STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495396	A. BUILDING ______ B. WING ______	C 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HILL HEALTH AND REHAB CENTER	**6106 HEALTH CENTER LANE FREDERICKSBURG, VA 22407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/25/22 through 1/27/22. 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 1/25/22 through 1/27/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints, VA00053909-Substantiated with deficiency & VA00051447-Substantiated with deficiency, were investigated during the survey. The census in this 150 certified bed facility was 125 at the time of the survey. The survey sample consisted of 52 resident reviews.	F 000		
F 563 SS=F	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's	F 563		3/8/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/17/2022

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 563	Continued From page 1 right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to allow all residents to receive visitors from 7:00 P.M. through 10 A.M. for an undetermined length of time. The findings included: On 01/25/2022 at 12:15 P.M. upon survey entrance, a sign was observed on the front door of the facility which read: "Visiting Hours 10AM to 7PM Please wear a face mask, sanitize hands upon entry and departure, and social distance during your visit. If you have any questions or concerns, please ask the Charge Nurse." The sign was also observed on the front door on the morning and afternoon of 01/26/2022. On 01/26/2022 at 2:05 P.M., an interview with Employee G, the front desk receptionist, was conducted. Employee G verified that she worked from 11:00 A.M. through 7 P.M. When asked	F 563	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. Facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F563 1) No residents were identified as to having been impacted, sign was removed. 2) All residents have the potential to be affected by deficient practice. 3) Administrator or Designee will re-educate all center staff regarding the	

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F 563	Continued From page 2 when visiting hours were, the receptionist stated the visiting hours were from 10:00 A.M. through 7 P.M. The receptionist also stated that the front doors get locked around 7:00-7:05 P.M. nightly. When asked why visiting was limited to that time frame, the receptionist stated she didn't know why. On 01/26/2022 at 2:20 P.M., the regional nurse consultant was interviewed. When asked about their visitation policy, the regional nurse consultant stated they go by the CMS (Centers for Medicare and Medicaid) guidance. A copy of the facility policy pertaining to visitation was requested. At 3:50 P.M., the administrator provider a copy of their policy with a review/revise date of 12/31/2021 entitled, "COVID-19 Visitation." In Section 6(a), it was documented, "Indoor visitation will be conducted in a manner that reduces the risk of COVID-19 transmission based on the following guidelines: (a) The facility will allow indoor visitation at all times for all residents and will not limit the frequency and length of visits, the number of visitors, or require advanced scheduling of visits." When asked about visiting hours, the administrator stated that visitation is allowed at all times. When asked about the sign on the door that states visiting hours are from 10:00 A.M.-7:00 P.M., the administrator stated that those are "recommended hours" but that visitors could also come before or after those times. On 01/26/2022 at 4:00 P.M., there were 3 visitors at the bedside of a resident. The Resident was identified and placed in the sample as Resident #42. The visitors identified themselves as friends of Resident #42. When asked about when visiting hours were, one of the visitors stated that visiting	F 563	visitation policy 4) The Administrator will complete a monthly review of the grievance log to ensure compliance with visitation policy weekly for 12 weeks and report findings to QAPI committee. 5) Date of Compliance is March 8,2022	

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F 563	Continued From page 3 hours were from 10:00 A.M. through 7:00 P.M. When asked how long the visiting hours were restricted to that time frame, the visitor stated they did not know. The visitor then stated that they were in to visit around the end of December to assist their friend (Resident #42) to remove Christmas decorations and the visiting hours at that time were also 10:00 A.M. through 7:00 P.M. On 01/26/2022 at 4:45 P.M., the administrator and DON were notified of findings. At 5:00 P.M., the visitation sign was no longer on the front door. On 01/27/2022 at 4:20 P.M., the administrator and Director of Nursing were interviewed. When asked when the visitation sign was posted on the door, the administrator stated he didn't know how long the sign was there and suggested maybe since December (2021). On 01/27/2022 at 5:55 P.M., the regional nurse consultant stated they had no further information or documentation to submit.	F 563		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		3/8/22

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F 600	Continued From page 4 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; 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 Residents were free from neglect for 3 Residents (#'s 310, 311, and 312) in a survey sample of 52 Residents. The findings included: For Resident #'s 310, 311, and 312 the facility staff neglected to ensure that Fentanyl patches remained on the Resident for the appropriate length of time. The 3 Residents involved were all on comfort care measures and receiving Fentanyl patches every three days to manage pain. The facility submitted 2 documents related to the diversion of narcotics by a former employee (RN D). The documents included a letter reporting the incident to the board of nursing, and a document entitled "Summary of Findings in the Investigation of Suspected Diversion of Fentanyl at [name of facility redacted]." Per the above mentioned documents, it was found that the RN D admitted to diverting medications and did overdose at the facility, on Fentanyl patches. The RN involved denied removing patches prior to the scheduled times however there was evidence that the patches were not on the Residents' and the MD/ NP nor DON was not always documented as being notified.	F 600	F600 1) Resident #310, #311, #312 no longer reside in the facility. 2) All residents have the potential to be affected by deficient practice. An audit of resident□s currently receiving Fentanyl patches was conducted no additional concerns identified. 3) a.) Administrator or Designee will re-educate all facility staff on abuse, neglect, and the reporting policy. b.) Administrator or Designee will re-educate all licensed nursing staff on the medication administration policy and facility process of validation of placement of fentanyl patches. 4) a.) The DON or Designee will conduct 5 random resident interviews regarding abuse and neglect 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through QAPI process. b.) The DON or designee will audit residents that have a fentanyl patch to ensure proper placement and administration 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5.) Date of Compliance is March 8,2022	

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F 600	Continued From page 5 On 1/27/21 an interview was conducted with the DON who stated she was working at the facility at the time of the incident, however she was not in the roll of DON at that time. The Administrator was also working at the facility, however he was an AIT (Administrator in Training) at that time. Both the Administrator and the DON remember the incident of narcotics missing and the subsequent overdose of RN D while at work. On 1/26/22 a review of the clinical record for Resident #310 revealed documentation of Fentanyl patches missing from her body prior to scheduled date of removal on 8 occasions between 2/19/20 and 4/9/20. On 3/23/20 at 4:21 PM again progress notes documented Fentanyl patch was not found on the Resident however they did document the Nurse Practitioner (NP) was notified. On 3/24/20 a Fentanyl patch was not found and the MD notified. On 3/29/20 and on 3/30/20 the documentation reflects no Fentanyl patch being found and the MD/NP notified. On 4/7/20, 4/8/20 and 4/9/20 the documentation reflects no Fentanyl patch found on the Resident. (Please note that on 2/19/20, 4/7/20, 4/8/20 and 4/9/20 the progress notes do not indicate notification of MD / NP or DON.) A review of the clinical record for Resident #311 revealed that on 2/28/20 at 4:28 AM no Fentanyl Patch was found on the Resident's body and the supervisor was made aware. On 3/6/20 once again an entry was made in the progress notes that no Fentanyl patch was found on the resident and the MD and RP were made aware. A review of the clinical record for Resident #312	F 600		

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F 600	Continued From page 6	F 600		

revealed that on 3/3/20 an entry was made in the progress notes that no patch was found on the Resident and the NP was made aware. On 3/4/20 the notes indicate once again no patch was found. On 4/2/20 again an entry was made in the progress notes that no patch was found on the Resident. On 4/9/20 and 4/12/20 entries were made in the progress notes that no Fentanyl patch was found on the Resident. (Please note on 4/2/20, 4/9/20 and 4/12/20 no documentation of notification of DON / MD / NP was present)

On 1/27/22 at approximately 2:00 PM a copy of the facility policy for Controlled Substance Loss, Diversion and Impairment was reviewed and read as follows:

Page 2 C -Internal Notifications
1. Supervisor will Immediately notify the Unit Manager and or Director of Nursing and Center Human Resources. If not previously notified the Unit Manager will notify the DON
2. DON will Immediately notify the Administrator.
3. The Administrator will immediately notify the Regional Director of Operations as well as the Compliance Officer or the Director of Legal Services.
4. The DON will immediately report the theft to the Clinical Services Specialist and the Pharmacy Vendor's Pharmacist-in-Charge.

