STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING _____ B. WING _____	C 12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted on 12/28/2021 through 12/30/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Four complaints (VA00053904: substantiated with deficiency; VA00050366: unsubstantiated; VA00053589: substantiated with deficiency; VA00052876: substantiated with deficiency) were investigated during the survey. The census in this 68 certified bed facility was 27 at the time of the survey. The survey sample consisted of 6 resident reviews.	F 000	This plan of correction is submitted as required under State and/or Federal Law. The submission of this Plan of Correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.	
F 561 SS=D	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 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	F 561		

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

Michael K. Simmocks — INTERIM EXECUTIVE DIR. — 1/21/2022

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 561	Continued From page 1 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 interview, clinical record review, facility documentation and in the course of a complaint investigation, the facility staff failed to ensure a Residents right to self determination for 1 Resident (#1) in a survey sample of 6 Residents. The findings included For Resident #1 the facility staff placed orders in his chart prohibiting leaving the facility, prohibiting liberal diet on holidays or celebrations, and prohibiting alcohol on occasions. Resident #1 was admitted to the facility on 6/14/21, with diagnoses of but not limited to history of stroke, parkinsons disease, and unsteady gait. According to his most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/19/21 the Resident used a walker and a wheelchair for mobility and he had a BIMS (Brief Interview of Mental Status) score of 15/15 indicating no cognitive impairment. He was listed as his own Responsible Party. On 12/29/21 a review of the clinical records revealed the following orders: "Order Date:" " 6/14/21 - Diet Orders - May not omit diet restrictions on special occasions"	F 561	F 561 Right of Self Determination 1. Resident #1 is no longer a resident. 2. Conduct audit of all current residents to ensure any restrictions are appropriately authorized by accurately enter physician order. 3. Educate Nursing and Dietitian regarding Rights of Resident Self Determination and that any restrictions are physician required through review and re-attestation of WRC-SNF-P022 Residents Rights. 4. Ensure a Negotiated Risk Agreement is present when resident chooses to disregard physician advice. 5. Date of Compliance February 15, 2022	

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F 561	Continued From page 2 "Alcohol - No alcohol on special occasions." "No leave of absence visits with responsible party with meds" On 12/29/21 at 4:45 PM an interview was conducted with the DON who was asked about why these orders were entered for this Resident. The DON stated "These are standing orders." A review of the leave of absence policy revealed that Residents can go on leave of absence the policy states leaves of absence must be documented and does not address Prohibiting a leave of absence. On 12/30/29 at approximately 10:30 AM the DON was interviewed. The DON stated she might have figured out why the orders were written that way. She showed a copy of the handwritten admission orders transcribed by the nurse on duty the day of admission. The admitting nurse checked the boxes for LOA (leave of absence) visits as NO leave of absence with Responsible Party and No leave of absence with medications. She also checked the boxes for alcohol on special occasion and omit dietary restrictions on special occasions as NO. When the DON was asked if the orders were standard for all Residents she stated "I thought they were standing orders and I looked through the charts and found some of them have this and some of them don't then I realized this is the admitting nurse who checked these boxes, not the doctor." The doctor signed them on 6/15/21. When asked if there were any notes as to why the resident would not be allowed to leave the facility she stated no there are not.	F 561	F 561 Right of Self Determination 1. Resident #1 is no longer a resident. 2. Educate Nurses that we do not utilize "Standing Orders". 3. Review and re-attestation of P224 Physician Orders for nursing staff members who receive/transcribe orders. 4. Every resident is to have individual physician orders. 5. Date of Compliance January 19, 2022. F 561 Right of Self Determination 1. Re-educate the Clinical Review Process and require re-attestation of WRC-QI-P007 for all nursing associates.	

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F 561	Continued From page 3 A review of the progress notes did not reveal any reason why the physician would order no leave of absence from facility. The physician was unable to interviewed as he was on vacation. On 12/30/21 during the end of day meeting, the Acting Administrator was made aware of the concerns and no further information was provided	F 561		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of	F 623	F 623 Notice Requirements Before Transfer/Discharge 1. Resident #1 is no longer a resident. 2. Educate Social Worker on notice requirements for out of state transfers. 3. Review discharge planning with IDT. 4. Update resident or responsible party regarding discharge process and data. 5. Ensure discharge data is documented in resident record. 6. Date of Compliance February 1, 2022.	

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F 623	Continued From page 4	F 623		

this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(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,

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F 623	Continued From page 5 codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. 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 interview, clinical record review and facility documentation the facility staff failed to appropriately notify before transfer for 1 Resident (#1) in a survey sample of 6 Residents. The findings include: For Resident #1 the facility staff failed to notify the Virginia State office of Long Term Care Ombudsman of the transfer of the Resident to a facility in Pennsylvania.	F 623		

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F 623	Continued From page 6	F 623		

Resident #1 was admitted on 6/14/21 and the family notified the facility of their plans to take the Resident to another facility closer to them in Pennsylvania.

A review of the progress notes read:
"7/17/21 at 1:36 PM Family had requested that patient's paperwork be sent to an ALF for potential transfer which was sent. Response from that ALF was expected to state if resident was accepted, and for the discharge process to proceed. On Thursday the family called and spoke with the IDT and during that meeting family indicated that they were coming in on Saturday to get patient. It was clearly told to family that, we were hoping to hear from ALF and then our discharge process will commence to discharge patient. No feedback was received from the facility and today family was here to pick up patient. Cons of such decisions discussed but family insisted that they will take patient no matter the outcome. Patient was therefor discharge AMA. MD and Administrator.[sic]"

On 12/30/21 at approximately 12:00 PM an interview with the current Social Worker was conducted and she stated that it is her understanding and her practice that Ombudsman Notification is done with any discharges.

