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	495328	A. BUILDING _____ B. WING _____	C 01/20/2022

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CARRINGTON PLACE OF TAPPAHANNOCK	1150 MARSH STREET TAPPAHANNOCK, VA 22560

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/19/2022 through 1/20/2022. The facility was in substantial compliance with 42 CFR Part 483.73, (emergency preparedness) Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/19/2022 through 1/20/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint (VA00053399 substantiated with deficiency) was investigated during the survey. The census in this 60 certified bed facility was 46 at the time of the survey. The survey sample consisted of 22 Resident reviews.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		2/25/22

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

Electronically Signed | 02/07/2022

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F 584	Continued From page 1 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and in the course of an investigation the facility staff failed to provide safe, comfortable homelike environment for 1 Resident (#30) in a survey sample of 22 Residents. The findings include: On 1/19/22, during initial tour, it was observed in Resident #30's room that the front facing was off	F 584	1. The dresser for Resident # 30 was repaired by Maintenance on 1/20/2022. 2. A 100% audit of all resident dressers to be completed by Maintenance by 2/11/2022. Repairs of any affected resident dressers to be completed by 2/11/2022. 3. In service to be conducted to facility	

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F 584	Continued From page 2 of the top drawer of his dresser. Clothing was visible as there was no way to open and close the drawer. On 1/19/22 at 12:25 PM an interview was conducted with CNA D who stated "The drawer has been like that for a while now." When asked is it more than a week, she stated that it would probably be closer to a month or more. On 1/19/22 at approximately 1:00 PM an interview was conducted with RN C who stated that Resident #30's top drawer had been broken for "a few weeks." When asked for the maintenance log book she stated that the nurses usually fill out a work order request and place it in the box for the maintenance person and he collects them daily and starts working on them. On 1/20/21 at approximately 2:30 PM an interview was conducted with the Employee C. Employee C was asked how the process works for getting work orders completed. He stated that the nurses or aids will fill out work orders when they see something that needs to be repaired, and he checks the box every morning for work orders. When asked if he has a log book or some way to see if a work order was put in for a particular Resident he stated that there was not. When asked if he received a work order for Resident #30's room he stated that he had not. When asked if he was aware that the drawer facing was completely off of the dresser he stated he was not. Surveyor C and Employee C went to Resident room and Employee C stated he was unaware of the problem but would get it fixed. Complaint deficiency.	F 584	staff regarding the location of work orders as well as the need for work orders to be completed when items are in need of repair. Maintenance to retain copies of work orders as well as placing completion date when work order is completed. Maintenance to audit all work orders twice weekly to ensure completion of all work orders in a timely fashion. Maintenance to audit all dressers once a week to ensure they are in good standing and working order. 4. Findings of weekly audits will be reported to the QA committee, who will determine the need and/or duration of future audits. 5. Compliance Date: 2/25/2022	

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F 677	Continued From page 3	F 677		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review and clinical record reviews, the facility staff failed to provide assistance with ADL's (activities of daily living) (bathing, dressing, toileting, personal hygiene, incontinence care, etc.) to four Residents (Residents #11, #24, #45, #43) who were dependent upon staff assistance, in a survey sample of 22 Residents. 1. For Residents #11, #24, and #45, all who were dependent upon facility staff for assistance with ADL's, the facility staff 1a) failed to provide personal hygiene assistance and 1b) failed to provide baths and/or showers. The findings included: 1. For Residents #11, #24, and #45, all who were dependent upon facility staff for assistance with ADL's, the facility staff 1a) failed to provide personal hygiene assistance and 1b) failed to provide baths and/or showers. Review of the clinical records for Residents #11, #24, and #45 were conducted. This review revealed the following: Resident #11's care plan read, "ADL/Restorative Nursing program Self-care deficit- I require	F 677	1. Resident numbers 24 and 45 were shaved on 1/20/2022. Resident # 11 refused shaving and this was documented in nurses note on 1/20/2022. Incontinence care was provided to Resident #43 on 1/20/2022 at time of notification by Nurse and CNA. 2. A 100% audit was done on 1/20/2022 to ensure no more residents needed incontinence care at that time with no further residents being soiled. A 100% audit of residents regarding facial hair was completed on 1/21/2022 with no other residents being affected at that time. A 100% audit of resident preference for shower/bed bath to be completed by 2/15/2022 and care plan is to reflect this preference by 2/15/2022. 3. In service will be conducted to nursing staff regarding ADL care, shaving, shower schedule, documentation, refusal of care documentation by 2/18/2022. DON/ or designee to randomly check the briefs and facial hair of six residents five times weekly to ensure incontinence care and grooming are completed (as resident desires). DON/ or designee to audit showers four times weekly to ensure	3/4/22

