a601246.html (9) Prednisone reduces swelling and inflammation caused by many conditions. Information obtained from https://medlineplus.gov/druginfo/meds/a601102.html (10) Potassium chloride treats low potassium levels which can affect how the heart works. Information obtained from https://medlineplus.gov/druginfo/meds/a601102.html (11) Keppra is used to prevent seizures. Information obtained from https://medlineplus.gov/druginfo/meds/a699059.html	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 804	**F804 SS=E Nutritive Value/Appearance, Palatable/Preference Temperature** **CFR(s): 483.60(d)(10(2)** A resident Food Council meeting was held on 1/19/2022 to discuss resident concerns regarding food temperatures and quality of food being served.	**2/8/2022**

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F 804	Continued From page 111 Based on observation, resident interview and staff interview, it was determined that the facility staff failed to provide food at a palatable temperature during the lunch meal service on the Tuckahoe unit. The facility staff failed to provide food at a palatable temperature during lunch service on 1/12/2022. A test tray sampled on the Tuckahoe unit found the food was not warm or palatable. The findings include: During the dates of the survey, group gatherings were limited due to an active COVID-19 (1) outbreak. A group interview was not conducted, however private interviews were conducted. Review of the resident council meeting minutes for 9/23/2021, 10/20/2021 and 12/16/2021 was conducted. The minutes dated 12/16/2021 documented complaints regarding the temperature of the food being cold when served at the facility. Resident #105 was admitted to the facility with diagnoses that included diabetes (2) and liver disease. Resident #105's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/9/2021, coded Resident #105 as being cognitively intact. On 1/11/2022 at 12:51 p.m., Resident #105 was interviewed. When asked about the quality of the food, Resident #105 stated: "It's terrible. Some days, I wouldn't even give it to my dog." Resident #15 was admitted to the facility with diagnoses that included but were not limited to major depressive disorder (3) and chronic	F 804	Residents who reside at Canterbury Rehab and Healthcare and eat meals prepared in house have the potential to be affected by this process. An audit was completed by the Dietary Director/Designee on all units, for each meal service time, to ensure palatable temperatures were being maintained. Resident Hot plate system will be utilized for maintaining temperature of food at a palatable temperature. Education was provided by the Administrator/Designee for dietary staff on palatable temperatures of meal service, Nutritive Value/Appearance, Palatable/Preference Temperature. An audit will be completed by the Director of Dietary services weekly x 4 weeks and then monthly x 2 months to monitoring palatable temperatures of meals on all three meals on all three units at Canterbury Rehab and Healthcare. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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obstructive pulmonary disease (4). Resident #15's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/12/2021, coded Resident #15 as being cognitively intact. On 1/11/2022 at approximately 2:15 p.m., an interview was conducted with Resident #15. Resident #15 complained about the temperature and quality of the food being served.

Resident #13 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease and diabetes. Resident #13's most recent MDS, a quarterly assessment with an ARD of 10/10/2021, coded Resident #13 as being cognitively intact. On 1/12/2022 at approximately 10:45 a.m., an interview was conducted with Resident #13. Resident #13 complained about the temperature and quality of the food served at the facility.

On 1/12/2022 at 12:20 p.m., a test tray was plated and sent to the Tuckahoe unit. On 1/12/2022 at 12:40 p.m., (when the final meal was served on the Tuckahoe unit), the temperatures of the food on the test tray were obtained by OSM (other staff member) #12, the assistant dietary manager. The temperatures were:
Chicken and dumplings- 116 degrees Fahrenheit
Pureed chicken and dumplings- 108 degrees Fahrenheit
Mechanical soft chicken and dumplings- 112 degrees Fahrenheit
Mashed potatoes- 122 degrees Fahrenheit

The food on the test tray was sampled by a surveyor who determined the chicken and dumplings were not warm enough to be

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palatable. A second surveyor confirmed this and stated these food items were not warm enough to be palatable.

On 1/12/2022 at 2:35 p.m., an interview was conducted with OSM #12, the assistant dietary manager, OSM #11, the dietary manager and OSM #13, the district manager. OSM #11 stated that to provide warm palatable food to residents they checked temperatures of all foods prior to starting the tray line, and used plate warmers and chargers to hold the temperature. OSM #13 stated that they had decreased the amount of trays on the carts and staggered the delivery times to help staff in passing them out efficiently. OSM #11 stated that they had received complaints from residents regarding the food in the past and had resolved some of the complaints. OSM #13 stated that they performed tray audits twice a week and the goal was for the temperature of the food to be at least 135 degrees Fahrenheit when it was served. OSM #13 stated that any temperature below 135 degrees Fahrenheit would trigger them to investigate why it was low.