On 1/27/22 at approximately 4:15 PM an interview was conducted with the DON who was asked why the facility did not act on the missing patches prior to 4/12/20 she stated "We acted as soon as we found out on 4/12/20." When asked what the expectation was for acting on Diversion of medication and she stated that it should be immediately reported to the DON and

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F 600	Continued From page 7 Administrator. When asked if this was done she stated that it was done on 4/12/20. When asked why it was not acted upon on several occasions when the MD / NP /and supervisor were notified of patches were missing from these 3 Residents, she stated again that the facility acted on it when they found out on the 4/12/20 after a staff member (RN D) overdosed on Fentanyl while on duty. On 1/27/22 during the end of day meeting the Administrator was made aware of this concern and no further information was provided. Complaint Deficiency	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview and facility documentation review, the facility staff failed to implement their abuse policy for one Resident (Resident #410) in a survey sample of 52 Residents.	F 607	F607 1) Certified nurse assistant B was removed from resident # 410 care. 2) All residents have the potential to be affected by deficient practice. Resident and staff interview was conducted to	3/8/22

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F 607	Continued From page 8 For Resident #410, who reported an allegation of abuse to the facility staff, the facility staff failed to carry out their abuse policy with regards to protecting the Resident while an investigation was being conducted and failing to report an allegation of abuse. The findings included: On the afternoon of 1/25/22, Surveyor C conducted an interview with Resident #410. During the interview Resident #410 reported that in the past CNA B had poured a pan of hot water onto her back while bathing her. Review of the facility grievances revealed that a grievance form dated 12/6/21, read, "Resident reported her CNA, [CNA B name redacted], threw hot water on her back while assisting her with getting cleaned up and bed bath [sic]". The facility conducted an investigation, which included a head to toe assessment of the Resident, checking the water temperature in the room and obtaining statements from staff. There was no indication that during the investigation process, that the facility staff removed CNA B from providing care to or having access to Resident #410, while a determination of if abuse had taken place. On 1/25/22, a request for all FRI's (facility reported incidents) was requested and received. The FRI's were reviewed with no report of Resident #410's allegation being noted being sent to the State Agency. On 1/26/22, an interview was conducted with the facility Administrator and Corporate Clinical	F 607	determine if any other allegations of abuse existed. 3) The DON or Designee will re-educate all staff on abuse and report policy 4) The DON or Designee will conduct 5 random resident interviews regarding abuse, neglect and care provided 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5) Date of Compliance is March 8, 2022	

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F 607	Continued From page 9 Consultant. The facility Administrator confirmed that a neither a report nor follow-up report had been submitted to the State Agency, Adult Protective Services or other agencies as required. The Administrator and Corporate Clinical Consultant were made aware that there was no evidence of CNA B being removed from having access to Resident #410, in an effort to protect the Resident, during the course of the investigation. Both of them (Administrator and Corporate Clinical Consultant) confirmed this. A review of the facility policy titled, "Abuse Prevention" was conducted. This policy read, "...VI. Protection: A. The Center will immediately assess the resident, notify the physician and Responsible Party, and take steps to protect the resident from further harm or incident...VII. Reporting/Response: A. Allegations of Abuse, Neglect, Misappropriation of Property, Exploitation: The Center Administrator, DON, or designee must timely report all alleged incidents of abuse, neglect, exploitation or mistreatment including injuries of unknown origin, misappropriation of property and unusual occurrences using the Virginia Office of Licensure & Certification "Facility Reported Incident" form to the (OLC) and to all other required agencies including Adult Protective Services (APS), and local law enforcement....A final report with results of the investigation is filed with the OLC within 5 working days of the alleged incident. If the allegation involves a licensee, the Department of Health Professions should be notified only after the investigation has been completed and in accordance with section B. The Administrator should consult the [corporate company name redacted] Legal Team when reporting a licensee...."	F 607		

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F 607	Continued From page 10 No further information was provided.	F 607		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, facility documentation and in the course of a complaint investigation, the facility staff failed to report the	F 609	1) Resident #310, #311, #312 no longer reside in the facility. Resident #410 facility report incident was submitted to the office	3/8/22

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F 609	Continued From page 11	F 609		

allegation of neglect for 4 Residents (#'s 310, 311, 312, and 410) in a survey sample of 52 Residents.

The findings included:

For Resident #'s 310, 311, and 312 the facility staff failed to report missing Fentanyl for three Residents, the incident of RN D overdosing at the facility on Fentanyl and the investigation that ensued.

The 3 Residents involved were all on comfort care measures and receiving Fentanyl patches every three days to manage pain.

The facility submitted 2 documents related to the diversion of narcotics by a former employee. The documents included a letter reporting the incident to the board of nursing, and a document entitled "Summary of Findings in the Investigation of Suspected Diversion of Fentanyl at [facility name redacted]."

Per the above mentioned documents, it was found that the RN D admitted to diverting medications and did overdose at the facility, on Fentanyl patches. The RN involved denied removing patches prior to the scheduled times, however there was evidence that the patches were not on the Residents' and the MD/ NP nor DON was not always documented as being notified.

On 1/27/21 an interview was conducted with the DON who stated she was working at the facility at the time of the incident, however she was not in

of licensure on 1-25-22.
2) All residents have the potential to be affected by deficient practice. An audit of all residents currently receiving fentanyl patches was conducted, no additional concerns identified.
3.) a.) Administrator or Designee will re-educate all facility staff on abuse, neglect, and the reporting policy.
b.) Administrator or Designee will re-educate all licensed nursing staff on the medication administration policy and the fentanyl patch placement validation process.
4.) a.) The DON or Designee will conduct 5 random resident interviews regarding abuse and neglect 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through QAPI process.
b.) The DON or designee will audit residents that have fentanyl patch to ensure proper placement and administration 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee.
5.) Date of Compliance is March 8,2022

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the roll of DON at the time. The Administrator was also working in facility, in the capacity of AIT (Administrator in Training) at that time. Both the Administrator and the DON remember the incident of narcotics missing and the subsequent overdose of RN D while at work.

The Regional nurse consultant provided a copy of the letter notifying the Board of Nursing of the incident of drug diversion. They also provided a document entitled "Summary of Findings in the investigation of suspected diversion of Fentanyl at [facility name redacted]" (see excerpt below).

"During an interview with [RN D] on 4/17/20, she acknowledged that she had been diverting controlled substances from the center since February 2020. [RN D] reported that she diverted medications that were pulled from the medication carts which were intended for destruction, including the 3 Fentanyl patches she consumed on April 12th."

Page 2.
"CDR/MAR Documentation"
A center wide audit was conducted of CDR's and MAR's for PRN controlled substances and revealed [Information redacted by facility] medication doses that were documented as having been pulled from the medication cart but were not documented as being administered to patients on their MAR's [Facility redacted information].

"The complaint names 3 Residents that were found to have Fentanyl patches missing prior to the scheduled removal dates."

A review of the clinical records for Resident #310

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revealed documentation of Fentanyl patches missing from her body prior to scheduled date of removal on 8 occasions between 2/19/20 and 4/9/20.

The progress notes revealed that on 2/19/20 at 9:29 PM that the Fentanyl patch was not found on the Resident. On 3/23/20 at 4:21 PM again progress notes documented Fentanyl patch was not found on the Resident and the NP was notified. On 3/24/20 again the Fentanyl patch was not found and the MD notified. On 3/29/20 and on 3/30/20 the documentation reflects no Fentanyl patch being found and the MD/NP notified. On 4/7/20, 4/8/20 and 4/9/20 the documentation reflects no Fentanyl patch found on the Resident. (Please note that on 2/19/20, 4/7/20, 4/8/20 and 4/9/20 the progress notes to not indicate notification of MD / NP or DON).

A review of the clinical record for Resident #311 revealed that on 2/28/20 at 4:28 AM no Fentanyl Patch was found on the Resident's body and the supervisor was made aware. On 3/6/20 once again an entry was made in the progress notes that no Fentanyl patch was found on the resident and the MD and RP were made aware.