The current Social Worker was not employed by the facility at the time of Resident #1's discharge to another facility. She attempted to locate the Ombudsman notification without success.

There was no record of the notification in the "Book" where they keep records of the monthly notifications.

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F 623	Continued From page 7 On 12/30/21 during the end of day meeting the Acting Administrator was made aware of the concerns and no further information was provided.	F 623		
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, the facility staff failed for one resident (Resident # 3) to maintain a complete and accurate clinical record in the survey sample of 6 residents. 1. For Resident # 3, no documentation of orders for oxygen were listed on the Physicians orders or in the Minimum Data Set assessment in the clinical record for Resident # 3. The findings included: 1. Resident # 3, was readmitted to the facility on 11/23/2021. Diagnoses included but were not limited to: congestive heart failure, hypertension, and atrial fibrillation. Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/28/2021 was coded as a 5 Day Medicare assessment. Resident # 3 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, indicative of no cognitive impairment or cognitively intact.	F 641	F 641 Accuracy of Assessments 1. Resident #3 is no longer a resident. 2. Perform audit of all current residents utilizing oxygen to ensure supporting physician orders are in place. 3. Educate nurses and MDS coordinator regarding oxygen policies and that any oxygen use by resident must include supporting physician orders. 4. Ensure oxygen administration will be documented in resident care plan and MDS assessments. 5.Ensure oxygen orders include frequency, route and flow are in agreement with physician orders. 6. Date of Compliance February 1, 2022.	

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F 641	Continued From page 8 Resident # 3 was also coded as requiring limited to total assistance of one staff person to perform activities of daily living. The clinical record was reviewed on 12/28/2021 and 12/29/2021. Clinical Notes showed the following: 11/23/2021 18:02 -Type: Admission Summary Note Text: ..(identifying information redacted).Alert and oriented x 3. Denies any pain. No edema to all extremities. Bowel sounds active to all quadrants, abdomen soft and non-distended. All medications cleared by MD (medical doctor). Admitting Diagnosis include: Pulmonary HTN (Hypertension), A-Fib (Atrial Fibrillation). Oxygen at 1L/min via nasal cannula, SPO2 94%,no respiratory distress. Able to make all needs known." 12/3/2021 20:31 (8:31 p.m.) N Adv -Skilled EvaluationV6.3 Vitals: Temperature:T 97.8 -12/4/2021 00:37 (12:37 a.m.) Route:Forehead (non-contact) Pulse:P 87 - 12/4/2021 00:37 (12:37 a.m.) Pulse Type: Regular Regular Normal Blood Pressure:BP 154/54 -12/4/2021 00:37 (12:37 a.m.) Position:Sitting r/arm (right arm) Respirations:R 18 - 12/4/2021 00:37 (12:37 a.m.) Pulse Oximetry:O2 96 % -12/4/2021 00:37 (12:37 a.m.) Method: Oxygen via Nasal Cannula....." Review of the Minimum Data Set (MDS) assessment with an ARD of 11/28/2021 under "Section O-" revealed no coding of the need for oxygen noted for Resident #3.	F 641		

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F 641	Continued From page 9 On 12/30/2021, the MDS Coordinator the MDS Coordinator stated the assessments should have had oxygen included on the assessments. On 12/30/2021 at approximately 10:00 a.m., the Director of Nursing was interviewed, and stated the MDS should have coded the need for oxygen since Resident # 3 was supposed to have an order for oxygen. On 12/30/2021 at 10:30 a.m. during a debriefing with the Administrative Staff, the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the Social Services Director and Medical Records Assistant were made aware regarding coding of oxygen. The Director of Nursing stated the clinical record should be accurate for each resident. The Director of Nursing stated there should have been an order for oxygen, the need for oxygen should have been listed in the care plan and should have been coded on the MDS assessment. No further information was provided by the facility.	F 641		
F 656 SS=D	COMPLAINT DEFICIENCY 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	F 656		

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F 656	Continued From page 10 §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 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, the facility	F 656	F 656 Develop/Implement Comprehensive Care Plan 1. Resident #3 is no longer a resident. 2. Perform audit of all current residents to ensure oxygen use is accurately noted in resident care plan. 3. Educate nurses, MDS coordinator and Social Services regarding policies of oxygen therapy to ensure that oxygen use is included in resident care plan. 4. Ensure oxygen administration will be documented in resident care plan and MDS assessments. 5.Ensure oxygen orders include frequency, route and flow are in agreement with physician orders. 6. Date of Compliance February 1, 2022.	

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F 656	Continued From page 11	F 656		

failed to develop a comprehensive care plan for one resident (Resident # 3) in a survey sample of 6 residents.

The findings included:

1. For Resident # 3, the care plan revealed no documentation of the concern or need for oxygen.

Resident # 3, was readmitted to the facility on 11/23/2021. Diagnoses included but were not limited to: congestive heart failure, hypertension, and atrial fibrillation.

Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/28/2021 was coded as a 5 Day Medicare assessment. Resident # 3 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, indicative of no cognitive impairment or cognitively intact. Resident # 3 was also coded as requiring limited to total assistance of one staff person to perform activities of daily living.

The clinical record was reviewed on 12/28/2021 and 12/29/2021.

The review showed the following Nurses Progress Notes that revealed Resident # 3 did use oxygen during the stay at the facility.