On 1/12/2022 at approximately 5:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy on serving palatable food to residents.

On 1/13/2022 at 1:10 p.m., ASM #1 stated that the facility did not have a policy on palatable food.

On 1/12/2022 at approximately 5:00 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concern.

No further information was presented prior to exit.

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F 804	Continued From page 114 References: 1. COVID-19 COVID-19 is caused by a coronavirus called SARS-CoV-2. Coronaviruses are a large family of viruses that are common in people and may different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people. This occurred with MERS-CoV and SARS-CoV, and now with the virus that causes COVID-19. The SARS-CoV-2 virus is a betacoronavirus, like MERS-CoV and SARS-CoV. All three of these viruses have their origins in bats. The sequences from U.S. patients are similar to the one that China initially posted, suggesting a likely single, recent emergence of this virus from an animal reservoir. However, the exact source of this virus is unknown. This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/faq.html#How-COVID-19-Spreads 2. Diabetes mellitus A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 3. Major depressive disorder Major depression is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm.	F 804		

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F 804	Continued From page 115 4. Chronic obstructive pulmonary disease (COPD) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.	F 804		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined facility staff failed to maintain kitchen equipment in a sanitary manner and in accordance with professional standards for food service safety. The findings include:	F 812	**F812 SS=D Food Procurement, Store/Prepare/Serve-Sanitary** **CFR(s): 483.60(i)(1) (2)** The deli slicer was cleaned in a sanitary manner and in accordance with the professional standards for food service safety on 1/12/2022. Residents who eat meals prepared by the kitchen at Canterbury Rehab and Healthcare have potential to be affected by this practice. Education was provided to kitchen staff on the cleaning of the deli slicer to ensure it is cleaned in a sanitary manner in accordance with the professional standards for food service safety. A random audit alternating shifts will be accomplished by the Director of Dietary/ Designee weekly x 4 weeks and then monthly x 2 months on proper cleaning of the deli slicer in a sanitary manner in accordance with the professional standards for food service safety. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	**2/8/2022**

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F 812	Continued From page 116 The facility failed to fully clean the deli slicer that was available for use in the facility kitchen. On 1/11/2022 at approximately 11:00 a.m., an observation of the facility's kitchen was conducted with OSM (other staff member) #11, the dietary manager. Observation of the kitchen revealed a deli slicer located on a stainless steel table in the kitchen. The deli slicer was observed to be covered with a clear plastic bag. When asked about the deli slicer, OSM #11 stated that it was used the day before and was cleaned and available for use. Upon inspection of the deli slicer, visible food debris was observed to be on the surface of the deli slicer and a grease-like film was observed on the deli slicer blade surface. OSM #11 observed the deli slicer and the blade and stated that it was not cleaned properly and would have to be taken apart and cleaned again. OSM #11 stated that the staff should take the deli slicer apart after each use, clean the entire surface and the blade and ensure that all debris was removed prior to putting it back together and covering it. On 1/12/2022 at approximately 5:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy on maintaining the deli slicer. The facility policy, "Sanitation" documented in part, "...All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions..." The policy further documented, "...For fixed equipment or utensils that do not fit in the dishwashing	F 812		

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F 812	Continued From page 117 machine, washing shall consist of the following steps: a. Equipment will be disassembled as necessary to allow access of the detergent/solution to all parts; b. Removable components will be scraped to remove food particle accumulation and washed according to manual or dishwashing procedures..." According to the FDA (food and drug administration) Food Code 2017, it documented in part, "4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. Pf (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." This information was obtained from the website: https://www.fda.gov/food/fda-food-code/food-code-2017 On 1/12/2022 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880	**F880 SS=D Infection Prevention & Control** **CFR(s): 483.80(a)(1)(2)(4)€(f)**	**2/8/2022**

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F 880	Continued From page 118 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880	LPN #3 was provided with education on Infection Prevention & Control the use of gloves and proper administration of medication following infection prevention guidelines. Resident # 23 physician was notified on the improper administration of medication at the time of survey and no new orders were received at that time. Residents who reside at Canterbury Rehab and Healthcare and receive medication have the potential to be affected by this practice. An audit was completed by the Staff Development Coordinator/Designee during various medication pass times to ensure Licensed Nursing staff were not wearing gloves and touching medications during preparation of medications. Medication Administration Policy reviewed no revisions necessary. Education was completed by the Staff Development Coordinator/Designee for Licensed Nursing staff on the Medication Administration policy and not wearing gloves and touching medications during preparation of medications.	