A review of the clinical record for Resident #312 revealed that on 3/3/20 an entry was made in the progress notes that no patch was found on the Resident and the NP was made aware. On 3/4/20 the notes indicate once again no patch was found. On 4/2/20 again an entry was made in the progress notes that no patch was found on the Resident. On 4/9/20 and 4/12/20 entries were made in the progress notes that no Fentanyl patch was found on the Resident. (Please note on 4/2/20, 4/9/20 and 4/12/20 no documentation

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F 609	Continued From page 14 of notification of DON / MD / NP was present) On 1/27/22 at approximately 2:00 PM a copy of the facility policy for Controlled Substance Loss, Diversion and Impairment was reviewed and read as follows: Page 2 "C -Internal Notifications 1. Supervisor will immediately notify the Unit Manager and or Director of Nursing and Center Human Resources. If not previously notified the Unit Manager will notify the DON 2. DON will immediately notify the Administrator. 3. The Administrator will immediately notify the Regional Director of Operations as well as the Compliance Officer or the Director of Legal Services. 4. The DON will immediately report the theft to the Clinical Services Specialist and the Pharmacy Vendor's Pharmacist-in-Charge." On 1/27/22 at approximately 4:15 PM an interview was conducted with the DON who was asked why the facility did not act on the missing patches prior to 4/12/20 she stated "We acted as soon as we found out on 4/12/20." When asked what the expectation was for acting on Diversion of medication and she stated that it should be immediately reported to the DON and Administrator. When asked if this was done she stated that it was done on 4/12/20. When asked why it was not acted upon on several occasions when the MD / NP /and supervisor were notified of patches were missing from these 3 Residents, she stated again that the facility acted on it when they found out on the 4/12/20 after a staff member overdosed on Fentanyl while on duty.	F 609		

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F 609	Continued From page 15 On 1/27/22 during the end of day meeting the Administrator was made aware of this concern and no further information was provided. Complaint Deficiency For Resident #410, who reported an allegation of abuse, the facility staff failed to report the allegation or investigation results to the state survey agency (Office of Licensure and Certification), adult protective services and other officials as required. On the afternoon of 1/25/22, an interview was conducted with Resident #410. During this interview, the Resident verbalized that previously she had reported that CNA B dumped a pan of hot water on her during a bath. Review of the facility grievances revealed that a grievance form dated 12/6/21, read, "Resident reported her CNA, [CNA B name redacted], threw hot water on her back while assisting her with getting cleaned up and bed bath [sic]". The facility conducted an investigation, which included a head to toe assessment of the Resident, checking the water temperature in the room and obtaining statements from staff. On 1/25/22, a request for all FRI's (facility reported incidents) was requested and received. The FRI's were reviewed with no report of Resident #410's allegation being sent to the State Agency.	F 609		

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F 609	Continued From page 16 On 1/26/22, an interview was conducted with the facility Administrator and Corporate Clinical Consultant. The facility Administrator confirmed that neither a report nor follow-up report had been submitted to the state survey agency, adult protective services or other agencies as required. A review of the facility policy titled, "Abuse Prevention" was conducted. This policy read, "...VII. Reporting/Response: A. Allegations of Abuse, Neglect, Misappropriation of Property, Exploitation: The Center Administrator, DON, or designee must timely report all alleged incidents of abuse, neglect, exploitation or mistreatment including injuries of unknown origin, misappropriation of property and unusual occurrences using the Virginia Office of Licensure & Certification "Facility Reported Incident" form to the (OLC) and to all other required agencies including Adult Protective Services (APS), and local law enforcement....A final report with results of the investigation is filed with the OLC within 5 working days of the alleged incident. If the allegation involves a licensee, the Department of Health Professions should be notified only after the investigation has been completed and in accordance with section B. The Administrator should consult the [corporate company name redacted] Legal Team when reporting a licensee...." No further information was provided.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 610		3/8/22

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F 610	Continued From page 17 must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed to implement measures to protect the Resident while an abuse investigation was conducted, for one Resident (Resident #410) in a survey sample of 52 Residents. For Resident #410, who reported an allegation of abuse, the facility staff failed to protect the Resident by not allowing the alleged perpetrator to have continued access to the Resident while an investigation was being conducted. The findings included: On 1/25/22, an interview was conducted with Resident #410. During this interview, the Resident verbalized that previously she had reported that CNA B dumped a pan of hot water on her during a bath.	F 610	1) Certified nurse assistant B was removed from resident # 410 care. 2) All residents have the potential to be affected by deficient practice. Resident and staff interviews were conducted to determine if any other allegations of abuse identified. 3) The DON or Designee will re-educate all staff on abuse and report policy 4) The DON or Designee will conduct 5 random resident interviews regarding abuse, neglect and care provided 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5) Date of Compliance is March 8, 2022	

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F 610	Continued From page 18 Review of the facility grievances revealed that a grievance form dated 12/6/21, read, "Resident reported her CNA, [CNA B name redacted], threw hot water on her back while assisting her with getting cleaned up and bed bath [sic]". The facility conducted an investigation, which included a head to toe assessment of the Resident, checking the water temperature in the room and obtaining statements from staff. There was no indication that during the investigation process, that the facility staff removed CNA B from providing care to or having access to Resident #410, while a determination of if abuse had taken place or not. On 1/26/22, an interview was conducted with the facility Administrator and Corporate Clinical Consultant. Both, the Administrator and Corporate Clinical Consultant were made aware that there was no evidence of CNA B being removed from having access to Resident #410, in an effort to protect the Resident, during the course of the investigation. Both of them (Administrator and Corporate Clinical Consultant) confirmed this. A review of the facility policy titled, "Abuse Prevention" was conducted. This policy read, "...VI. Protection: A. The Center will immediately assess the resident, notify the physician and Responsible Party, and take steps to protect the resident from further harm or incident..." No further information was provided.	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		3/8/22

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§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

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(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.

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F 623	Continued From page 21 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 resident interview, staff interviews, facility documentation review and clinical record review, the facility staff failed to provide notice in writing before a facility transfer or discharge of a Resident to the Resident and Resident Representative (RP) for 1 Residents (Resident #410) in a survey sample of 52 Residents. The findings included: On 1/25/22 at 3:00 PM, Surveyor C interviewed Resident #410. Resident #410 stated she recalled going to the hospital and actually requested the transfer herself. Review of the clinical record for Resident #410 revealed on the census tab of the electronic health record (EHR), Resident #410 had discharged on 1/16/22. There was no further indication in the clinical record to indicate Resident #410 and/or her representative had	F 623	1) Resident #410 received written notice of discharge on 1-27-22. 2) All residents have the potential to be affected by deficient practice. A 7-day review of all residents that have been transferred was reviewed to ensure written notification of transfer/discharge to resident and/or resident representative was provided and any variance noted will be corrected. 3) The Administrator or designee will re-educate Social Services department, Admissions department, Business office department and licensed nurses on providing written notification of a transfer or discharge to resident and resident representative for transfer to hospital and discharge home. 4) The Administrator or designee will audit notifications of transfer twice weekly for 12 weeks and report findings to QAPI	

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received reason for the transfer in writing, prior to, or at the time of transfer/discharge.

Review of the progress notes for Resident #410 revealed the following entry on 1/16/22, "Resident c/o [complained of] nausea/vomiting around 2030, chest pain started at approx. 0400. VS: BP = 105/52, pulse = 139, Temp = 97.3, Resp = 18, O2 = 97%. Color pale, skin warm and dry. [Doctor Name redacted] called. Order received to send to ER [emergency room]. Two attempts made to reach emergency contacts [Resident #410's family member names redacted], sons. Message left to call facility. Res. [Resident] left via stretcher/911 at approx. 0500. NP [nurse practitioner] notified."

Review of the miscellaneous tab of the EHR revealed a "Notice of Transfer or Discharge" dated 1/16/22. This form further indicated that "verbal notification was made" to Resident #410. The line reading, "date of written notification" was blank.

On 1/26/22 at 11:20 AM, Surveyor C met with the Corporate Clinical Consultant. The Corporate Clinical Consultant was asked about the Notice of Transfer or Discharge form. The Corporate clinical consultant said, "The social worker fills it out if it is a planned discharge. If not planned, then nursing does it and the social worker sends to the ombudsman".

On 1/26/22 at approximately 11:30 AM, Surveyor C met with Employee D, the social worker. Employee D said, "If verbal notice is given they went to the hospital, if written they went home". Employee D further confirmed that the written notice is only given to the Resident and/or family

Plan of correction:

committee.
5) Date of compliance 3-8-2022

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in the event of a planned/scheduled discharge.

On 1/27/22 at 9:42 AM, an interview was conducted with RN F. RN F stated that when Residents are transferred or discharged to the hospital, items [clinical records] to include the bed hold policy, face sheet, DNR (do not resuscitate), medication list, etc. are put into a brown envelope and given to the transport personnel. RN F confirmed that the documents are for the hospital staff and not the Resident. RN F was shown the "Notice of Transfer or Discharge" form in the EHR for Resident #410 and said she wasn't familiar with the form and didn't provide such forms to Residents.