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F 677	Continued From page 4 extensive assistance with dressing, bed mobility, transfers, personal hygiene, and toileting. I am dependent for bathing related to weakness, cerebral palsy, tremors, cognition impairment, intellectual disability, and poor safety awareness." Resident #24's care plan read, "ADL/Restorative Nursing program. Self-care deficit - I require supervision with transfers, walking, eating and toileting. Extensive assistance with personal hygiene and dressing. Total assistance with bathing related to HX [history of] CVA [cerebral vascular accident]." Resident #45's care plan for ADL's read, "I require staff assistance with ADLS r/t [related to] generalized weakness, UTI [urinary tract infection], COPD [Chronic obstructive pulmonary disease], CHF [congestive heart failure], anemia, hypothyroidism, depression, mood disorder. Resident requires extensive assistance with 1 assist with bed mobility, transfers, locomotion, dressing and hygiene. Total assistance with 1 assist with toileting and bathing. Resident prefers to remain in bed." On 1/19/21, Residents #11, #24 and #45 were observed and visited in their rooms. These observations revealed the following: Resident #11 was lying in bed asleep. She was noted to have a significant amount of facial hair on her chin that measured approximately 1/4- 1/2 inch long. Resident #24 was noted with a significant amount of facial hair on her chin and upper lip. Resident #24 was asked about this and said, "My husband takes care of that for me".	F 677	showers have been obtained and documented accordingly. 4. Findings of weekly audits will be reported to the QA committee, who will determine the need and/or duration of future audits 5. Compliance Date: 3/4/2022	

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F 677	Continued From page 5	F 677		

Resident #45, was observed lying in bed awake. She was also observed to have a significant amount of facial hair on her chin and her hair appeared very disheveled and oily. When asked about the facial hair she didn't answer.

On 1/20/22 at approximately 10 AM, all three Residents (#11, #24, and #45) were observed in their rooms. All three still had significant facial hair.

On 1/20/22, LPN C was asked about Resident #11. LPN C said Resident #11 had received a shower earlier in the morning. LPN C confirmed that Resident #11 has behaviors and if she refused to be shaved, it should be documented. Resident #11's clinical record revealed no indication of refusing to be shaved.

On 1/20/22 at approximately 11:30 AM, Surveyor E accompanied LPN C and LPN F into the room of Resident #24 and #45. Surveyor E asked Resident #24 about her facial hair, she said "Yes it bothers me". Resident #45 when asked about her facial hair said she would like to be shaved.

On 1/20/22, LPN C stated she had told the assigned CNA to shave the Residents. LPN C said Residents are to be shaved on their shower days and as needed.

According to ADL records Resident #11 received 2 showers from 12/26/21-1/19/22. This document also coded Resident #11 as being totally dependent upon facility staff for personal hygiene and bathing.

There was no indication that Resident #11

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refused to be shaved or showered during this time frame.

Review of ADL records revealed that Resident #24 had received 4 showers or tub baths from 11/25/21-1/19/22. Resident #24's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 12/3/21, coded the Resident as having required extensive assistance of staff for personal hygiene and being totally dependent upon staff for showers.

There was no indication that Resident #24 refused to be shaved or showered during this time frame.

Review of ADL records for Resident #45 revealed she had received 3 showers or tub baths from 11/25/21-12/31/21. This document had her coded as being totally dependent upon facility staff for personal hygiene and bathing.

Review of the clinical record revealed no indication that Resident #45 refused to be shaved or showered.

On 1/20/22 at approximately 12:45 PM, an interview was conducted with LPN F. LPN F said she expects all Residents, male and female to be shaved as needed.

On 1/20/22, the Director of Nursing was made aware of the concern regarding the lack of and frequency of Resident showers. She confirmed that women are to be showered on Mondays and Thursday of each week and the men are showered on Tuesday and Fridays. She reviewed the ADL sheet for Resident #24 and

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F 677	Continued From page 7	F 677		

confirmed the documentation did not reflect this being done.

A review of the facility policy titled, "Activities of Daily Living (ADLs), Supporting" was conducted. This policy read, "...2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care)..."