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F 880	Continued From page 119 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to follow infection control practices for the administration of medication for one of 6 residents in the Medication Administration task; Resident #23. The findings include: Resident #23 was admitted on 5/14/21 and had the diagnosis of but not limited to dysphagia, stroke, dementia, chronic obstructive pulmonary disease, bilateral above knee amputations, depression, aphasia, and high blood pressure. The most recent MDS (Minimum Data Set) was a	F 880	A weekly audit x 4 weeks and then monthly x 2 months will be accomplished by the Staff Development Coordinator/Designee on the proper infection control practices for the administration of medication. These audits will be accomplished at varying medication times and shifts to ensure ongoing compliance with this process. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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F 880	Continued From page 120	F 880		

quarterly assessment with an ARD (Assessment Reference Date) of 10/21/21. The resident was coded as being severely cognitively impaired in ability to make daily life decisions.

On 1/12/22 at 8:59 AM, LPN #3 (Licensed Practical Nurse) was observed during the Medication Administration task for Resident #23. She was observed sanitizing her hands and putting clean gloves on. Then she proceeded to touch the medication cart on the top and sides of it, the computer that was on the cart, the keys to the medication cart, the drawer to the medication cart after she unlocked it, the medication packages and bottles for all the medications listed below, that she then prepared, all medication below with this pair of gloves on:

(1) Norvasc 10 mg (milligrams) 1 tab.
(2) Aspirin 81 mg 1 tab.
(3) Baclofen 5 mg 1 tab.
(4) Hydralazine 25 mg 1 tab.
(5) Ondansetron 4 mg 1 tab.
(6) Pantoprazole 40 mg powder.
(7) Prednisone 2.5 mg 1 tab.
(8) Potassium chloride 20 meq (milliequivalents) per 15 ml (milliliters), poured 15 ml.
(9) Keppra 100 mg/ml, give 5 ml for 500 mg.

LPN #3 was observed poping all the medications that were in pill form (#1-5 and #7) onto her gloved hand and then placed each one in individual cups.

On 1/12/22 at 9:34 AM in an interview with LPN #3, when asked about popping the pills into her (gloved) hand from the pill cards or bottles, she stated that she had gloves on. When asked if the gloves were contaminated after touching all the

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F 880	Continued From page 121	F 880		

above listed items, LPN #3 stated that she changed them after each resident.

A review of the facility policy, "Administering Medications" documented, "24. Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable."

According to Potter and Perry's, Fundamentals of Nursing, 6th edition, page 847, "For safe administration, the nurse uses aseptic technique when handling and giving medications."

"Skill 1: Administering Oral Medications: 6. Prepare the required medications: b. Multidose containers: When removing tablets or capsules... pour the necessary number into the bottle cap and then place the tablets or capsules in a medication cup. .. Do not touch tablets or capsules with hands. Rationale: Pouring capsules or tablets into your hand is unsanitary. 12. Transport medications to patient bedside carefully... 14. Perform hand hygiene and put on PPE [personal protective equipment] if indicated. Rationale: Hand hygiene and PPE prevent the spread of microorganisms. PPE is required based on transmission based precautions. 20. Administer the medications." Lippincott Photo Atlas of Medication Administration, Sixth Edition, Pamela B Lynn, EdD, MSN RN, Wolters Kluwe, 2019, pages 2, 3, 4 and 6.