On 1/27/22 at approximately 10:00 AM, Surveyor C met with LPN C, the unit manager. LPN C stated when Residents are transferred out to the hospital that various items [forms/documents] are put into an envelope and given to the transport. LPN C confirmed that the documents are important so that the receiving facility [hospital] would know information about the Resident. LPN C was shown the "Notice of Transfer or Discharge" form in the EHR for Resident #410 and was not able to confirm if such notices are given to Residents and their RP's.

On 1/27/22 at 2:06 PM, Surveyor C attempted to call and speak to the responsible person (RP) for Resident #410. The RP for Resident #410 was not able to be reached prior to the conclusion of the survey.

On 1/27/22, Surveyor C met with Resident #410 and asked if she had received a notice of transfer prior to her being sent to the hospital. Resident #410 said she wasn't given any paperwork.

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F 623	Continued From page 24 Review of the facility policy titled, "Resident Transfer (Emergent or Planned)", with an effective date of 12/14/21, was reviewed. This policy read, "... 3. The Resident Transfer Envelope and designated EHR copies (current labs/consults/progress notes, e-Interact Transfer form, face sheet, bed hold policy, care plan goals, advanced directives, etc.) Are to be completed and accompany the resident to the hospital. 4. Medical records pertinent to the acute episode or consultation visit should be included with transfer envelope to aide in medical history information for the receiving facilities review..." On 1/27/22 at approximately 2:30 PM, Surveyor C met with the facility Administrator, Director of Nursing and Corporate Clinical Consultant and notified them of the lack of Resident #410 and her RP being provided a written notice of transfer at the time of transfer/discharge. No further information was received.	F 623		
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;	F 625		3/8/22

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F 625	Continued From page 25 (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 resident interview, staff interviews, facility documentation review and clinical record review, the facility staff failed to provide written information about bed-hold policy before the transfer of a Resident (Resident #410) to the hospital in a survey sample of 52 Residents. The findings included: On 1/25/22 at 3:00 PM, Surveyor C interviewed Resident #410. Resident #410 stated she recalled going to the hospital and actually requested the transfer herself. Review of the clinical record for Resident #410 revealed on the census tab of the electronic health record (EHR), Resident #410 had discharged on 1/16/22. There was no further indication in the clinical record to indicate Resident #410 and/or her representative had received in writing information regarding the	F 625	1) Resident #410 was given bed hold policy on 1-27-22 2) All residents have the potential to be affected by deficient practice. A 7day review all residents that have transferred to the hospital were reviewed to ensure written information regarding bed-hold policy was received before transfer and completed on 2-24-22 with any variances corrected. 3) The Administrator or designee will re-educate the social services department, Admissions department, Business Office and license nurses on the bed hold policy and process. 4) The DON or designee will audit written bed-hold policy given prior to resident transfer twice weekly for 12 weeks and report findings to QAPI committee. 5) Date of compliance 3-8-2022	

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F 625	Continued From page 26	F 625		

facility bed-hold policy.

Review of the progress notes for Resident #410 revealed the following entry on 1/16/22, "Resident c/o [complained of] nausea/vomiting around 2030, chest pain started at approx. 0400. VS: BP = 105/52, pulse = 139, Temp = 97.3, Resp = 18, O2 = 97%. Color pale, skin warm and dry. [Doctor Name redacted] called. Order received to send to ER [emergency room]. Two attempts made to reach emergency contacts [Resident #410's family member names redacted], sons. Message left to call facility. Res. [Resident] left via stretcher/911 at approx. 0500. NP [nurse practitioner] notified."

There were no further notes in the progress notes that made any mention of a bed hold policy being discussed and provided.

Review of the miscellaneous tab of the EHR revealed no indication of a bed-hold policy/notice being discussed or provided to Resident #410.

On 1/26/22 at 11:20 AM, Surveyor C met with the Corporate Clinical Consultant. The Corporate Clinical Consultant was asked about the bed hold notice at the time of transfer. The Corporate clinical consultant said they have an envelope that has the policy printed on the outside and the paperwork accompanying the Resident is put inside the envelope.

On 1/27/22 at 9:42 AM, an interview was conducted with RN F. RN F stated that when Residents are transferred or discharged to the hospital, items [clinical records] to include the bed hold policy, face sheet, DNR (do not resuscitate), medication list, etc. are put into a brown envelope

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F 625	Continued From page 27 and given to the transport personnel. RN F confirmed that they tell the Resident of the bed hold policy at the time of transfer and if they have any questions they are to call the Admissions office. RN F further confirmed that all "paperwork" is given to the transport providers to give the hospital staff and are not given to the Resident. On 1/27/22 at approximately 10:00 AM, Surveyor C met with LPN C, the unit manager. LPN C stated when Residents are transferred out to the hospital that various items [forms/documents] are put into an envelope and given to the transport. LPN C confirmed that the documents are important so that the receiving facility [hospital] would know information about the Resident. LPN C was unable to locate a bed hold policy on her unit. LPN C then went to the other nursing station within the facility and showed Surveyor C an envelope which had the printed bed hold policy on the exterior of the envelope. LPN C confirmed that the envelope of paperwork is given to the transport providers. On 1/27/22 at 2:06 PM, Surveyor C attempted to call and speak to the responsible person (RP) for Resident #410. The RP for Resident #410 was not able to be reached prior to the conclusion of the survey. On 1/27/22, Surveyor C met with Resident #410 and asked if she had received a notice of bed hold policy prior to her being sent to the hospital. Resident #410 said she wasn't told or provided anything with regards to her room while she was gone and/or her ability to return to the same room. Review of the facility policy titled, "Notice of bed	F 625		

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F 625	Continued From page 28 hold policy", with an effective date of 1/13/22, was reviewed. This policy read, "...Policy Explanation and Compliance Guidelines: Nursing Services is responsible for: 1. providing policy to resident BEFORE the resident goes to the receiving hospital, appointment, etc. Admissions/Designee is responsible for: 1. Admission Director or designee will follow up with patient/resident or resident agent by the next business day following admission to an acute setting, to inquire about a bed hold. 2. Admission Director or designee will document Patient/resident or resident agent choice to accept or deny bed hold in PCC under the Residents general note tab in PCC. 3. If patient/resident or resident agent accepts bed hold, a bed hold agreement will be issued, and a signed copy will be located under the Resident's Misc. tab in PCC. 4. Notifying Business Office if the resident or Responsible Party would like to execute a Bed Hold". On 1/27/22 at approximately 2:30 PM, Surveyor C met with the facility Administrator, Director of Nursing and Corporate Clinical Consultant and notified them of the lack of Resident #410 and her RP being provided a written notice of bed hold policy at the time of transfer/discharge. No further information was received.	F 625		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		3/8/22

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F 657	Continued From page 29 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 observation, Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to revise the care plan for for three Residents (Resident #55, #97, and #64) of the 52 residents in the survey sample. The findings included; 1. For Resident #55, the staff failed to revise the care plan for pressure sore interventions. Resident #55 was originally admitted on	F 657	1) Resident #55 no longer resides in center. Resident #97 care-pan reviewed and revised to include skin integrity management. Residents #64 care plan reviewed and revised to include AV fistula management. 2) All residents have the potential to be affected by deficient practice. 3) The DON or designee will re-educate the Department of Social Services, MDS Department, and all licensed nurses on reviewing and revising the care plans 4) Administrator or designee will audit 10 resident care plans to ensure skin integrity	

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10-16-21. Diagnoses for Resident #55 included but were not limited to; acute pubic and lumbar fracture resulting from a fall at home.

Resident #55's admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 10-22-21 coded Resident #55 as alert, oriented to person, place, time and situation, with a BIMS (brief Interview for Mental status score of 14 out of a possible 15 points indicating no cognitive impairment. The Minimum Data Set further coded Resident #55 as being extensively dependent, on 1-2 staff members for all Activities of Daily Living care. The Resident was coded as completely independent physically and mentally prior to the fractures which were the result of a fall at home. The Resident was coded as always incontinent of bowel and bladder, and at risk for developing pressure sores, however, had none upon admission to the facility.

A Braden scale for ascertaining pressure sore risk was completed upon admission and revealed a score of "12" indicating "High Risk".

A review of Resident #55's clinical record was conducted during the survey. The review revealed a progress note from the staff on the following date and time that revealed the initial identification and initial treatment of the coccyx pressure sore.

11-17-21 Nursing progress notes revealed "intact sacral", also the physician was in to evaluate the Resident and those documents notates no concerns in regard to skin issues found, nor brought to the attention of the physician by nursing staff's assessment.