On 1/20/22 at approximately 1:40 PM, the facility Administrator and Director of Nursing were made aware of the concerns regarding the lack of assistance with personal hygiene and the lack of showers/baths.

No further information was provided.

2. For Resident #43, the facility staff failed to provide incontinence care.

On 01/19/2022 at approximately 4:00 P.M., this surveyor and Certified Nursing Assistant (CNA D) entered Resident #43's room to make an observation. Resident #43 was observed lying supine in his bed with the head of the bed elevated approximately 30 degrees. Resident #43 was wearing a yellow shirt and covered with a blanket from the chest down. CNA D removed the top covers to reveal a soaked brief. The white brief was yellow and bloated throughout the front portion of the brief to indicate there was a large amount of urine in the brief. CNA D covered

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Resident #43 after the observation, washed her hands, and left the room. CNA D did not change Resident #43's soaked brief.

On 01/19/2022 at 4:30 P.M., the Director of Nursing (DON) was notified of findings. This surveyor and the DON entered Resident #43's room to do an observation. The DON pulled the covers down to reveal the saturated brief. The DON stated that the brief was "soaking wet" and that it was "time to be changed." When asked about the expectation for incontinence care, the DON stated that the CNA should've changed the soaked brief when she first saw it. The DON then stated she would find help and change the brief.

On 01/20/2022, Resident #43's clinical record was reviewed. The Minimum Data Set with an Assessment Reference Date of 12/31/2021 was coded as a quarterly assessment. Functional status for bed mobility and toileting were coded as "4" meaning total dependence on staff.

Resident #43's Activities of Daily Living flowsheet for January 2022 (01/01/2022-01/19/2022) was reviewed. There was no documentation for toileting on 01/13/2022, 01/15/2022, 01/16/2022, and 01/18/2022. Toileting on 01/06/2022 and 01/11/2022 was coded as "8" meaning "Activity did not occur/Family/Non-facility staff provided care = unknown." Toileting was documented on only one shift in a 24-hour period for 10 out of the 19 days reviewed.

On 01/20/2022, the facility staff provided a copy of their policy entitled, "Activities of Daily Living (ADL), Supporting." An excerpt under the header, "Policy Statement" documented, "Residents who are unable to carry out activities of daily living

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F 677	Continued From page 9 independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene." On 01/20/2022 at approximately 3:45 P.M., the administrator and DON were notified of findings and stated there was no further information or documentation to submit.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide care consistent with professional standards of practice to prevent pressure ulcer development for one Resident (Resident #43) in a sample size of 22 Residents. For Resident #43, the facility staff failed to provide soft boots on 01/19/2022 and 01/20/2022 as ordered by a physician.	F 686	1. Prevalon boots were placed on Resident #43 on both 1/19/2022 and 1/20/2022. 2. All other residents upon inspection on 1/20/2022 have boots, splints and palm guards on and in place per md order. A 100% audit of all pressure relieving boots, splints, and palm guards orders to be completed by 2/15/2022 to ensure appropriateness. Any resident with splint,	2/25/22

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F 686	Continued From page 10 The findings included: On 01/19/2022 at 2:38 P.M., Resident #43 was observed sleeping in his bed. Resident #43 was lying supine with the head of the bed elevated approximately 30 degrees. Resident #43 was wearing a yellow shirt and covered with a blanket from the chest down. There were 3 soft boots on the bedside table. At 3:55 P.M., Resident #43 was observed sleeping in his bed as before and the 3 soft boots were still on the bedside table. On 01/19/2022 at approximately 4:00P.M., this surveyor and Certified Nursing Assistant CNA D entered Resident #43's room to make an observation. When asked if Resident #43 wears soft boots, CNA D stated, "Yes." CNA D pulled down the cover to reveal Resident #43 had his right leg crossed over and resting on the anterior (front) lower portion of his left leg over the tibial bony prominence. CNA D lifted Resident #43's right leg off the left leg to reveal redness over the left tibial bony prominence where the right leg was resting. CNA D then stated that Resident #43 did not have his soft boots on. CNA D then replaced the covers, washed her hands, and left Resident #43's room. CNA D did not put the soft boots on Resident #43. On 01/19/2022 at 4:30 P.M., this surveyor and the Director of Nursing (DON) entered Resident #43's room to do an observation. The DON pulled the covers down to reveal Resident #43 did not have soft boots on. Resident #43's right leg was crossed over and resting on the anterior (front) lower portion of his left leg over the tibial bony prominence. When asked about the expectation for wearing the soft boots, the DON stated that	F 686	boot or palm guard orders in place to have skin assessment to ensure skin integrity is intact and current usage is being documented appropriately. 3. In service to be conducted with nursing staff regarding skin integrity, pressure ulcer prevention as well as applying boots, splints, and palm guards per md order. DON/ or designee to audit all residents with such orders three times weekly to ensure compliance with md orders such as boots, splints, and palm guards as well as documentation accuracy for these orders. 4. Findings of such weekly audits will be reported to the QA committee, who will determine the need and / or duration of future audits. 5. Compliance Date: 2/25/2022	