"11/23/2021 18:02 -Type: Admission Summary Note Text: ..(identifying information redacted).Alert and oriented x 3. Denies any pain. No edema to all extremities. Bowel sounds active to all quadrants, abdomen soft and non-distended. All medications cleared by MD (medical doctor). Admitting Diagnosis include:

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THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 656	Continued From page 12 Pulmonary HTN (Hypertension), A-Fib (Atrial Fibrillation). Oxygen at 1L/min via nasal cannula, SPO2 94%,no respiratory distress. Able to make all needs known." 12/3/2021 20:31 (8:31 p.m.) N Adv -Skilled EvaluationV6.3 Vitals: Temperature:T 97.8 -12/4/2021 00:37 (12:37 a.m.) Route:Forehead (non-contact) Pulse:P 87 - 12/4/2021 00:37 (12:37 a.m.) Pulse Type: Regular Regular Normal Blood Pressure:BP 154/54 -12/4/2021 00:37 (12:37 a.m.) Position:Sitting r/arm (right arm) Respirations:R 18 - 12/4/2021 00:37 (12:37 a.m.) Pulse Oximetry:O2 96 % -12/4/2021 00:37 (12:37 a.m.) Method: Oxygen via Nasal Cannula....." On 12/28/2021 at 4:15 p.m., an interview was conducted with the Social Services Director who stated she observed the oxygen equipment in Resident # 3's room when she visited Resident # 3's room to make sure everything was ready for discharge to the Assisted Living Facility of choice. On 12/29/2021 at 11:00 a.m., an interview was conducted with the Assistant Director of Nursing (ADON) who stated Resident # 3 had oxygen equipment in the room and had an order for oxygen to be used PRN (as needed). The ADON stated Resident # 3 did not use the oxygen but it was ordered so it could be available for use whenever it was needed. On 12/30/2021 at approximately 10:00 a.m., the Director of Nursing was interviewed, and stated the MDS should have documentation of the need for oxygen since Resident # 3 was supposed to	F 656		

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F 656	Continued From page 13 have an order for oxygen. However, review of the care plan revealed no documentation of the concern or need for oxygen. On 12/30/2021 at 10:30 a.m. during a debriefing with the Administrative Staff, the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON), Social Services Director, and MDS Coordinator were informed that the care plan did not include the need for oxygen. The Director of Nursing stated the care plan should have reflected the resident and should have been comprehensive to include the need for oxygen. The Director of Nursing stated there should have been an order for oxygen and the need for oxygen should have been listed in the care plan. No further information was provided by the facility.	F 656		
F 658 SS=D	COMPLAINT DEFICIENCY Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 658		

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F 658	Continued From page 14 documentation review, and clinical record review, the facility staff failed to follow the professional standards of nursing practice for medication and treatment administration for three Residents (Residents' #3, #1, and #4) in the survey sample of 6 Residents. The findings include: 1. For Resident #3, the facility staff failed to obtain a physician's order for oxygen prior to administration of oxygen. Resident # 3, was readmitted to the facility on 11/23/2021. Diagnoses included but were not limited to: congestive heart failure, hypertension, and atrial fibrillation. Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/28/2021 was coded as a 5 Day Medicare assessment. Resident # 3 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, indicative of no cognitive impairment or cognitively intact. Resident # 3 was also coded as requiring limited to total assistance of one staff person to perform activities of daily living. Review of the clinical record was conducted on 12/28/2021 and 12/29/2021. Review of the Physicians orders revealed no valid physician's orders for oxygen until a handwritten hard script on 12/8/2021. On 12/28/2021 at 4:15 p.m., an interview was conducted with the Social Services Director who stated she observed the oxygen equipment in	F 658	F 658 Services Provided Meet Professional Standards 1. Residents #3,1 and 4 are no longer residents. 2. Perform audit of all current residents to ensure any oxygen use has supporting physician orders. 3. Educate nurses regarding policies of oxygen therapy. 4. Ensure oxygen administration will be documented in resident care plan and MDS assessments. 5.Ensure oxygen orders include frequency, route and flow are in agreement with physician orders. 6. Compliance Date February 1, 2022.	

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F 658	Continued From page 15 Resident # 3's room. On 12/29/2021 at 11:00 a.m., an interview was conducted with the Assistant Director of Nursing (ADON) who stated Resident # 3 had oxygen equipment in the room and had an order for oxygen to be used PRN (as needed). The ADON stated Resident # 3 did not use the oxygen but it was ordered so it could be available for use whenever it was needed. On 12/29/2021 at approximately 11:10 a.m., an interview was conducted with the Director of Nursing (DON) who stated she knew that Resident # 3 had an oxygen equipment available if administration of oxygen was necessary. The DON stated Resident # 3 did not use the oxygen. The Assistant Director of Nursing stated Resident # 3 did not use the oxygen. The Social Worker stated she had not observed Resident # 3 using oxygen. Review of the Nurses Progress Notes revealed Resident # 3 had oxygen administered at least twice during the stay at the facility. There were notes on 11/23/2021 (the day of admission) and 12/3/2021 when oxygen was administered. Review of the Facility document on Oxygen Therapy Rev. 11/18/15 revealed: A. Policy Statement: It is the policy of _____ (Corporate name of the facility) to provide a resident with the oxygen who has insufficient oxygen carried by the blood. B. Procedure: I. Review the resident's care plan for any special needs of the resident. II. Verify physicians order.	F 658		