F 657

management and av fistula management is care-planned as per physician orders and standard of practice, weekly for 12 weeks and report findings to QAPI committee.

5) Date of compliance is 03-08-2022

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"Body Audit" forms were reviewed and documented the first observation of sacral skin alteration on this form in the clinical record was on 10-23-21, and documented "Sacrum red." and signed by a traveling nurse.

"Skin and Wound Evaluation" forms were reviewed and documented the first observation of skin alteration on this form in the clinical record was on 11-23-21, four days after identification of the unstageable pressure sore identification and documented "Pressure/sacrum/unstageable/100% of wound filled with slough." and the document had no signature to denote who completed the evaluation.

The original admission baseline care plan dated 10-16-21 obtained and reviewed by electronic health care (EHR) computer copy and was found to be entirely canceled on 11-30-21.

A new care plan was devised on 12-11-21 revealing no active care plan between the 2 care plans for 12 days. Physician ordered resident centered treatments, PICC central line catheter care, and antibiotic infusion orders with descriptions of how to provide the care were not documented on the care plan. No instruction was given in the care plan as to how the treatments should be completed. No direction was given as to use of the an ordered air mattress, nor an ordered wound vac.

The facility Administrator, regional RN (Registered Nurse) consultant, and DON (Director of Nursing) were informed of the findings during an end of day briefing on 1-26-22 at approximately 5:00 p.m. They were again

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notified of findings on 1-27-22 at the end of day debrief at approximately 5:00 p.m.. The facility stated they had no further information to present at the time of exit at 6:30 p.m. on 1-27-22.

2. For Resident #97, the staff failed to revise the care plan for pressure sore interventions.

Resident #97 was originally admitted on 12-21-21. Diagnoses for Resident #97 included but were not limited to; COVID -19 pneumonia, Osteoarthritis, Chronic Hyponatremia, malnutrition, and viral hepatitis C.

Resident #97's admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 12-28-21 coded Resident #97 as alert, and oriented to person, and place, with a BIMS (brief Interview for Mental status score of 7 out of a possible 15 points indicating moderate dementia. The Minimum Data Set further coded Resident #97 as being extensively dependent, on 1-2 staff members for all Activities of Daily Living care. The Resident was coded as frequently incontinent of bowel and bladder, and at risk for developing pressure sores, however, had none upon admission to the facility.

A Braden scale for ascertaining pressure sore risk was completed upon admission and revealed a score of "11" indicating "High Risk".

The following physician orders with start dates and discontinuance dates for malnutrition are as follows;

Regular diet with thin liquids for the entire stay.

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12-23-21 Hi Cal supplement two times per day. Discontinued 1-1-22 when discharged to the hospital.

12-24-21 Boost plus supplement once per day at lunch. Discontinued 1-1-22 when discharged to the hospital.

Start 1-11-22 Active Liquid protein sugar free 30 cc (cubic centimeters = milliliters) every morning. Continued through survey.

Start 1-11-22 Hi Cal supplement three times per day. Continued through survey.

Start 1-10-22 Boost Breeze supplement once per day with lunch. Continued through survey.

Start 1-11-22 multi vitamin once per day. Continued through survey.

"Body Audit" forms after the Residents readmission on 1-6-22 were reviewed and revealed that on 1-7-22 neither heel exhibited any problem on the document. On 1-14-22 the document denoted neither heel exhibited any problem, and finally on 1-21-22, "bilateral heel DTI (deep tissue injury)", was documented. No further description was given.

The Resident's only care plan was obtained and reviewed by electronic health care (EHR) computer copy. None of the person centered physician ordered wound treatments and supplements for malnutrition were found to have been described on the care plan. No direction instruction given as to descriptive modalities for off loading pressure on the Residents heels.

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The facility Administrator, regional RN (Registered Nurse) consultant, and DON (Director of Nursing) were informed of the findings during an end of day briefing on 1-26-22 at approximately 5:00 p.m. They were again notified of findings on 1-27-22 at the end of day debrief at approximately 5:00 p.m.. The facility stated they had no further information to present at the time of exit at 6:30 p.m. on 1-27-22.

3. For Resident #64, the facility staff failed to revise the care plan to include interventions pertaining to Resident #64's fistula management, specifically, to ensure blood pressures were not taken on the left arm where the fistula was located.

On 01/25/2022 at approximately 1:15 P.M., Resident #64 was interviewed. When asked about receiving dialysis, Resident #64 nodded 'yes' and lifted her left sleeve to reveal 2 small white dressings (clean, dry and intact) covered with tape on the left upper extremity.

On 01/25/2022 and 01/26/2022, Resident #64's clinical record was reviewed. A physician's order dated 08/18/2021 documented, "Monitor LUE [left upper extremity] fistula for bruit/thrill [sound/vibration] Qshift [every shift]." A physician's order dated 08/18/2021 documented, "Monitor LUE fistula for s/s [signs and symptoms] of infection Qshift [every shift]." There was no physician's order prohibiting obtaining blood pressures in the left upper extremity where

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F 657	Continued From page 35 Resident #64's fistula was located. The care plan was reviewed. A focus initiated on 08/06/2021 entitled, "[Resident #64] needs hemodialysis r/t [related to] ESRD [end stage renal disease]." Interventions listed for this focus did not include monitoring for bruit/thrill of fistula and prohibiting blood pressures in the left upper extremity where the fistula was located. The vital signs flowsheet for blood pressures from December 2021 through January 2022 were reviewed. Of the 12 blood pressures recorded, there were 2 occurrences of the blood pressure taken in the left arm (12/15/2021 and 12/29/2021). On 01/27/2022 at 11:30 A.M., the Regional Nurse Consultant was interviewed. When asked about the expectations on the care plan for dialysis management, the regional nurse consultant expected that monitoring for bruit and thrill and prohibiting blood pressures in the extremity where the hemodialysis access was located would be included on the care plan. On 01/27/2022 at 5:55 P.M., the regional nurse consultant stated they had no further information or documentation to submit.	F 657		
F 658 SS=D	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	F 658		3/8/22

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F 658	Continued From page 36 by: Based on observation, staff interview, and clinical record review, the facility staff failed to transcribe orders for 2 Residents (Resident #64, Resident #2) in a sample size of 52 Residents. The findings included: 1. For Resident #64, the facility staff failed to transcribe the wound physician's wound treatment orders into the facility's electronic health record on 01/24/2022 resulting in the wrong wound treatment on 01/26/2022 and 01/27/2022. On 01/25/2022 and 01/26/2022, Resident #64's clinical was reviewed. An active physician's order dated 01/10/2022 documented, "left heel DM [diabetic mellitus] ulcer. clean with normal saline. pat dry. skin prep wound edges apply small piece of calcium Alginate over wound bed secure with DD [dry dressing] Q MWF and PRN [every Monday, Wednesday, and Friday and as needed]." The Treatment Administration Record for the above order with a start date of 01/12/2022 was signed off as administered as ordered including on 01/24/2022 and 01/26/2022. The wound physician document dated 01/24/2022 under the header "Assessment/Plan" documented the following headers and input: "Cleanser: wound cleanser; Primary dressing: hydrofera blue; Secondary dressing: foam; Frequency: QMWF & prn [every Monday, Wednesday, Friday & as needed]." On 01/27/2022 at 11:00 A.M., this surveyor observed Registered Nurse C (RN C) perform wound care on Resident #64's left heel. RN C checked the orders in the electronic health record	F 658	1) Resident #64 physician orders updated to include current wound treatment orders. Resident #2 physician order updated to include the current order for Celexa. 2) All residents have the potential to be affected by deficient practice. A 7-day review was completed to ensure proper transcription of new provider orders. 3) DON or Designee will re-educate all licensed nurses on proper transcription of provider orders. 4) DON or designee will randomly review 10 resident□s new provider orders to ensure accurate transcription 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through and report findings to QAPI committee. 5) Date of compliance is 03-08-2022	

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F 658	Continued From page 37	F 658		

and gathered supplies from the treatment cart. After removing the old outer dressing, RN C rinsed the wound with normal saline, applied skin prep around the wound, placed calcium alginate on the wound and covered it with a foam dressing.

On 01/27/2022 at 12:20 P.M., the administrator was notified that the wound physician wound treatment order was not the same as the wound treatment order in the electronic health record. At approximately 12:45 P.M., the regional nurse consultant indicated that the wound physician changed the wound treatment on 01/24/2022 but that it was not updated in the electronic health record. When asked about the process for transcribing wound physician orders, the regional nurse stated that the nurse that accompanies the wound physician on rounds was responsible for entering the orders into the electronic health record. The regional nurse consultant also stated that the wound treatment would now be updated in the electronic health record and the nurse would be notified to apply the dressing as ordered by the wound physician.