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F 686	Continued From page 11	F 686		

Resident #43 should be wearing the soft boots to "protect from pressure" injury. The DON then put the soft boots on Resident #43's feet.

On 01/20/2022 at 9:23 A.M., this surveyor and Licensed Practical Nurse C (LPN C) entered Resident #43's room to make an observation. LPN C confirmed she was the nurse caring for Resident #43. LPN C confirmed that Resident #43 did not have the soft boots on. LPN C pulled down the cover to reveal Resident #43 had his right leg crossed over and resting on the anterior (front) lower portion of his left leg over the tibial bony prominence. LPN C lifted Resident #43's right leg off the left leg to reveal redness over the left tibial bony prominence where the right leg was resting. When asked if the reddened area was blanchable, LPN C assessed the area by palpation. This surveyor and LPN C observed the reddened region on the left lower anterior tibial bony prominence to be blanchable. When asked why the soft boots were not on, LPN C stated that Resident #43 "didn't have his bath yet." When asked when Resident #43 was supposed to wear the soft boots, LPN C referred to the physician's order in Resident #43's electronic health record and stated, "at all times." LPN C then re-entered Resident #43's room and put the soft boots on Resident #43. When asked why Resident #43 wears the soft boots, LPN C referred back to Resident #43's electronic record. LPN C then stated, "For pressure relief."

On 01/19/2022 and 01/20/2022, Resident #43's clinical record was reviewed. The Minimum Data Set with an Assessment Reference Date of 12/31/2021 was coded as a quarterly assessment. In the section entitled, "Is this resident at risk for developing pressure ulcers?",

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F 686	Continued From page 12 it was coded as "1" meaning "yes." Functional status for bed mobility was coded as "4" meaning total dependence on staff. An active physician's order dated 03/12/2021 documented, "Resident to wear BLE [bilateral lower extremities] heel lift suspension boots (Prevelon HLSB) at all times when in bed and up in w/c [wheelchair] for pressure relief." A review of Resident #43's Treatment Administration Record for January 2022 revealed that the heel lift suspension boots were signed off as administered even though there were three observations the boots were not on during survey. Resident #43's care plan was reviewed. A goal entitled, "I will remain free from injury, skin breakdown, edema, atrophy, and pain through next review" included but not limited to the following nursing intervention: "Resident to wear BLE [bilateral lower extremities] heel lift suspension boots (Prevelon HLSB) at all times when in bed and up in w/c [wheelchair] for pressure relief." On 01/20/2022, the facility staff provided a copy of their policy entitled, "Pressure Ulcers/Skin Breakdown - Clinical Protocol." Under the header, "Treatment/Management" in Section 1, an excerpt documented, "The physician will order pertinent wound treatments, including pressure reduction surfaces ....." On 01/20/2022 at approximately 3:45 P.M., the administrator and DON were notified of findings and stated there was no further information or documentation to submit.	F 686		
F 689	Free of Accident Hazards/Supervision/Devices	F 689		2/25/22