The CDC (center for Diseas Control) documents the following regarding hand hygeine in part: "Hand Hygiene Guidance
The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare

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F 880	Continued From page 122 Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings.Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient Before performing an aseptic task...." "Gloves are not a substitute for hand hygiene." This information was obtained from the website: https://www.cdc.gov/handhygiene/providers/guideline.html On 1/12/22 at approximately 5:30 PM at the end of day meeting, ASM #1 and ASM #2 (Administrative Staff Members) the Administrator and Director of Nursing, respectively, were made aware of the findings. No further information was provided by the end of the survey. References: (1) Norvasc is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a692044.html (2) Aspirin is used to relieve some types of pain and prevent heart attacks and strokes. Information obtained from https://medlineplus.gov/druginfo/meds/a682878.html (3) Baclofen is a muscle relaxant. Information obtained from https://medlineplus.gov/druginfo/meds/a682530.html	F 880		

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F 880	Continued From page 123 (4) Hydralazine is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682246.html (5) Ondansetron is used to prevent nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a606022.html (6) Pantoprazole is used to treat gastroesophageal reflux Information obtained from https://medlineplus.gov/druginfo/meds/a601246.html (7) Prednisone reduces swelling and inflammation caused by many conditions. Information obtained from https://medlineplus.gov/druginfo/meds/a601102.html (8) Potassium chloride treats low potassium levels which can affect how the heart works. Information obtained from https://medlineplus.gov/druginfo/meds/a601102.html (9) Keppra is used to prevent seizures. Information obtained from https://medlineplus.gov/druginfo/meds/a699059.html	F 880		
F 909 SS=F	Resident Bed CFR(s): 483.90(d)(3)	F 909	**F909 SS=F Resident Bed** **CFR(s): 483.90(d)(3)**	2/8/2022

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F 909	Continued From page 124 §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to perform regular bed inspections per the manufacturers" instructions for 10 of 62 residents in the survey sample, Residents #105, #138, #326, #148, #146, #131, #22, #13, #15, and #168. The facility staff failed to perform regular bed inspections per the manufacturer's instructions for 2021 for Residents #105, #138, #326, #148, #146, #131, #22, #13, #15, and #168 beds. The failure to conduct regular inspections to identify possible entrapment hazards as part of the routine maintenance program had the potential to affect all 177 residents using beds in the facility. The findings include: 1. Resident #105 was admitted to the facility on 8/31/20, and most recently readmitted on 7/13/21, with diagnoses including diabetes and liver disease. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/9/21, he was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status).	F 909	The Maintenance Director performed bed inspection on resident #105, #138,#326, #148, #146, #131, #22, #13, #15, and #168 beds. Any items related to bed function and manufactures instructions was addressed and no concerns noted regarding possible entrapment hazards as part of the inspection. Facility maintenance director/designee will perform 100% inspection audit on all beds in the building to ensure beds our functioning and maintained per manufacturer's instructions, as well as inspection of bed frames, mattresses and bed rails to ensure residents our free from any areas of possible entrapment. The Administrator/Regional Director of Maintenance will educate the maintenance director/staff on conducting inspections on bed frames, bed dimensions, mattresses, bed rails to ensure safety and eliminate risk of entrapment. The Maintenance Director/designee will perform house audits every month for 4 months to ensure regulatory and manufacturer compliance on all beds. Any patterns or trends will be reported to the Quality Assurance and Performance Committee at least quarterly. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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F 909	Continued From page 125 He was coded as requiring the extensive assistance of staff for bed mobility. On 1/11/22 at 12:51 p.m. and 1/12/22 at 9:32 a.m., Resident #105 was observed sitting up in bed. Bilateral side rails were engaged. Resident #105 stated he regularly uses the side rails for turning and positioning. A review of Resident #105's comprehensive care plan dated 9/14/20 revealed, in part: "Instruct pt. to use bed assist rails and pull with UEs (upper extremities) during ADLs (activities of daily living) to assist w/ (with) rolling." On 1/12/22 at 12:40 p.m., OSM (other staff member) #5, the regional director of plant operations, and OSM #6, maintenance director, were interviewed. When asked to provide information regarding regular maintenance inspection of beds utilizing any type of side rails, OSM #5 stated that not all facility beds have rails. He stated the majority of residents do not utilize bed rails. He stated historically, the maintenance staff does an initial inspection of the bed when rails are initially applied. However, he stated he does not retain evidence of these initial inspection. He stated ordinarily the facility makes certain a load to ground test on each bed is performed once a year. He stated the facility employs an outside vendor to perform the annual bed inspections. He stated this test includes bed frames and mattresses. However, he knows this test was not performed on any bed in the facility during 2021. He did not provide a reason for the lack of inspections. When asked to provide a policy regarding bed inspections, he stated the facility does not have a policy specific to bed	F 909		

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F 909	Continued From page 126	F 909		

inspections, but the facility follows the general maintenance policy to maintain equipment per the manufacturers' instructions. He stated all beds for residents identified with this concern are manufactured by [name of bed manufacturer].