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F 658	Continued From page 16 III. Assemble equipment needed. On 12/30/2021 at 10:30 a.m. during a debriefing with the Administrative Staff, the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON), Social Services Director, and MDS Coordinator were informed that there were no noted orders for oxygen. The DON, ADON, Social Services Director, and MDS Coordinator stated they saw oxygen equipment in Resident # 3's room but that the oxygen was not used. The Director of Nursing stated her expectation was for staff to obtain orders for oxygen, administer the oxygen per physician's orders and to document oxygen as having been administered, immediately following administration. A thorough review of Resident #3's clinical record after readmission on 11/23/2021, revealed no evidence that an order for oxygen was written until the nurse practitioner wrote an order on 12/8/2021. Review of the copy of a handwritten hard script order for oxygen dated 12/8/2021 revealed an order for oxygen written by the Nurse Practitioner which stated: 2 L (liters) oxygen NC (nasal cannula) to keep sats (saturation levels) above 92%." Under refills, a zero was written. The order as written was incomplete. It did not state how often oxygen was to be administered. Review of the Nurses Progress Notes revealed Resident # 3 had used oxygen via nasal cannula at least two times according to the notes. On	F 658		

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F 658	Continued From page 17 11/23/2021 the day of admission) there was documentation of 1 liter per minute via nasal cannula and on 12/3/2021, there were notes about oxygen being administered via nasal cannula but no documentation of the amount of oxygen administered. On 12/29/2021 at approximately 11:50 a.m., the Director of Nursing stated the professional guidance used by the facility was Lippincott. According to Lippincott, "Fundamentals of Nursing, by Lippincott", stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients." On 12/30/2021 at 10:30 a.m. during a debriefing with the Administrative Staff, the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the Social Services Director and Medical Records Assistant were made aware of the findings of no orders for oxygen administration until 12/8/2021 which was written as an incomplete order for oxygen. The Director of Nursing stated there should have been an order for oxygen. The expectation was for the physicians to write orders and the nurses to follow the orders of the physician. The Director of Nursing stated Resident # 3 had oxygen in the room because there was supposed to be an order for oxygen as needed. No further information was provided. COMPLAINT DEFICIENCY	F 658		

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F 658	Continued From page 18 2. For Resident #1 the facility physician pre-signed Certification and Recertification on the same day (6/15/21) and left the forms in the chart to be filled in by staff. On 12/29/21 while reviewing the chart of Resident #1 the hard chart (Paper based chart) was found to contain 2 forms not filled out however signed by the physician. One form signed and dated 6/15/21 was entitled " Skilled Nursing Medicare Certification" the other form signed and dated 6/15/21 was entitled " Skilled Nursing Medicare Recertification of Continued Stay - 14 Days." Both forms were totally blank except for the signature and date of the physician. On 12/29/21 an interview was conducted with the MDS Coordinator who stated that the forms were photocopies, the physicians leave the photocopies in the chart to be filled out. When asked if this is usual practice for the physician she stated that the doctor leaves the photocopies in the chart he puts the date on them and signs them. She is quoted as saying " Yes there are a lot of blank forms they put one in each chart when they are setting up the charts for admissions." Several attempts were made to contact the physician by the ADON and the Surveyors however the physician in question was on vacation and unable to be reached. https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics "Principles of medical ethics: 2. A physician shall uphold the standards of	F 658	F 658 Services Provided meet Professional Standards 1. Resident #1 is no longer a resident. 2. Educate associates that Physician pre-signed certification and recertification forms are never to be accepted by any staff member for use in resident care. 3. Educate physicians providing services that pre-signed blank certifications/re-certifications will not be acceptable practice. 4. Date of Compliance February 1, 2022.	

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F 658	Continued From page 19 professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities. On 12/29/21 during the end of day meeting the Acting Administrator was made aware and no further information was provided 3. For Resident #5, medications were administered several hours after the ordered administration time on 12/02/2021 and 12/07/2021. On 12/30/2021 at approximately 9:40 A.M., the Director of Nursing was interviewed. When asked about the expectation for timely medication administration, the DON stated that medications should be given with one hour before to one hour after the scheduled administration time. On 12/30/2021, the facility staff provided a copy of Resident #5's Medication Administration Audit Report for December 2021. On 12/02/2021, there were 12 medications scheduled to be administered at 9:00 A.M. According to the audit report, the medications were administered at 11:46 A.M. On 12/07/2021, there were 12 medications scheduled to be administered at 9:00 A.M. According to the audit report, the medications were administered at 11:19 A.M. A reason for the late administration was not documented on Resident #5's Medication Administration Record. The progress notes from 12/02/2021 through	F 658		

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F 658	Continued From page 20 12/07/2021 were reviewed. There was no documentation addressing the cause for the late medication administrations. An excerpt of a nurse's note dated 12/02/2021 at 6:06 P.M. documented, "Mood is pleasant, no unwanted behaviors witnessed. Resident is coherent." An excerpt of a nurse's note dated 12/07/2021 at 2:06 P.M. documented, "Mood is pleasant, no unwanted behaviors witnessed. Resident is coherent." The care plan was reviewed. There was no evidence on the care that Resident #5 refused care, medications, or treatments. On 12/30/2021, the facility staff provided a copy of their policy entitled, "Medication Pass Policy." In Section X, an excerpt documented, "The Right Time - Medications need to be given an hour before and an hour after the prescribed /ordered time. A medication ordered for 9A can be given as early as 8A and as late as 10A." According to Lippincott Nursing Procedures, 7th Edition, 2016, under the header, "Safe Medication Administration Practices, General", it was documented, "To promote a culture of safety and to prevent medication errors, nurses must ...adhere to the 'five rights' of medication administration: identify the right patient by using at least two patient-specific identifiers; select the right medication; administer the right dose; administer the medication at the right time; and administer the medication by the right route. Recent literature identifies nine rights of medication administration, which in addition to the five rights includes the right documentation, the right action (or appropriate reason for prescribing the medication), the right form, and the right response."	F 658	F 658 Services Provided meet Professional Standards 1. Resident #5 is no longer a resident. 2. Medication Administration is to be performed in accordance with accepted professional standards. 3. Educate nurses on the importance of maintaining professional standards of medication administration and of adhering to WRC-SNF-P098 Medication Pass Policy. 4. Nurses will document in resident record any delay and reason for delay of medication administration. 5. Date of Compliance is February 1, 2022.	