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F 689 SS=E	Continued From page 13 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, facility documentation, and in the course of a complaint investigation, the facility staff failed to ensure the environment was free from accidents and hazards for 1 Resident (#32) in a survey sample of 22 Residents and failed to store oxygen cylinders in a safe and secure manner. The findings include: 1. For Resident #32, the facility staff failed to ensure the proper placement of sling hooks on the mechanical lift while transferring from the chair to the bed on 08/19/2021 causing Resident #32 to fall to the floor resulting in a sprained toe and contusion on her back. On 01/19/2022 at 1:15 P.M., an interview Resident #32 was conducted. When asked if she had fallen recently, Resident #32 stated she had fallen recently. When asked about how the fall occurred, Resident #32 explained that in the process of getting transferred from the chair to the bed with a mechanical lift, the sling "wasn't hooked right." Resident #32 went on to say that the staff member "didn't double check the loops" to make sure they were on correctly and when the	F 689	1. Resident #42 has been free from falls via hoyer transfers since incident in 8/2021. Two staff assist with both staff verifying placement of hoyer straps prior to transfer via hoyer lifts. Oxygen tanks were placed in designated area in rack to secure the portable tank. 2. A 100% audit of all resident with current hoyer lift orders conducted by 2/15/2022.All resident transfers via hoyer will be conducted with two staff members present as well as both staff members verifying placement of hoyer straps. A 100% audit of facility on 1/20/2022 revealed no further loose etanks. 3. In service conducted with nursing staff regarding verification of hoyer strap placement as well as two staff members present for all hoyer lift residents. In service regarding etanks and proper storage by 2/18/2022. DON/ or designee to audit three hoyer lift transfers three times weekly to ensure lift compliance. DON/ or designee to do facility wide sweep three times weekly to ensure no	

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F 689	Continued From page 14 lift was raised, Resident #32 fell to the floor. When asked if there were injuries, Resident #32 indicated that the fall resulted in a sprained toe and a sore back. When asked how many staff members were helping in the transfer, Resident #32 stated, "2." On 01/19/2022 and 01/20/2022, Resident #32's clinical record was reviewed. Resident #32's most recent Minimum Data Set previous to the fall with an Assessment Reference Date of 06/09/2021 was coded as an annual assessment. Functional status for transfers was coded as "4" meaning total dependence on staff. Resident #32's most recent Minimum Data Set with an Assessment Reference Date of 12/22/2021 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition. A nurse's note dated 08/20/2021 at 12:26 A.M. documented the following excerpts: "2040 [8:40 P.M. on 08/19/2021]: This nurse was notified patient had fell, it was a witness fall by two CNA's. This nurse found pt [patient] on floor in hallway. PT was being transferred from automatic wheelchair via hoyer lift when fall occurred. The hoyer lift was being operated by two CNA's [certified nursing assistants], when one of the loop slipped off of the hanger resulting in the patient hitting the floor. Pt landed on back, and stated "I might of hit my head on the wall when the fall occurred." No bump or abrasions on head. No apparent injuries after fall. PT VS [vital signs] were done and WNL [within normal limits]. PT denies any pain at time of fall. Pt is alert and orient x4 [meaning person, place, time, situation]."	F 689	loose etanks are present. Etanks to be secured properly if present 4. Findings of such weekly audits will be reported to the QA committee, who will determine the need and/or duration of future audits. 5. Compliance Date: 2/25/2022	

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"2100 [9:00 P.M.]: MD and DON notified."
"2200 [10:00 P.M.]: Pt started complaining of severe lower back pain. PT has no bumps or abrasion on head at this
time. This nurse did not see any bruises at this time. Pt left great toe was redden and pt complain of
left great toe hurting."
"2245 [10:45 P.M.]: 2 EMS responders arrived and took patient to hospital via stretcher."

A nurse's note dated 08/20/2021 at 12:30 P.M., documented, "Resident returned from hospital via stretcher. O2 via nc [oxygen via nasal cannula] intact. Resident alert and oriented. VS: 97.3-70-16 108/65.O2 sat 97% on room air [vital signs: (temperature), (pulse), (respirations), (blood pressure), (oxygen saturation)]."

Resident #32's care plan was reviewed. A problem entitled, "Problem: I have the potential for falls related to quadriplegia, neuralgia, muscle spasms, insomnia, depression, L [left] hand contracture, incontinence, psychoactive medications, weakness, opioid medication use, and hx [history] falls prior to admission. 8/20/21: Resident fell while being transferred via hoyer lift; left great toe sprain and contusion to back" included but not limited to the following intervention: "Hoyer [mechanical] lift for transfers: educate staff on operation."

On 01/20/2022 at approximately 8:45 A.M., a copy of the fall investigation was requested and the facility staff provided a document entitled, "Event Report" dated 08/20/2021 at 12:16 A.M. and a closed date of 08/23/2021 at 1:55 P.M. Under the header entitled, "Evaluation Notes", it was documented, "Resident sent out to the

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hospital for evaluation, staff in-serviced on hoyer [mechanical] lift protocol."