On 1/12/22 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. On 1/13/22 at 1:24 p.m., ASM #1 confirmed understanding of the number of residents included in this concern.

A review of the facility policy, "Maintenance Service," revealed, in part: "Maintenance service shall be provided to all areas of the building, grounds, and equipment...Maintenance personnel shall follow the manufacturer's recommended maintenance schedule."

A review of the bed manufacturer's instructions revealed, in part: "Visually inspect the bed and accessories for broken welds or cracks and check for loose hardware on a monthly basis."

No further information was provided prior to exit.

2. Resident #138 was admitted to the facility on 6/1/18, and most recently admitted on 7/31/20, with diagnoses including diabetes, a history of a stroke, and peripheral vascular disease. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) 12/14/21, the resident was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring the

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F 909	Continued From page 127 extensive assistance of two staff members for bed mobility. On 1/11/22 at 12:45 p.m., Resident #138 was observed lying in his bed. He was not interviewable at the time of the observation. A review of Resident #138's comprehensive care plan dated 7/30/20 revealed, in part: "Grab bars to aide in bed mobility/positioning." On 1/12/22 at 12:40 p.m., OSM (other staff member) #5, the regional director of plant operations, and OSM #6, maintenance director, were interviewed. When asked to provide information regarding regular maintenance inspection of beds utilizing any type of side rails, OSM #5 stated that not all facility beds have rails. He stated the majority of residents do not utilize bed rails. He stated historically, the maintenance staff does an initial inspection of the bed when rails are initially applied. However, he stated he does not retain evidence of these initial inspection. He stated ordinarily the facility makes certain a load to ground test on each bed is performed once a year. He stated the facility employs an outside vendor to perform the annual bed inspections. He stated this test includes bed frames and mattresses. However, he knows this test was not performed on any bed in the facility during 2021. He did not provide a reason for the lack of inspections. When asked to provide a policy regarding bed inspections, he stated the facility does not have a policy specific to bed inspections, but the facility follows the general maintenance policy to maintain equipment per the manufacturers' instructions. He stated all beds for residents identified with this concern are manufactured by [name of bed manufacturer].	F 909		

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F 909	Continued From page 128 On 1/12/22 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. On 1/13/22 at 1:24 p.m., ASM #1 confirmed understanding of the number of residents included in this concern. No further information was provided prior to exit. 3. Resident #326 was admitted to the facility on 1/4/22. Resident #326's diagnoses included but were not limited to chronic kidney disease, history of breast cancer and an underactive thyroid. Resident #326's admission minimum data set assessment was not completed. An admission nursing evaluation dated 1/4/22 documented Resident #326 was alert and oriented to person, place and time. On 1/11/22 at 1:55 p.m., Resident #326 was observed lying in bed. On 1/12/22 at 12:40 p.m., OSM (other staff member) #5, the regional director of plant operations, and OSM #6, maintenance director, were interviewed. When asked to provide information regarding regular maintenance inspection of beds utilizing any type of side rails, OSM #5 stated that not all facility beds have rails. He stated the majority of residents do not utilize bed rails. He stated historically, the maintenance staff does an initial inspection of the bed when rails are initially applied. However, he stated he does not retain evidence of these initial inspections. He stated ordinarily the facility makes certain a load to ground test on each bed is performed once a year. He stated the facility employs an outside vendor to perform the annual bed inspections. He stated this test includes bed	F 909		

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frames and mattresses. However, he knows this test was not performed on any bed in the facility during 2021. He did not provide a reason for the lack of inspections. When asked to provide a policy regarding bed inspections, he stated the facility does not have a policy specific to bed inspections, but the facility follows the general maintenance policy to maintain equipment per the manufacturers' instructions. He stated all beds for residents identified with this concern are manufactured by [name of bed manufacturer].

On 1/12/22 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. On 1/13/22 at 1:24 p.m., ASM #1 confirmed understanding of the number of residents included in this concern.

No further information was presented prior to exit.