According to a Lippincott publication entitled, "Taylor's Clinical Nursing Skills", 5th Edition, 2019, Chapter 8, page 431, an excerpt under the sub-header "Assessment" documented, "Confirm any prescribed orders relevant to wound care and any wound care included in the nursing care plan."

On 01/27/2022 at 5:55 P.M., the regional nurse consultant indicated they had no further information or documentation to submit.

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F 658	Continued From page 38	F 658		

2. For Resident #2, the facility staff failed to transcribe a verbal order to decrease the dosage of a Celexa (Citolpram, an anti-depressant), resulting in the medication being discontinued.

On 1/28/22 at 10:30 A.M., an observation was made of Resident #2 on the memory unit. Resident #2 was sitting in the activity area of the unit with her daughter. Resident #2 appeared to be clean and well-groomed.

On 1/28/22, a review was conducted of Resident #2's clinical record. An excerpt from a Medication Error Report, dated 1/18/22 read, "[Resident #2] last received Celexa on 8/4/21. This medication was discontinued by NP (nurse practitioner) on 8/4/21. This discontinuation of the medication was not put in the que. On 8/4/21 a call was placed to the responsible party stating physician (Employee O) wanted to decrease medication to 10 mg instead of 20 mg to have a dose reduction. The Celexa 10 mg order was not activated resulting in a medication error. Resident has not had adverse effects related to medication error."

On 1/28/22, a review was conducted of facility documentation. The charge nurse (Employee C) received in-service education on 1/19/22. An excerpt from the Individual In-service document read, "[Charge Nurse - Employee C] received order from (Physician- Employee O) to reduce Citolpram on 8/4/21. Nurse failed to update the chart as documented. Reviewed verbal orders policy."

An excerpt from the Verbal Orders policy, dated

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F 658	Continued From page 39 6/21/21 read, "1. Repeat any prescribed orders back to the physician...Use clarification questions to avoid misunderstandings...Enter the order into the electronic record...The physician should sign the order electronically...Follow through with orders by making appropriate contact or notification..." On 1/28/22 at approximately 2:20 P.M., an interview was conducted with the Director of Nursing (DON- Employee B) in the conference room. When asked about the importance of this anti-depressant medication, she stated, "[Charge Nurse - Employee C] did not input the verbal order. A patient not receiving ordered medication, an anti-depressant, could become more depressed. It could cause anxiety, more depression, change of appetite, change in mental state. I don't believe it had an ill effect on (Resident #2). We got lucky. Yeah, cause it could have been much worse." Guidance for professional standards of nursing for documentation of medication administration was identified. "Document all medications administered in the patient's MAR or EMAR. If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions." Lippincott Solutions "Safe Medication Administration Practices, General" 10/02/2015.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		3/8/22

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F 677	Continued From page 40 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to ensure that Residents receive assistance to carry out Activities of Daily Living necessary to maintain good grooming and personal hygiene for 4 Residents (# 's 45, 43, 14, and 410) in a survey sample of 52 Residents The findings included: 1. For Resident #45, the facility staff failed to provide the resident's preference of 2 showers per week. A review of the minutes from the 12/21/21 Resident Council meeting read: "Residents reporting baths/ showers are not getting done 2x a week and some of the more dependant Residents (roommates of Council Members) were not being toileted promptly." On 1/26/22 at approximately 2:30 PM a Resident Council meeting was held and the subject of not getting 2 showers per week was brought up. The Residents complained of not getting 2 showers per week. They stated they believe it is due to lack of staff. They stated that had been told this by CNAs but declined to mention anyone by name. When asked if this issue has gotten any better since it was brought up in the December meeting, they all agreed that it had not gotten any better. On 1/26/22 a review of the care plan for Resident #45 revealed that Resident #45 requires	F 677	1) Resident #14, #43, #45 shower preference was updated in the resident□s plan of care. Resident #410 was provided incontinence care on 1-25-22. 2) All residents have the potential to be affected by deficient practice. 3) DON or designee will re-educate all licensed nurse and certified nursing assistant on the shower and ADL care policy. 4) DON or designee will randomly audit 10 residents ADL documentation to ensure showers were given and incontinence care was provided timely 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5) Date of compliance is 03-08-2022	

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assistance with transfers and ADL care this Resident is not independent with ADL care.

A review of the ADL records for Resident # 45 revealed that between 12-28-21 and 1-26-22 the Resident had received showers on the following dates:

12/28/21, 1/14/22, 1/18/22 and 1/25/22. There were no documented refusals of showers.

On 1/26/22 at approximately 11:30 AM the DON interviewed and she was asked what the minimum number of baths a Resident should receive each week. The DON stated that each Resident should be bathed or showered at least 2 times per week. When asked what should happen if they do not want a shower or bath she stated they should be given a complete bed bath and document in the notes that they refused their shower.

On 1/27/22 during the end of day meeting the Administrator was made aware of this concern and no further information was provided.

2. For Resident #43, the facility staff failed to provide the resident's preference of 2 showers per week.

A review of the minutes from the 12/21/21 Resident Council meeting read:

"Residents reporting baths/ showers are not getting done 2x a week and some of the more dependant Residents (roommates of Council Members) were not being toileted promptly."

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On 1/26/22 at approximately 2:30 PM a Resident Council meeting was held and the subject of not getting 2 showers per week was brought up. The Residents complained of not getting 2 showers per week. They stated they believe it is due to lack of staff. They stated that had been told this by CNAs but declined to mention anyone by name. When asked if this issue has gotten any better since it was brought up in the December meeting, they all agreed that it had not gotten any better.

A review of the care plan for Resident # 43 revealed that Resident #43 requires assistance with bathing.

A review of the ADL records for Resident # 43 revealed that during the month of January 2022 Resident # 43 received showers on 1/7/22, 1/11/22, 1/18/22 and 1/25/22. There were no documented refusals for this Resident.

On 1/26/22 at approximately 11:30 AM the DON interviewed and she was asked what the minimum number of baths a Resident should receive each week. The DON stated that each Resident should be bathed or showered at least 2 times per week. When asked what should happen if they do not want a shower or bath she stated they should be given a complete bed bath and document in the notes that they refused their shower.

On 1/27/22 during the end of day meeting the Administrator was made aware of this concern and no further information was provided.

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F 677	Continued From page 43	F 677		

3. For Resident #14, the facility staff failed to provide the resident's preference of 2 showers per week.

A review of the minutes from the 12/21/21 Resident Council meeting read:

"Residents reporting baths/ showers are not getting done 2x a week and some of the more dependant Residents (roommates of Council Members) were not being toileted promptly."

On 1/26/22 at approximately 2:30 PM a Resident Council meeting was held and the subject of not getting 2 showers per week was brought up. The Residents complained of not getting 2 showers per week. They stated they believe it is due to lack of staff. They stated that had been told this by CNAs but declined to mention anyone by name. When asked if this issue has gotten any better since it was brought up in the December meeting, they all agreed that it had not gotten any better.

A review of Resident #14's care plan revealed that the Resident requires assistance with all aspects of ADL Care.

A review of the ADL record for January 2022 revealed that Resident #14 received showers on 1/6/22, 1/10/22, 1/13/22 and 1/17/22.

On 1/26/22 at approximately 11:30 AM the DON interviewed and she was asked what the minimum number of baths a Resident should receive each week. The DON stated that each Resident should be bathed or showered at least 2 times per week. When asked what should

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happen if they do not want a shower or bath she stated they should be given a complete bed bath and document in the notes that they refused their shower.

On 1/27/22 during the end of day meeting the Administrator was made aware of this concern and no further information was provided.

4. The facility staff neglected to provide ADL assistance to include incontinence care, for a period of six (6) hours, for Resident #410.

On 1/25/22 at approximately 1:00 PM, during initial tour Resident #410 and her roommate's call bell was observed to be engaged.

While an interview with the roommate of Resident #410 was being conducted, Surveyor C observed a staff member [who was later identified as CNA B] to enter the room and exit shortly thereafter.