On 01/20/2022 at 11:40 A.M., this surveyor and Certified Nursing Assistant C (CNA C) approached the mechanical lift for an observation. There were 4 sling hooks on the spreader bar and there was a sling loop on each corner of the sling. This surveyor observed CNA C demonstrate how the sling loops on the sling were inserted into the sling hooks on the spreader bar. CNA C explained the sling loops were color-coded so the blue loops are attached closest to the head and the green loops are attached closest to the feet. The four sling hooks on the spreader bar had a space approximately 1 inch wide at the top of the hook to allow the insertion of the sling loops. This small opening at the top mitigated the possibility of a sling loop sliding off the sling hook.

On 01/20/2022 at 1:15 P.M., an interview with CNA E was conducted. CNA E verified she was one of the aides involved in Resident #32's fall incident in August 2021. When asked what happened, CNA E explained they were transferring Resident #32 from her chair to her bed using the mechanical lift. CNA E went on to say that "one got loose" in reference to the sling loops and "Slipped out" as we were lifting Resident #32 using the mechanical lift. When asked which loop, CNA E stated it was the loop by Resident #32's left leg. When asked who attached the sling loops to the sling hooks, CNA E stated that her and the other CNA "hooked her up together." CNA E stated that when the lift was activated, Resident #32 fell to the floor on her back.

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On 01/20/2022 at 3:30 P.M., CNA D was interviewed. CNA D verified she was one of the aides involved in Resident #32's fall incident in August 2021. When asked what happened, CNA D stated she didn't know. CNA D also stated that sometimes the lift "jumps" and maybe a loop came out if the machine jumped. When asked which loop came out, CNA D stated, "I'm not sure." CNA D went on to say that "maybe it wasn't in the hook all the way."

On 01/20/2022, a copy of the manufacturer's instructions for the mechanical lift was requested and provided. The sling attachment instructions on page 19 of the instructions did not address the color-coated loops. At 3:45 P.M., the administrator and Director of Nursing (DON) were notified of findings. When asked about Resident #32's fall incident, the DON stated that staff reported to her that one of the loops slipped off the hook "but there's no way" for the loops to slip off the hooks. The DON also stated that a root cause analysis was done and determined the sling loop was not all the way on the sling hook. When asked about the action plan, the DON stated that all care staff were retrained on operation the [mechanical] lift. A copy of the in-service signature sheets was requested and the facility staff provided a copy of an in-service sheet dated 08/28/2021. Under the header, "Summary of Content", it was documented, "Hoyer lift. 2-person assist. Hoyer pad loops should be on hoyer rings. Use same color loops." There were 32 signatures on the page including CNA D and CNA E.

On 01/20/2022, the facility staff provided a copy of their policy entitled, "Lifting Machine, Using a Mechanical." Under the header, "Steps in the

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Procedure" in Section 12(a)(c)(d) documented, "(a) Make sure the sling is securely attached to the clips and that it is properly balanced. (c) Before resident is lifted, double check the security of the sling attachment. (d) Examine all hooks, clips or fasteners."

On 01/20/2022 at approximately 4:30 P.M., the administrator and DON were notified of findings and stated there was no further information or documentation to submit.

3. The facility staff failed to store oxygen cylinders in a safe and secure manner, which had the potential to create a hazardous environment.

On 1/19/22 at 12:15 PM, during initial tour, a broda [specialized wheelchair] was observed stored in the hallway outside of room 104. A portable oxygen cylinder (E-tank) resting on the foot rest in an upright position, unsecured.

On 1/19/22 at 4:00 PM, observations were made of the portable oxygen cylinder which were the same as previously noted.

On 01/19/22 at 04:22 PM, an interview was conducted with LPN B. LPN B was asked about the storage of oxygen cylinders. LPN B said, "Portable oxygen tanks are used when resident goes out. When not in use, they are stored in the oxygen room in a rack that room has a key pad because we don't want anyone getting in there". LPN B was asked, what are the risks of them not being stored in the rack? LPN B said, "It could explode". LPN B was asked to observe the

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oxygen tank that was sitting in the broda chair in the hallway. LPN B said, "Oh my. Yes, that is a problem, it could fall over and explode". LPN B then removed the oxygen cylinder and took it to the oxygen storage room to put it in the storage rack. LPN B confirmed that the cylinder had oxygen in it and was not empty.