4. Resident #148 was admitted to the facility on 6/19/20. Resident #148's diagnoses included but were not limited to diabetes, chronic kidney disease and COVID-19. Resident #148's quarterly minimum data set assessment with an assessment reference date of 12/20/21, coded the resident's cognition as severely impaired.

On 1/11/22 at 2:16 p.m., Resident #148 was observed lying in bed.

On 1/12/22 at 12:40 p.m., OSM (other staff member) #5, the regional director of plant operations, and OSM #6, maintenance director, were interviewed. When asked to provide information regarding regular maintenance inspection of beds utilizing any type of side rails, OSM #5 stated that not all facility beds have rails.

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F 909	Continued From page 130 He stated the majority of residents do not utilize bed rails. He stated historically, the maintenance staff does an initial inspection of the bed when rails are initially applied. However, he stated he does not retain evidence of these initial inspections. He stated ordinarily the facility makes certain a load to ground test on each bed is performed once a year. He stated the facility employs an outside vendor to perform the annual bed inspections. He stated this test includes bed frames and mattresses. However, he knows this test was not performed on any bed in the facility during 2021. He did not provide a reason for the lack of inspections. When asked to provide a policy regarding bed inspections, he stated the facility does not have a policy specific to bed inspections, but the facility follows the general maintenance policy to maintain equipment per the manufacturers' instructions. He stated all beds for residents identified with this concern are manufactured by [name of bed manufacturer]. On 1/12/22 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. On 1/13/22 at 1:24 p.m., ASM #1 confirmed understanding of the number of residents included in this concern. No further information was presented prior to exit. 5. Resident #146 was admitted to the facility on 9/17/20 with diagnoses that included but were not limited to: non-traumatic intracerebral hemorrhage (bleeding within the brain) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and chronic kidney disease (decreased function of the kidneys frequently as a complication of diabetes) (3).	F 909		

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F 909	Continued From page 131 Resident #146's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/17/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, bathing, toileting and personal hygiene; supervision in eating. Observation of Resident #146 resting in bed on 1/12/22 at 2:30 PM with bilateral upper handrails raised on bed. A list was provided to ASM (administrative staff member) #1, the administrator, on 1/12/22 at 5:00 PM. The list consisted of a request for evidence of the documentation of the annual bed safety inspection. Resident #146 was included on this list. There was no evidence of requested documentation for Resident #146. An interview was conducted on 1/12/22 at 2:05 PM with OSM (other staff member) #5, the regional director of plant operations. When asked about the bed inspections, OSM #5 stated, "I don't have any bed inspections since August 2020, none for 2021 and none for 2022. Walk through of the rails and do the rail inspection. We do a yearly inspection, but it is out of date, it has not been done since 8/20. Includes the frame, mattress, load to ground railing, for which an outside vendor comes into the facility." When asked to review the manufacturer's guidelines for Resident #146's bed, OSM #5	F 909		

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F 909	Continued From page 132 stated, "They are all the same bed." On 1/13/22 at 2:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 304. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 119. 6. Resident #131 was admitted to the facility on 9/12/20 with diagnoses that included but were not limited to: cerebral infarction (hemorrhage or blockage of blood vessels of the brain leading to a lack of oxygen) (1) hemiplegia (paralysis affecting one side of the body) (2) and atherosclerotic cardiovascular disease (plaque consisting of lipids and cholesterol building up in arterial walls) (3). Resident #131's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/18/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, toileting and	F 909		

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F 909	Continued From page 133 personal hygiene; independent in eating and total dependence in bathing. Observation of Resident #131 resting in bed on 1/11/22 at 11:30 AM with bilateral upper handrails raised on bed. A list was provided to ASM (administrative staff member) #1, the administrator, on 1/12/22 at 5:00 PM. The list consisted of a request for evidence of the documentation of the annual bed safety inspection. Resident #131 was included on this list. There was no evidence of requested documentation for Resident #131. An interview was conducted on 1/12/22 at 2:05 PM with OSM (other staff member) #5, the regional director of plant operations. When asked about the bed inspections, OSM #5 stated, "I don't have any bed inspections since August 2020, none for 2021 and none for 2022. Walk through of the rails and do the rail inspection. We do a yearly inspection, but it is out of date, it has not been done since 8/20. Includes the frame, mattress, load to ground railing, for which an outside vendor comes into the facility." When asked to review the manufacturer's guidelines for Resident #146's bed, OSM #5 stated, "They are all the same bed." On 1/13/22 at 2:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. No further information was provided prior to exit.	F 909		