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F 658	Continued From page 21 On 12/30/2021 at approximately 12:30 P.M., the administrator and DON were notified of findings. By approximately 1:30 P.M., the Director of Nursing indicated there was no further information or documentation to submit.	F 658		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and	F 660	F 660 Discharge Planning Process 1. Residents #1 and 3 are no longer residents. 2. Perform audit of all current residents utilizing oxygen and ensure supporting physician orders exist. 3. Educate Nurses, MDS Coordinator and Social Services on policies relating to the Discharge Planning process to ensure discharge information is disseminated in an accurate and timely fashion for care team and for residents/responsible party. 4. Review discharge planning with IDT and audit 3 sessions to ensure discharge planning communication is occurring. 5. Update resident or responsible party regarding discharge process and data. 6. Ensure discharge data is documented in resident record per policy by audits of 10 discharges for record completions. 7.. Date of Compliance February 1, 2022.	

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resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident

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information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:
Based on interview, clinical record review, facility documentation and in the course of a complaint investigation the facility staff failed to implement the discharge planning process for 2 Residents (#1 & #3) in a survey sample of 6 Residents.

The findings included:

For Resident # 3, the facility staff did not inform the resident or family of the rationale for delaying the discharge date from 12/7/2021 to 12/9/2021 and failed to provide complete and accurate clinical information to include an order for oxygen to enable the Assisted Living Facility to prepare for Resident # 3's arrival and to meet the resident's needs.

Resident # 3, was readmitted to the facility on 11/23/2021. Diagnoses included but were not limited to: Congestive Heart Failure, Hypertension, and Atrial Fibrillation.

Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/28/2021 was coded as a 5 Day Medicare assessment. Resident # 3 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, indicative of no cognitive impairment or cognitively intact. Resident # 3 was also coded as requiring limited to total assistance of one staff person to perform activities of daily living.

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Review of the closed electronic clinical record was conducted 12/28/2021 and 12/29/2021.

Resident # 3 was readmitted to the facility on 11/23/2021 and discharged on 12/9/2021 to an Assisted Living facility.

On 12/28/2021 at 4:00 p.m., an interview was conducted with Resident # 3's daughter who stated Resident # 3 was discharged to the Assisted Living Facility (ALF) on 12/9/2021. The daughter stated she was upset that the date of discharge had been changed from 12/7/2021 to 12/9/2021 because the facility staff had not provided the appropriate information to the ALF timely for Resident # 3's admission on 12/7/2021. The daughter also stated the ALF did not have an order for oxygen for Resident # 3 when they arrived for Resident # 3 to be admitted to the ALF. Resident # 3's daughter also stated Resident # 3 became very anxious about not having oxygen available upon arrival to the ALF.

On 12/28/2021 at 4:15 p.m. during the end of day debriefing, an interview was conducted with the Social Services Director who stated she would provide a copy of the documentation regarding Resident # 3's discharge from the facility. The Social Worker (SW) stated Resident # 3 originally planned to return home to her townhouse but plans changed a few days later when the resident and family decided to go an Assisted Living Facility.

Review of the Discharge Timeline Summation revealed documentation of twelve steps taken to facilitate the discharge plans for Resident # 3. The steps listed were:
"1. On 11/24/21-daughter reported that she would

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F 660	Continued From page 25 like pt to discharge home. She went on to report that she would go home with care in place. SW explained that she will have to check with the discharge team for a date. 2. On 11/30/21 during the PPS meeting, the discharge team gave pt ___ (Resident # 3's name) a discharge date of 12/7/21. 3. on 11/30 SW issued pt's NOMNC (Notice if Medicare Non-Coverage) to reflect her 12/7/21 discharge date. 4. On 12/1/21 SW was notified by (name of ALF) that the pt would discharge to their facility and family will transport her at 2 pm. 5. On 12/2/21 SW emailed H&P (History and Physical) to NP (Nurse Practitioner) to complete and requested she completed (sic)and forward back. 6. On 12/3/21 SW emailed face sheet, med list and vitals to facility 7. On 12/3/21 SW emailed DNR (Do Not Resuscitate) 8. On 12/6/21 (name of ALF) emailed SW and requested discharge date be pushed back to the 8th or the 9th. 9. On 12/6/2021 SW asked discharge team and they pushed date to 12/9/21 to accommodate facility's request. 10. On 12/6/21 Physician ordered new medications that were not in the previous med list provided to (name of ALF) on 12/3/21 11. On 12/7/21 new medications were in PCC 12. On 12/8/21 SW email new med list to facility" Review of Social Worker progress notes and emails revealed documentation of the information written in the above summation. There was no documentation that the Social Worker informed the resident or family of the reason for the change in the date of discharge. The above	F 660		

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documentation revealed that the Assisted Living facility requested the planned discharge date be changed to 12/8/2021 or 12/9/2021. During the interviews, the Social Worker stated the date of discharge was changed at the request of the Assisted Living Facility.

Review of the facility documentation of an email from the facility's sales representative dated 12/8/2021 at 9:38 a.m., revealed documentation of an email dated 12/7/2021 at 11:21 p.m. submitted by Resident # 3's daughter. There was a handwritten note stapled to the back of the email which stated "12/9-Team responded by completing the discharge with facility. All scripts were sent with patients (sic) O2 (oxygen) ordered and delivered. No DME (Durable Medical Equipment) needed."