On 1/25/22 at approximately 1:10 PM, Surveyor C then went over to talk to Resident #410. Resident #410 was observed lying in bed, with no covers, wearing a hospital gown. Resident #410 immediately told Surveyor C that she was "soaking wet and needed to be changed", and had not been provided any care on this shift. Surveyor C was able to see Resident #410's incontinence brief and noted that it appeared wet and the blue indicator line was visible to indicate the brief was wet. Resident #410 reported that she asked CNA B who was her assigned CNA because she needed to be changed and CNA B told her, she was but that Resident #410 didn't like her and then left the room. Resident #410

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F 677	Continued From page 45 said the nurse had told her she would change her when she was done with her medication pass. On 1/25/22 at approximately 1:25 PM, Surveyor C then interviewed CNA B who said Resident #410 had asked, who her assigned CNA was and CNA B knew she didn't like her so she was going to get another CNA but that person was busy, so she told the nurse. CNA B didn't provide care because she knew Resident #410 had requested that she not provide her care. On 1/25/22 at approximately 1:30 PM, Surveyor C talked with LPN B who was at the medication cart. LPN B stated she was aware that Resident #410 needed incontinence care and was going to provide her care as soon as she finished her medication pass. LPN B further confirmed that Resident #410 had last been provided care on the "overnight shift" which ended at 7:00 AM. LPN B confirmed that about a month or two ago Resident #410 had a complaint about CNA B and that is why she, [LPN B] was going to assist Resident #410. On 1/25/22 at approximately 1:35 PM, LPN B then stopped her medication administration task and went to provide incontinence care to Resident #410. Resident #410 confirmed that she was not afraid of CNA B, but didn't like conflict and would just prefer that she not provide for her care needs. Review of the clinical record for Resident #410 revealed on the ADL (activities of daily living) sheets that she [Resident #410] required limited to extensive assistance of facility staff, for her daily care needs.	F 677		

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F 677	Continued From page 46 On 1/25/22 at approximately 1:40 PM, Surveyor C met with the facility Administrator and Director of Nursing to share the concerns of Resident #410 not having any care provided from 7 AM until after 1:30 PM. Both acknowledged that Resident #410 had a history of lodging complaints against staff and 2 staff should be present when providing care. Both further indicated that a Resident should not go this long without having care needs provided for. On 1/26/22 and again on 1/27/22, Resident #410 was visited in her room mid-morning around 9:30-10:30 AM. Each time, Resident #410 stated staff had come in to check on her and see if she needed anything. She denied having any skin breakdown or burning sensation as a result of not being changed timely on 1/25/22. Review of the facility policy titled "incontinence" was reviewed. This policy read, "...4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible". On 1/27/22 at approximately 2:30 PM, the facility Administrator, Director of Nursing and Corporate Clinical Consultant were made aware of the findings. No further information was provided.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		3/8/22

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F 689	Continued From page 47 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, clinical record review and facility documentation the facility staff failed to ensure Residents were free from accidents / hazards for 1 Resident (#20) in a survey sample of 52 Residents. The findings included: For Resident #20 the facility staff failed to ensure the Resident was in the correct shower chair. On 1/26/22 at approximately 3:00 PM while in Resident Council meeting, Resident #20 mentioned that he had fallen out of a shower chair and hit his head because he was "in the wrong chair." The Resident described being taken for a shower and placed in the "wrong shower chair" he stated it was not the chair he usually used. The Resident stated that he slid out of the shower chair. On 1/26/22 a review of the clinical record revealed that on 6/24/21 Resident #20 did indeed slid out of the shower chair. "6/24/21 at 8:43 PM Health Status Note: Resident slid out of shower chair @ 1540 and sat on the floor. Fall was witness by CNA [name redacted] who was assigned to resident this shift. Resident assess with ROM WNL resident safely assisted into W/C by four staff. No injuries noted at this	F 689	1) Resident #20 provided with correct shower chair on 6-25-21. 2) All residents have the potential to be affected by deficient practice. 3) The DON or designee will re- educate all licensed nurses and certified nursing assistants on fall prevention and investigation to include proper use of equipment. 4) DON or designee will randomly audit 5 falls to ensure appropriate use of equipment 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through and report findings to QAPI committee. 5) Date of compliance is 03-08-2022	

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time. Education provided to CNA on which shower chair to use next time for his shower to prevent further falls. VS 153/89 97.3 74 97 18. Resident is resting in his room at this time. NP aware. His sister [name redacted] made aware of fall."

On 1/27/21 an interview was conducted with CNA F who was asked how to know which shower chair to use. CNA F stated some chairs are for bariatric patients and some chair are for average size people. When asked if that is the only difference she stated yes. When asked how you transfer a Resident to a wheel chair she stated you make sure the wheels are locked on the wheel chair and on the shower chair and then you transfer them depending on their ability it could be stand and pivot or with a lift.

A review of the fall investigation read as follows:
"Location of fall - Shower central bathing

Environmental / Situational Conditions - [none checked]

Impact from fall: no injury [box checked]

Rolled out of bed [box checked]

What was the resident doing before the fall describe resident's behavior prior to fall?
[3 boxes checked]
Calm
Cooperative
Sleeping

Additional Comments: Education provided to CNA as to which shower chair to use next time to prevent further falls.

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	495396	A. BUILDING ______ B. WING ______	C 01/27/2022

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CARRIAGE HILL HEALTH AND REHAB CENTER	6106 HEALTH CENTER LANE FREDERICKSBURG, VA 22407

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F 689	Continued From page 49 Investigation completed by [LPN signature redacted] 6/24/21 Quality Review By: [not signed] Date: [not dated]" On the afternoon of 1/27/22 an interview was conducted with the DON who stated the fall investigation was incorrect where it says the Resident was asleep and rolled out of bed. The Resident fell from the shower chair DON stated that the casters were not locking and the Resident slid out of the chair onto the floor. She stated that once the fall happened the chair was immediately removed from the shower room. She was asked what the note meant when it said CNA Educated on which shower chair to use to prevent future falls she stated that meant not to use the one with broken casters. On 1/27/21 the Administrator was made aware of the concern and no further information was made provided.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide appropriate dialysis care for one Resident (Resident #64) in a sample size of 52 Residents. Specifically, the facility staff obtained blood	F 698	1) Resident #64 physician orders was updated to include av fistula management. 2) All residents have the potential to be affected by deficient practice.	3/8/22

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F 698 Continued From page 50

pressures in the same arm where Resident #64's fistula was located which is contraindicated.

The findings included:

On 01/25/2022 at approximately 1:15 P.M., Resident #64 was interviewed. When asked about receiving dialysis, Resident #64 nodded 'yes' and lifted her left sleeve to reveal 2 small white dressings (clean, dry and intact) covered with tape.

On 01/25/2022 and 01/26/2022, Resident #64's clinical record was reviewed. A physician's order dated 08/18/2021 documented, "Monitor LUE [left upper extremity] fistula for bruit/thrill [sound/vibration] Qshift [every shift]." A physician's order dated 08/18/2021 documented, "Monitor LUE fistula for s/s [signs and symptoms] of infection Qshift [every shift]." There was no physician's order prohibiting obtaining blood pressures in the left upper extremity where Resident #64's fistula was located.

The care plan was reviewed. A focus initiated on 08/06/2021 entitled, "[Resident #64] needs hemodialysis r/t [related to] ESRD [end stage renal disease]." Interventions listed for this focus did not include monitoring for bruit/thrill of fistula and prohibiting blood pressures in the left upper extremity where the fistula is located.

The vital signs flowsheet for blood pressures from December 2021 through January 2022 were reviewed. Of the 12 blood pressures recorded, there were 2 occurrences of the blood pressure taken in the left arm (12/15/2021 and 12/29/2021).