On 01/19/22 at 04:43 PM, observations were made in the social work/admissions office, where the survey team was assigned as a work space by the facility Administrator. In this office 2 oxygen cylinders (e-tanks) were noted sitting beside a file cabinet, unsecured. The gauge indicated each tank was half full.

On 01/19/22 at 04:52 PM, Employee C, the maintenance director came to the social worker/admissions office. Employee C was asked how oxygen cylinders are stored. Employee C said, "We have an oxygen room and they are stored in racks and the rack is chained to the wall, so they won't fall over". Employee C was asked why it is important that they be stored in this manner. Employee C said, "Oxygen is not flammable but it can make the flame worse. They are stored under pressure, if the nozzle is hit they could shoot off". Employee C then confirmed the two tanks in the office were not properly stored and confirmed that each was half full. Employee C further stated that he didn't know why the tanks would be stored in the office. He then exited the room without making corrections of the storage of the tanks.

On 01/19/22 at 05:09 PM, the facility Administrator provided the survey team with the facility policy regarding oxygen storage. While in the room, the Administrator was asked how the

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portable oxygen cylinders are to be stored. He said, "They should be in a rack". When asked why they are stored this way, he said, "So they don't tip over, they could tip burst open and let all that air out and it could become a projectile. " The Administrator was shown the two oxygen cylinders in the room and he confirmed they both had oxygen in them and would be of concern. He then said, "I'll get that taken care of for you", and removed them.

Review of the facility policy titled, "Fire Safety and Prevention" was conducted. The policy read, "Oxygen Safety: ... f. Store oxygen in racks with chains, sturdy portable carts, or approved stands. Never leave oxygen cylinders free-standing. Do not store oxygen cylinders in any resident room or living area".

The NFPA (National Fire Protection Association) gives the following guidance with regards to "Medical Gas Cylinder Storage". "One of the most common hazards in a health care facility is the storing and handling of medical Gas cylinders. NFPA 99, Health Care Facilities Code, provides guidance to keep patients, staff, and the public safe in facilities with these types of cylinders...Types of Hazards: There are two types of hazards associated with medical gas equipment: general fire and explosions, and mechanical issues such as physical damage to compressed gas cylinders. ..Compressed gas cylinders that sustain mechanical damage can also be a hazard. Gases inside cylinders are generally under high pressures, and the cylinders often have significant weight. The cylinders can cause injuries directly due to their weight and inertia. Damage to the regulators or valves attached to a cylinder can allow the escaping gas

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F 689	Continued From page 21 to propel the cylinder violently in a dangerous manner.... Gas Cylinder Storage: Requirements for the storage of medical gas cylinders....Racks, chains, or other fastenings to secure cylinders from falling..." Accessed online at: https://www.nfpa.org/~/media/4B6B534171E04E369864672EBB319C4F.pdf On 1/20/22 at approximately 1:30 PM, the facility Administrator and Director of Nursing were made aware of the noted concerns with regards to oxygen storage. No further information was provided.	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		2/25/22

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all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

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

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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F 842	Continued From page 23 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 3 Residents (Residents #11, #24, and #45) in a survey sample of 22 Residents. For Residents #11, #24, and #45, the facility staff failed to document ADL care provided, therefore rendering an incomplete clinical record. The findings included: On 1/19/22 and 1/20/22, clinical record reviews were conducted for Residents #11, #24, and #45. The surveyor was not able to access ADL (activities of daily living) (bathing, dressing, toileting, personal hygiene, etc.) records and therefore, the facility staff were asked to provide the ADL records to the survey team. On 1/20/22, Surveyor E was provided and reviewed the requested ADL records. This review revealed the following: 1. For Resident #11, no ADL information was recorded for the following dates: 12/26/21, 12/29/21, 1/4/22, 1/5/22, 1/12/22, 1/13/22, 1/16/22, and 1/18/22. 2. For Resident #24, ADL information was not recorded on the following dates: 11/25/21, 12/1/21, 12/3/21, 12/12/21, 12/14/21, 12/21/21, 12/25/21, 12/26/21, 12/27/21, 12/30/21, 1/4/22,	F 842	1. Residents number 11, 24, and 45 were charted on 1/19/2022 and 1/20/22 to reflect adl care. 2. A 100% audit of residents in facility will be reviewed for 7 day look back for adl documentation, refusal of care by 2/15/2022 to determine residents that is affected. Residents affected will be charted on every shift to determine adl care is rendered by staff. 3. In service conducted to nursing staff regarding adl documentation and refusal of care documentation. ADL documentation of all residents to be reviewed five times weekly by DON/or designee to ensure completion. 4. Findings of weekly audits will be reported to the QA committee, who will determine the need and/or duration of future audits. 5. Compliance Date: 2/25/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495328	A. BUILDING _____ B. WING _____	C 01/20/2022

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F 842	Continued From page 24	F 842		

1/9/22, 1/13/22, 1/14/22, 1/16/22, and 1/17/22.