On 12/29/2021 at 4:05 p.m., an interview was conducted with the Social Worker, Director of Nursing, Assistant Director of Nursing and Administrator during the end of day debriefing. The Social Worker stated she worked with the Responsible Party and Resident regarding the discharge to the Assisted Living facility. The Social Worker stated she was in contact with several family members of Resident # 3. The Social Worker stated she requested to have one person designated as the contact because it was difficult to communicate with several family members. The Social Worker stated she faxed the copy of the medical record including the face sheet, medication list and vital signs on 12/3/2021. The Social Worker stated that on 12/6/2021, the physician ordered new medications that were not on the previous medication list provided on 12/3/2021. On 12/7/2021, the new medications were in the

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electronic medical record Point Click Care system.

The number 12 item stated that on 12/8/2021, the Social Worker emailed the new medication list to the Assisted Living facility. The Social Worker stated when she went to Resident # 3's room, she observed the oxygen tank in the room. The Social Worker stated she had never observed the resident with oxygen and was unaware of an order for oxygen as needed (prn). The Social Worker stated she immediately asked the nursing staff to provide an order for the oxygen so it could be sent to the Assisted Living facility prior to transfer. The Social Worker stated she obtained a copy of the order for oxygen and faxed the order to the Assisted Living Facility.

Review of the oxygen order revealed the order was faxed on 12/9/2021 at 11:25 a.m. The Social Worker stated the order for oxygen was faxed as soon as it was provided and that it was after the resident was discharged from the facility at 10:00 a.m.

Review of the physician orders that were sent to the Assisted Living facility prior to discharge revealed no order for oxygen in the order summary. Review of the Medication Administration Record and Treatment Administration Record revealed no documentation of orders for oxygen.

On 12/29/2021 during the end of day debriefing, the Administrator and Director of Nursing were informed of the findings of no noted documentation of orders for oxygen for Resident # 3. The Director of Nursing stated Resident # 3 had oxygen available to be used when and if was

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needed.

Two telephone calls were made to the ALF with voicemail messages left return the call to the surveyor. No return calls for the ALF were received by the end of the survey.

Review of the Physicians Orders Summary that was sent to the ALF revealed no orders for oxygen listed on the summary.

Review of the copy of a handwritten hard script order for oxygen dated 12/8/2021 revealed an order for oxygen written by the Nurse Practitioner which stated:
2 L (liters) oxygen NC (nasal cannula) to keep sats (saturation levels) above 92%." Under refills, a zero was written.
The order as written was incomplete. It did not state how often oxygen was to be administered.

The top left corner of the oxygen order script had a fax confirmation of 12/9/2021 at 11:25 a.m. indicating it was faxed to the ALF on the day of the scheduled discharge from the nursing facility and admission to that ALF.
Therefore, the ALF did not have the information about the oxygen order prior to the planned admission to the facility.

The Social Worker stated she faxed the order as soon as she was given a copy of the order by the nursing staff. The Social Worker stated Resident # 3 was not scheduled to leave until 2 p.m. on 12/9/2021 but the family came for discharge around 10 a.m. The Social Worker stated she was still working on the details for the discharge when the family arrived.

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F 660	Continued From page 29 After further discussion, the Social Worker stated she understood that because the ALF did not receive the fax of the order until the day of the discharge from the facility, there was not enough time for the oxygen to be delivered prior to Resident # 3's admission to the ALF. During the end of day debriefing on 12/30/2021, the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator and the Social Services Director were informed of the findings that discharge plan was not implemented to meet the needs of Resident # 3. There was no documentation that the family was informed of the rationale for the change of the date of discharge from 12/7/2021 to 12/9/2021. Incomplete and inaccurate information was provided to the Assisted Living Facility. No prescription for oxygen was provided for the Assisted Living Facility prior to the day of discharge. The oxygen order written on 12/8/2021 that was faxed on 12/9/2021 was incomplete. No further information was provided. COMPLAINT DEFICIENCY 2. For Resident #1 the facility failed to implement the discharge process and failed to communicate effectively with the facility that the Resident was being transferred to. Resident #1 was admitted to the facility on 6/14/21, with diagnoses of but not limited to	F 660		

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history of stroke, parkinsons disease, and unsteady gait. According to his most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/19/21 the Resident used a walker and a wheelchair for mobility and he had a BIMS (Brief Interview of Mental Status) score of 15/15 indicating no cognitive impairment.

On 12/28/21 a review of the clinical record revealed the following note about care plan meeting:

Excerpts from the progress notes read as follows: "6/19/21 at AM 12:47 PM- Family Notification: Resident's Emergency Contact / Sister and his niece visited from Pennsylvania. Both resident and [family member] expressed concerns regarding talking with IDT about residents care, wallets with credit cards, ID's, money, house key and cell phone. This writer updated both resident and his sister about resident's care and also informed them that a member of the Team will call [family member] to schedule for care plan and they acknowledged understanding. MD was rounding and he also saw resident and spoke with family, new orders were written for psych consult and labs to be done on 6/22/21. Writer reviewed inventory with resident and [family member], wallets were brought to resident and contents were reviewed. Residents [family member] was made aware that the resident was not admitted with his cell phone. Per family resident last saw his cell phone while in the ER. Wallets were taken back to DON's office for safekeeping, Resident remains alert and oriented, denied pain."