F 698

3) The DON or designee will re-educate all licensed nurses and certified nurse assistants on av fistula management.
4) DON or designee will randomly audit 5 resident that have av-fistula or other medical contraindication to ensure blood pressure is not taken in the affect limb 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee.
5) Date of compliance is 03-08-2022

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F 698	Continued From page 51 On 01/27/2022 at 11:30 A.M., the Regional Nurse Consultant was interviewed. When asked about the expectations on the care plan for dialysis management, the regional nurse consultant expected that monitoring for bruit and thrill would be included. When asked about blood pressures, the regional nurse consultant expected blood pressures would not be taken in the extremity where the hemodialysis access was located. When asked why, the regional nurse consultant stated the blood pressure would not be accurate and there's a risk of clotting the shunt. The facility staff provided a copy of their policy entitled, "Hemodialysis." In Section 12, it was documented, "The resident will not receive blood pressures or laboratory sticks on the arm where the dialysis access device is located." According to the Lippincott Nursing Procedures, 7th edition, 2016, in the section entitled, "Blood Pressure Assessment" and sub-header entitled, "Nursing Alert", an excerpt documented, "Don't measure blood pressure in an extremity ....that has an arteriovenous fistula or hemodialysis shunt (because blood flow through the vascular device might become compromised)." On 01/27/2022 at approximately 4:20 P.M., the administrator and Director of Nursing were notified of findings. At 5:55 P.M., the regional nurse consultant stated they had no further information or documentation to submit.	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency	F 755		3/8/22

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F 755	Continued From page 52 drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed, for one resident (Resident # 105) in the survey sample of 52 residents, to administer physician-ordered medication. The facility staff failed to administer Levothyroxine Sodium Tablet 25 mcg.	F 755	1) Physician notified that resident #105 Synthroid was not administered on 12-11-21 an residents medical record updated. 2) All residents have the potential to be affected by deficient practice. 3) The DON or designee will re-educate all licensed nurses on the medication administration policy.	

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F 755

Continued From page 53

On 1/27/22 at 2:00 P.M., an observation was conducted of Resident #105. She was in the activity area of the memory unit. Resident #105 was dressed appropriately, and appeared to be clean and well-groomed.

On 1/27/22, a review was conducted of Resident #105's clinical record. The Medication Administration Record (MAR) dated December, 2022 was reviewed. On 12/11/22 at 6:00 A.M., Levothyroxine Sodium Tablet 25 mcg. was not documented as having been administered. There was no documentation regarding why it had not been administered on the MAR. In addition, the Nurse's Progress note dated 12/11/21 did not document the reason that the medication had not been administered.

The signed physician's order was reviewed. It read,"12/1/21. Levothroid Sodium Tablet 25 mcg. Give 1 tablet by mouth in the morning for Hypothyroidism."

The current Medication Administration Policy (5.3) was reviewed. An excerpt read, "Medications will be administered by legally-authorized and trained persons in accordance to applicable State, Local, and Federal laws and consistent with accepted standards of practice."

On 1/27/22 at approximately 2:25 P.M., an interview was conducted with the Director of Nursing (Employee B) in the conference room. When asked about the importance of administering this medication as ordered, she stated, "It's important to maintain the thyroid."

No further information was received.

F 755

4) The DON or designee will randomly audit 10 resident medication administration records to ensure medications were administered 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee.
5) Date of compliance is 03-08-2022

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		3/8/22

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F 880	Continued From page 55 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to adhere to infection control standards of practice for one Resident (Resident #64) in a sample size of 52 Residents. Specifically, 1) Resident #64 was on Contact Precautions for Klebsiella in the urine and the family was allowed to enter and remain in Resident #64's room without wearing the proper personal protective equipment (PPE) on 01/27/2022 and 2) the nurse	F 880	1) Resident #64 Isolation was discontinued on 2-16-22. Rn C was re-educated on handwashing process during wound care. 2) All residents have the potential to be affected by the deficient practice. 3) a) The Don or designee will re-educate all staff on the handwashing policy and procedure. b) The DON or designee will re-educate all staff on transmission base precautions	

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F 880	Continued From page 56 failed to wash hands between glove changes during wound care on 01/27/2022. The findings included: 1) On 01/25/2022 and 01/26/2022, Resident #64's clinical record was reviewed. A physician's order dated 01/20/2022 documented, "Contact Isolation - ESBL [extended-spectrum beta-lactamase]." A urine culture laboratory results with a report date of 01/19/2022 under the header "Organism" documented the following excerpt, "Klebsiella pneumoniae [opportunistic pathogen], ESBL." On 01/27/2022 at 9:50 A.M., this surveyor and RN C were standing outside Resident #64's room. A sign for Contact Isolation was observed on the wall next to the room door and a PPE supply cart outside the room door. Two family members arrived and walked into the room without donning PPE. RN C did not talk with the family about wearing the proper PPE when entering the room. On 01/27/2022 at 10:43 A.M., this surveyor observed that the family was still visiting Resident #64 in the room and not wearing proper PPE. One of the visitors identified herself as Resident #64's daughter. When asked if [Resident #64] was on isolation, the family member answered that her mom had a urinary tract infection and was on antibiotics and on isolation because of the infection. When asked if they were told about wearing PPE when visiting, the daughter stated, "No, they didn't tell me that." On 01/27/2022 at 10:50 A.M., RN C was	F 880	and education to visitors regarding transmission-based precautions. c)The DON or designee will re-educate all Licensed nurses on proper handwashing during wound care. 4) a.) DON or designee will randomly audit 3 visitors to ensure infection control practice followed 3x a week for 2 weeks, then weekly for 2 weeks than monthly x 2 and report findings to QAPI committee. b) DON or designee will complete 2 treatment observation to include proper handwashing 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5) Date of compliance is 03-08-2022.	

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F 880		F 880		

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interviewed. When asked why Resident #64's visitors were allowed to be in the room without donning proper PPE, RN C stated she "should've told them about that." When asked why it's important to adhere to Transmission-based precautions, RN C stated "to prevent the spread of infection." At approximately 10:55 A.M., RN C donned a gown and gloves and entered Resident #64's room. RN C stated to the visitors that she "forgot to mention to put on gown and gloves to contain the infection." RN C explained to the visitors to put a gown on first then gloves. RN C also instructed the visitors to throw away the gown and gloves in the red trash bag before leaving the room and wash their hands.

The facility staff provided a copy of their policy entitled, "Infection Prevention and Control Program." In Section 11 entitled, "Resident/Family/Visitor Education" it was documented,
"a. Residents, family members, and visitors are provided information relative to the rationale for the isolation, behaviors required of them in observing these precautions, and conditions for which to notify the nursing staff.
b. Information on various infectious diseases is available from our Infection Preventionist.
c. Isolation signs are used to alert staff, family members, and visitors of isolation precautions.
d. Reminders are posted in the facility to alert family members and visitors to adhere to handwashing, respiratory etiquette and other infection control principles so as to limit spread of infection from family members and visitors."

2)

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F 880	Continued From page 58	F 880		

On 01/25/2022 and 01/26/2022, Resident #64's clinical record was reviewed. A physician's order dated 01/10/2022 documented, "left heel DM [diabetic mellitus] ulcer. clean with normal saline. pat dry. skin prep wound edges apply small piece of calcium Alginate over wound bed secure with DD [dry dressing] Q MWF and PRN [every Monday, Wednesday, and Friday and as needed]. The Treatment Administration Record for the above order with a start date of 01/12/2022 was signed off as administered as ordered.

On 01/27/2022 at 11:00 A.M., this surveyor observed Registered Nurse C (RN C) perform wound care on Resident #64's left heel. After removing the old outer dressing, RN C removed her gloves, lifted the lid of the red bag trash receptacle, and disposed of the gloves and old dressing. RN C then donned a new pair of non-sterile gloves and rinsed the wound with normal saline as she removed the calcium alginate dressing from the wound. RN C then removed her gloves and disposed of the gloves and inner dressing into a trash bag on the tray table. RN C then donned a new pair of non-sterile gloves, opened the packaging for the new calcium alginate, cut it to size, opened the outer dressing package, and reached into her pocket to date the outer dressing. RN C then removed her gloves and donned a new pair of non-sterile gloves. RN C then applied skin prep around the wound, calcium alginate on the wound and covered it with a foam dressing. Each time RN C removed her gloves, she did not wash her hands before putting new gloves on. RN C then removed gloves for the final time and washed her hands. In a follow-up interview at 11:20 A.M., RN C was asked if she would do anything differently. RN C stated she would have opened all the

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F 880	Continued From page 59 packages at first so she wouldn't have to change gloves so often. RN C did not mention washing hands between glove changes. When asked if it was her usual practice to wash hands between glove changes, RN C stated "yes." When asked why, RN C explained she would want to wash off any germs that may be on her hands. According to a Lippincott publication entitled, "Taylor's Clinical Nursing Skills", 5th Edition, 2019, Chapter 8, page 421, excerpts under the sub-header, "Clean (non-sterile) Technique and Wound Care" documented, "The aim of the use of clean technique in wound care is to ensure that contamination of the wound, any supplies and the environment is minimized." "Clean technique in wound care involves: Meticulous hand hygiene before initiating care and before/after glove changes." "Sterile gloves should be worn if direct contact with the wound is necessary." On 01/27/2022 at 12:25 P.M., the administrator and Director of Nursing were notified of findings.	F 880		