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F 909	Continued From page 134 References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 111. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 264. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 52. 7. Resident #22 was admitted to the facility on 11/14/20 with diagnoses that included but were not limited to: cerebrovascular accident (hemorrhage of blockage of the vessels of the brain leading to a lack of oxygen) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and post-traumatic stress disorder (mood disorder occurring after a traumatic event) (3). Resident #22's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/20/21, coded the resident as scoring 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, toileting and personal hygiene; supervision in eating / total dependence in bathing. Observation of Resident #22 resting in bed on 1/11/22 at 11:40 AM with bilateral upper handrails raised on bed.	F 909		

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F 909	Continued From page 135 A list was provided to ASM (administrative staff member) #1, the administrator, on 1/12/22 at 5:00 PM. The list consisted of a request for evidence of the documentation of the annual bed safety inspection. Resident #22 was included on this list. There was no evidence of requested documentation for Resident #22. An interview was conducted on 1/12/22 at 2:05 PM with OSM (other staff member) #5, the regional director of plant operations. When asked about the bed inspections, OSM #5 stated, "I don't have any bed inspections since August 2020, none for 2021 and none for 2022. Walk through of the rails and do the rail inspection. We do a yearly inspection, but it is out of date, it has not been done since 8/20. Includes the frame, mattress, load to ground railing, for which an outside vendor comes into the facility." When asked to review the manufacturer's guidelines for Resident #22's bed, OSM #5 stated, "They are all the same bed." On 1/13/22 at 2:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 111. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and	F 909		

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F 909	Continued From page 136 Chapman, page 160. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 467. 8. Resident #13 was admitted to the facility on 4/2/21 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease [COPD] (chronic non-reversible lung disease) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and chronic kidney disease (decreased function of the kidneys frequently as a complication of diabetes) (3). Resident #13's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/17/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, bathing, toileting and personal hygiene; supervision in eating. Observation of Resident #13 resting in bed on 1/11/22 at 11:45 AM with bilateral upper handrails raised on bed. A list was provided to ASM (administrative staff member) #1, the administrator, on 1/12/22 at 5:00 PM. The list consisted of a request for evidence of the documentation of the annual bed safety inspection. Resident #13 was included on this list. There was no evidence of requested documentation for Resident #13.	F 909		

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F 909	Continued From page 137 An interview was conducted on 1/12/22 at 2:05 PM with OSM (other staff member) #5, the regional director of plant operations. When asked about the bed inspections, OSM #5 stated, "I don't have any bed inspections since August 2020, none for 2021 and none for 2022. Walk through of the rails and do the rail inspection. We do a yearly inspection, but it is out of date, it has not been done since 8/20. Includes the frame, mattress, load to ground railing, for which an outside vendor comes into the facility." When asked to review the manufacturer's guidelines for Resident #13's bed, OSM #5 stated, "They are all the same bed." On 1/13/22 at 2:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 119. 9. Resident #15 was admitted to the facility on 8/5/20 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease [COPD] (chronic non-reversible lung disease) (1), asthma (recurrent episodes of difficulty in	F 909		

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breathing) (2) and osteoarthritis (degenerative changes in the joints) (3).

Resident #15's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/12/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, toileting and personal hygiene; supervision in eating/total dependence in bathing.

Observation of Resident #15 resting in bed on 1/12/22 at 2:40 PM with bilateral upper handrails raised on bed.

A list was provided to ASM (administrative staff member) #1, the administrator, on 1/12/22 at 5:00 PM. The list consisted of a request for evidence of the documentation of the annual bed safety inspection. Resident #15 was included on this list.

There was no evidence of requested documentation for Resident #15.