A review of the progress notes revealed the note on 6/19/21 is the only note referring to IDT

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meeting or Care Planning until the discharge note on 7/17/21, written by the DON it read as follows:

"7/17/21 at 1:36 PM Family had requested that patient's paperwork be sent to an ALF for potential transfer which was sent. Response from that ALF was expected to state if resident was accepted, for the discharge process to proceed. On Thursday the family called and spoke with the IDT and during that meeting family indicated that they were coming in on Saturday to get patient. It was clearly told to family that, we were hoping to hear from ALF and then our discharge process will commence to discharge patient. No feedback was received from the facility and today family was here to pick up patient. Cons of such decisions discussed but family insisted that they will take patient no matter the outcome. Patient was therefor discharge AMA [Against Medical Advice]. MD and Administrator.[sic]"

On 12/30/21 at approximately 11:10 AM an interview was conducted with the DON who stated that the family had signed the Resident out AMA. A review of the AMA document revealed that the Resident did not sign the document . On the line for signature of Resident or Responsible Party [family member name redacted] signed and in the space "relationship to patient" she wrote niece. There was no witness signature. It had 2 spaces for "Facility Representative Signature" only one was signed ant per the DON the name was that of a weekend supervisor. The form stated "I further acknowledge that I have been fully informed of possible and probable dangers of [Resident name redacted] health or welfare that may result from his/her leaving the facility at this time including, this space was left blank

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F 660	Continued From page 32 nothing was written in this space. When asked what the physician stated would be the negative outcomes for AMA the DON could not produce any notes from the Physician or Nurse Practitioner to substantiate an AMA discharge. A review of the clinical record revealed the following note written by the DON: "7/17/21 at 1:36 PM Family had requested that patient's paperwork be sent to an ALF for potential transfer which was sent. Response from that ALF was expected to state if resident was accepted, and for the discharge process to proceed. On Thursday the family called and spoke with the IDT and during that meeting family indicated that they were coming in on Saturday to get patient. It was clearly told to family that, we were hoping to hear from ALF and then our discharge process will commence to discharge patient. No feedback was received from the facility and today family was here to pick up patient. Cons of such decisions discussed but family insisted that they will take patient no matter the outcome. Patient was therefor discharge AMA. MD and Administrator.[sic]" Excerpts from the facility AMA policy revealed the following: "B. Procedure 1. The resident or responsible party will acknowledge by signing the "Leave Against Medical Advice" form that they are leaving the community and taking any and all risks involved in health and wellness of the resident. 3. All spaces on the Leave Against Medical Advice will be filled in completely. 6. The physician will be notified of the decision of the resident or responsible party 7. Two signatures of the community	F 660	F660 Discharge Planning Process 1. Resident #1 is no longer a resident. 2. AMA form will be completed by staff indicating risk related to disregarding medical advice. 3.Date of Compliance is February 1, 2022.	

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F 660	Continued From page 33 representatives will be completed on the form.." The DON was asked if a discharge is AMA if you know ahead of time that a Resident is being discharged and she stated that it was not. The DON was asked about the discharge process and she stated that the facility Social Worker is usually the one who handles the discharges. At the time of this discharge the Social Worker was on family leave. She stated that the ADON, DON and the Administrator were filling in for the Social Worker while she was out. She stated the Social Worker did not return to work and they had to find another Social Worker however that was not until after this Resident discharged from the facility. A review of the facility policy for discharge planning revealed the following Pg 1 Procedure: "Discharge planning involves the resident, the family or responsible party, interdisciplinary staff, and external resources identified that may be needed following discharge such as home health care, hospice, meals on wheels, etc. Discharge planning must begin at the time of admission to best plan for the needs of the resident. upon their transition to a new location. Information needed for discharge includes a. Prior health status of resident including personal and social needs b. Current level of care needed c. The residents overall expectations and understanding of his/her situation and choices. If the resident is unable to provide clear responses, the family can provide d. Projected time frame for movement to next level of care	F 660		

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F 660	Continued From page 34 e. Therapies and teaching that must be accomplished prior to discharge and f. The family interrelationships, community resources, support systems necessary to meet resident needs." NOTE: the facility did not include any of disciplines in discharge planning. A review of the Resident Care Plan read as follows: 'FOCUS: The resident wishes to return to the Community. Date Initiated: 06/17/2021 Revision on: 07/20/2021 Canceled Date: 07/20/2021 GOAL: The resident will be able to verbalize/communicate required assistance post-discharge and the services required to meet needs before discharge. Date Initiated: 06/15/2021 Revision on: 07/20/2021 Target Date: 09/25/2021 Interventions: Make an arrangements with required community resources to support independence post-discharge: homes care, PT, OT and Nursing. Date Initiated: 06/15/2021 Revision on: 07/20/2021 Canceled Date: 07/20/2021 Prepare and give the resident, family member necessary contact numbers for all community	F 660		

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F 660	Continued From page 35 referrals as needed. Date Initiated: 06/15/2021 Revision on: 07/20/2021" Note: The discharge plan portion of the Care Plan was never updated after admission on 6/15/21 until his discharge on 7/16/21. On 12/30/21 the Acting Administrator was made aware of the concerns with discharge planning and no further information was provided.	F 660		
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. §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	F 700	F 700 Bedrails 1. Resident #1 is no longer a resident. 2. Perform audit of all current residents to ensure any residents utilizing bed rails have been appropriately assessed, educated regarding alternatives to bed rails and have provided written approval resident or responsible party prior to use of bed rails. 3. Staff to ensure assessment and approval is included in resident record. 4. Educate Nurses and therapy regarding bed rail policies to ensure appropriate bed rail use. 5. Date of Compliance February 1, 2022.	

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by:
Based on interview, clinical record review and facility documentation the facility staff failed to implement the correct measures for the use of side rails for 1 Resident (#1) in a survey sample of 6 Residents.

The findings include:

For Resident #1 the facility staff failed to obtain consent for bedrails.