3. For Resident #45, ADL information was missing on the following dates: 11/25/21, 12/1/21, 12/14/21, 12/21/21, 12/24/21, 12/25/21, and 12/30/21.

Review of the care plans for each of the Residents was conducted. This review revealed the following data:

1. Resident #11's care plan read, "ADL/Restorative Nursing program Self-care deficit- I require extensive assistance with dressing, bed mobility, transfers, personal hygiene, and toileting. I am dependent for bathing related to weakness, cerebral palsy, tremors, cognition impairment, intellectual disability, and poor safety awareness."

2. Resident #24's care plan read, "ADL/Restorative Nursing program. Self-care deficit - I require supervision with transfers, walking, eating and toileting. Extensive assistance with personal hygiene and dressing. Total assistance with bathing related to HX [history of] CVA [cerebral vascular accident]."

3. Resident #45's care plan for ADL's read, "I require staff assistance with ADLS r/t [related to] generalized weakness, UTI [urinary tract infection], COPD [Chronic obstructive pulmonary disease], CHF [congestive heart failure], anemia, hypothyroidism, depression, mood disorder. Resident requires extensive assistance with 1 assist with bed mobility, transfers, locomotion, dressing and hygiene. Total assistance with 1 assist with toileting and bathing. Resident prefers to remain in bed."

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F 842	Continued From page 25 On 1/20/22 at approximately 11:30 AM, the Director of Nursing (DON) was shown the ADL records provided. She was asked about the dates that read, "No ADL Data Recorded" and asked what this meant. The DON said, "That means they didn't chart". She confirmed that care was provided but not charted and said she expects them to chart what they [the nursing staff] do. Review of the facility policy titled, "Activities of Daily Living (ADLs), Supporting" was reviewed. This policy only addressed documentation of ADL's with regards to Resident refusals of care. It read, "(3) Refuses care and treatment to restore or maintain functional abilities and: ...(c) the refusal and information are documented in the resident's clinical record..." On 1/20/22 at approximately 1:30 PM, the DON and facility Administrator were made aware of the findings. The DON confirmed that these omissions in charting rendered an incomplete clinical record. No further information was provided.	F 842		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation and in the course of a complaint investigation, the facility staff failed to implement	F 925	1. No current resident or staff complaints regarding pest control in place. Maintenance has reached out to pest	2/25/22

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F 925	Continued From page 26 an effective pest control program affecting the parts of the facility. The findings include: For the Residents of the facility the facility staff failed to ensure the facility was free of pests to include mice, roaches, and snakes. On 1/20/22 an interview was conducted with Employee C (maintenance) who stated "When I first started last winter there was a problem with mice I will admit, and yes there was a snake issue in August." On 1/19/22 at 3:55 PM, Surveyor C interviewed Resident #4. She said they had an issue with rats last fall but they took care of it. She said she was very patient until one ran up the side of her bed. She said "I think they put poison out upstairs where no one could get to it, but it worked." On 1/20/22 an interview was conducted with the Administrator who stated "There are fields behind the facility and last year the grain was not exported so it sat there on the loading dock. There was an increase in mice activity because the grain was sitting there, and an increase in black snakes because they eat mice. Maintenance worked with [pest control company name redacted] and they got it taken care of."	F 925	control company regarding identifying potential problem areas. 2. A 100% facility sweep will be completed by 2/18/2022 to identify any signs of pest issues. Any concerns noted will be called to pest control company and treated in timely fashion. 3. In service conducted with all staff regarding logging in pest control log as well as notifying maintenance of any pest issues. Pest control log to be reviewed three times weekly by Maintenance/ or designee and pest control company notified of any pest control issues. 4. Findings of weekly audits will be reported to the QA committee, who will determine the need and/or duration of future audits. 5. Compliance Date: 2/25/2022	