An interview was conducted on 1/12/22 at 2:05 PM with OSM (other staff member) #5, the regional director of plant operations. When asked about the bed inspections, OSM #5 stated, "I don't have any bed inspections since August 2020, none for 2021 and none for 2022. Walk through of the rails and do the rail inspection. We do a yearly inspection, but it is out of date, it has not been done since 8/20. Includes the frame, mattress, load to ground railing, for which an

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F 909	Continued From page 139 outside vendor comes into the facility." When asked to review the manufacturer's guidelines for Resident #15's bed, OSM #5 stated, "They are all the same bed." On 1/13/22 at 2:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 50. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 420. 10. Resident #168 was admitted to the facility on 5/28/20 with diagnoses that included but were not limited to: intracerebral hemorrhage (bleeding within the brain) (1), hemiplegia (paralysis affecting one side of the body) (2) and cerebrovascular disease (buildup of plaque consisting of cholesterol and lipids in the cerebral vessels) (3). Resident #168's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/17/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact.	F 909		

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F 909	Continued From page 140 MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, bathing, toileting and personal hygiene; supervision in eating. Observation of Resident #168 resting in bed on 1/11/22 at 12:00 PM with bilateral upper handrails raised on bed. A list was provided to ASM (administrative staff member) #1, the administrator, on 1/12/22 at 5:00 PM. The list consisted of a request for evidence of the documentation of the annual bed safety inspection. Resident #168 was included on this list. There was no evidence of requested documentation for Resident #168. An interview was conducted on 1/12/22 at 2:05 PM with OSM (other staff member) #5, the regional director of plant operations. When asked about the bed inspections, OSM #5 stated, "I don't have any bed inspections since August 2020, none for 2021 and none for 2022. Walk through of the rails and do the rail inspection. We do a yearly inspection, but it is out of date, it has not been done since 8/20. Includes the frame, mattress, load to ground railing, for which an outside vendor comes into the facility." When asked to review the manufacturer's guidelines for Resident #168's bed, OSM #5 stated, "They are all the same bed." On 1/13/22 at 2:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns.	F 909		

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F 909	Continued From page 141 No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 304. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 264. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 111.	F 909		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 947	**F947 SS=D Required In-Service Training for Nurse Aides** **CFR(s): 483.95(g)(1)-(4)** Nursing Assistant #4, #5, and #6 completed annual education dementia training, and abuse prevention training. Residents who reside at Canterbury Rehab and Healthcare have potential to be affected by this practice. An audit was conducted for current Nursing Assistants to ensure completion of annual dementia and abuse prevention training. Nursing assistants identified that are not in compliance will be assigned dementia and abuse training.	2/8/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING _____ B. WING _____	C 01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 947	Continued From page 142 Based on staff interview and facility document review, it was determined that the facility staff failed to evidence mandatory CNA (certified nursing assistant) annual education in dementia training and abuse prevention training for three of five CNA records reviewed, CNA #4, CNA #5, and CNA #6. The findings include: During the sufficient and competent staffing facility task, CNA (certified nursing assistant) education for dementia and abuse prevention were not evidenced in the previous twelve months. Per CMS it is not waiving the requirements for 42CFR483.35[c], which requires facilities to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. CNA #4's employee record documented they were hired as a CNA with the facility on 10/1/20. CNA #4's education records failed to evidence either in-service training or on line training in dementia and abuse prevention. CNA #5's employee record documented they were hired as a CNA with the facility on 4/9/19. CNA #5's education records failed to evidence either in-service training or on line training in dementia and abuse prevention. CNA #6's employee record documented they were hired as a CNA with the facility on 2/12/19. CNA #6's education record evidenced abuse prevention training but no dementia education.	F 947	Education was provided by the Administrator/Designee for the Human Resource Director and Staff Development Coordinator on required educational components for Nursing Assistants on a yearly basis. An audit will be conducted by the Staff Development Coordinator/Designee weekly x 4 weeks and monthly x 2 months on all Nursing Assistants for completion of yearly educational requirements. A file will be kept on when Nursing Assistant educational requirements are met, and when they are due to be completed. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.	

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F 947	Continued From page 143 On 1/12/22 at 4:45 PM, ASM (administrative staff member) #1, the administrator was informed of the employee files were not evidencing education. ASM #1 stated, "Oh, we'll get it to you." An interview was conducted on 1/13/22 at 11:33 AM with RN (registered nurse) #4, the staff development coordinator. When asked about the education for CNA #4, CNA #5 and CNA #6, RN #4 stated, "CNA #4 does not have any education completed, CNA #5 did not have any completed, CNA #6 does not have any record in on line training, and she may have some in person. I will check. I started a QAPI (quality process improvement) project on 1/3/22 it is not completed yet. My plan is to audit, provide education to unit managers and monitor." On 1/13/22 at 3:45 PM, in person education for CNA #6 was evidenced for abuse prevention training. No further information was provided prior to exit.	F 947		