Resident #1 was admitted to the facility on 6/14/21, with diagnoses of but not limited to history of stroke, parkinsons disease, and unsteady gait. According to his most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/19/21 the Resident used a walker and a wheelchair for mobility and he had a BIMS (Brief Interview of Mental Status) score of 15/15 indicating no cognitive impairment. He was listed as his own Responsible Party.

On 12/29/21 a review of the clinical record revealed that Resident #1 had a side rail assessment on 6/15/21. Excerpts are as follows:
"Reason for Assessment : Admission"
"History of falls - No"
"Has resident attempted to climb over rails - No"
"Has resident sustained bruising, skin tears, lacerations, or fractures from use of a side rail or enabling device? NO"
"Does Resident have confusion regularly? NO"
"Does Resident have confusion intermittently? No"
"Is the resident cognitively aware enough to use the call bell to request assistance with transfers as needed? YES"

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F 700	Continued From page 37 "Alternatives Attempted Prior to Side Rail Request:" Note: This section left blank. None of the 21 questions listed were answered. The form was signed and dated by the nurse who did the assessment. "Resident / Responsible Party Acknowledgement: I, We understand that a side rail is being installed on the bed as an aid to enhance with independence and mobility, as an enabler for repositioning or transfer, and with the written consent / order of the attending physician. I acknowledge that using a side rail on the bed is my choice and preference and that I have been informed of and offered alternatives to using side rails." This section was left blank, it has no signature by Resident or Responsible Party. On 12/29/21 at approximately 12:00 PM the DON was asked if the form should be signed by the Resident or his Responsible Party. The DON stated that the Resident was his own RP and should have signed it. On 12/30/21 during the end of day meeting the Acting Administrator was made aware and no further information was provided.	F 700		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		

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	495288	A. BUILDING _____ B. WING _____	C 12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

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F 842	Continued From page 38 except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-	F 842	F 842 Resident Records - Identifiable Information 1. Resident #3,and 6 are no longer residents. 2. Correct record of resident #3 to redact any resident information not related to resident #3. 3. Audit all current residents to ensure all oxygen use has supporting physician orders. 4. Educate Nurses on oxygen use policy to ensure all oxygen use has supporting physician order. 5. Date of Compliance February 1, 2022. 6. Resident #4 is no longer a resident. 7. Educate Nurses and Wound Nurse on policies related to medical record entry to ensure all medical records are being entered into the electronic record system. 8. Administrator to ensure current and future physicians have access to electronic medical record system. 9. If physician electronic access is unavailable physician is to provide written resident care notes within 24 hours of seeing resident. Staff is to input notes into electronic record system within 24 hours of receiving physician notes. 10. Date of Compliance February 15, 2022.	

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F 842	Continued From page 39 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed, for two residents (Resident # 3, #4) to maintain a complete and accurate clinical record in the survey sample of 6 residents. The findings included: 1a) For Resident # 3, no documentation of orders for oxygen were listed on the Physicians orders. 1b) The Admission Residency Agreement information for another resident (Resident # 6) was scanned in Resident # 3's record. 1a) Resident # 3, was readmitted to the facility on 11/23/2021. Diagnoses included but were not limited to: congestive heart failure, hypertension, and atrial fibrillation.	F 842		

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F 842	Continued From page 40	F 842		

Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/28/2021 was coded as a 5 Day Medicare assessment. Resident # 3 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, indicative of no cognitive impairment or cognitively intact. Resident # 3 was also coded as requiring limited to total assistance of one staff person to perform activities of daily living.

The clinical record was reviewed on 12/28/2021 and 12/29/2021.

Review of the Physicians Orders revealed no order for the oxygen observed in Resident # 3's room and used by Resident # 3 during the stay at the facility.

1b) Further review of the electronic clinical record revealed a scanned document in the Miscellaneous section dated 12/3/2021 entitled RA (Residency Agreement). The 7 page document had the name of another resident. That resident's name was added to the survey sample as Resident # 6. Review of Resident # 6's clinical record revealed the correct RA document was correctly scanned in Resident # 6's record in the miscellaneous section on 12/3/2021.

On 12/30/2021 at 10:30 a.m. during a debriefing with the Administrative Staff, the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the Social Services Director and Medical Records Assistant were made aware of the incorrect information of Resident # 6 that was scanned in Resident # 3's clinical record. The Medical Records Assistant stated information should be scanned in the

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F 842	Continued From page 41	F 842		

correct record.

The Director of Nursing stated the clinical record should be complete and accurate for each resident. The Director of Nursing stated there should have been an order for oxygen.

No further information was provided by the facility.

COMPLAINT DEFICIENCY

2. For Resident #4, the wound physician notes were not in the clinical record.

On 12/28/2021 and 12/29/2021, Resident #4's closed (electronic and paper) clinical record was reviewed. A handwritten physician's progress note dated 08/03/2021 under the section entitled, "Suggestions", it was documented, "Wound care consult." A review of the clinical record revealed the wound physician notes could not be located.

On 12/29/2021 at approximately 10:00 A.M., a copy of the wound physician notes for Resident #4 were requested.

On 12/29/2021 at approximately 3:15 P.M., an interview with Employee F, the wound nurse and the Director of Nursing (DON) was conducted. When asked about the wound physician documentation, the wound nurse stated their wound service provider had changed and are now provided by a private wound physician. The wound nurse explained that this current wound physician didn't have access to document in Resident #4's electronic health record and documented on another system. The wound

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F 842	Continued From page 42 nurse explained that she would have to call and ask the wound physician for Resident #4's wound documentation. On 12/30/2021, the administrator and DON were notified of findings. The facility staff provided a copy of the wound physician notes for Resident #4 with the following dates of service: 07/19/2021, 08/02/2021, 08/09/2021, and 08/16/2021.	F 842		