STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. BUILDING _____ B. WING _____	C 12/09/2021

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CHOICE HEALTHCARE AT HARRISONBURG	94 SOUTH AVENUE HARRISONBURG, VA 22801

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 12/7/2021 through 12/9/2021. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/72021 through 12/9/2021. Two complaints were investigated during the survey. Complaint VA00052192 was substantiated with deficiencies. Complaint VA00053751 was unsubstantiated. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 117 certified bed facility was 68 at the time of the survey. The survey sample consisted of eighteen current resident reviews and two closed record reviews.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests,	F 561		

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Administrator 12/23/21

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

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F 561	Continued From page 1 assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on complaint investigation, clinical record review, resident interview, and review of facility documents, the facility failed to acknowledge the resident's personal choice for bathing, for one of 20 residents in the survey sample Resident # 13. Resident # 13, whose personal preference for bathing was a shower, received two showers between October 2, 2021 and December 1, 2021. The findings were: Resident # 13 in the survey sample was admitted to the facility on 3/31/2017 with diagnoses that included anxiety disorder, depression, morbid obesity, gastroesophageal reflux disease, lymphedema, slow transit constipation, and hypertrophic osteoarthropathy. According to the most recent Minimum Data Set (MDS), a Quarterly Review, with an Assessment	F 561	F 561 1. Facility interdisciplinary team implemented combining majority of resident to one unit to increase availability of CNA's for resident care. A CNA will be assigned as a shower aide for each day to ensure showers are completed 2x per week. 2. All residents have the potential to be affected by this. 3. Unit Managers will have shower sheets available and will monitor them. 4. Unit Manager provide shower sheets to the Clinical IDT for review 4 to 5 times per week for 6 weeks. Information will be reported at QA and determined if further monitoring will be needed.	1/25/22

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F 561	Continued From page 2 Reference Date (ARD) of 9/23/2021, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. Under Section G (Functional Status), the resident was assessed as totally dependent with one person physical assist for bathing. At approximately 2:30 p.m. on 12/7/2021, Resident # 13 was interviewed regarding her bathing. Asked if there was a scheduled bath day, the resident said, "I have no scheduled bath day. I get one when they have someone to give me one." The resident went on to say she last received a bath "...about five days ago." Resident # 13 also said her personal preference for bathing was a shower. Resident # 13's most recent Annual MDS, with an ARD of 3/23/2021, documented at F0400 (Interview for Daily Preferences), "How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?" that the resident responded "Very important." Resident # 13's plan of care included the following problem, "ADL (Activities of Daily Living) self-care performance deficit and dental care r/t (related to) OA (Osteoarthritis), Gait mobility, BMI (Body Mass Index) > (greater than) 65, Debility and Depression." The goal for the problem was, "(Name of resident) will maintain current level of function in transfers to supervision through the review date." Included as an intervention to the stated problem was, "BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Provide	F 561		

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F 561	Continued From page 3 sponge bath when a full bath or shower cannot be tolerated. Prefers shower." At 7:45 a.m. on 12/8/2021, the Director of Nursing (DON) was interviewed regarding showers for Resident # 13. Asked if there was a reason why Resident # 13 could not have a shower, the DON said, "There is no reason why she cannot have a shower." Review of ADL records and shower records revealed Resident # 13 received a shower on 10/3/2021 and 12/1/2021. The resident was scheduled for a shower on 10/7/2021, but did not receive a shower. The Shower Completion Sheet included the following notation next to the residents name for the scheduled shower on 10/7/2021, "Had on 10-3-21." Between the dates 10/1/2021 and 12/1/2021, the resident received either partial baths or bed baths. The findings were discussed during a meeting at 4:14 p.m. on 12/8/2021, that included the Administrator, DON, Corporate Nurse Consultant, and the survey team.	F 561		
F 607 SS=E	COMPLAINT DEFICIENCY 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	F 607		

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F 607	Continued From page 4 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 review of facility personnel files, facility policy and procedures, and staff interview, the facility failed to implement the policy and procedure to ensure applicants for employment completed a Sworn Disclosure Statement disclosing "...any criminal convictions or pending criminal charges...." Review of 25 personnel files revealed none of the 25 files reviewed contained a Sworn Disclosure Statement. The findings were: On 12/8/2021, 25 personnel files, selected from a list provided by the facility, were reviewed. The 25 files reviewed included 12 Certified Nursing Assistants, six Registered Nurses, three Licensed Practical Nurses, and four non-licensed personnel. There was no Sworn Disclosure Statement in 25 of the 25 files reviewed. During an interview at 2:00 p.m. on 12/8/2021, the facility Administrator provided a copy of the facility's Sworn Disclosure Statement form, a copy of an explanation of the facility's background check process, and a general information form, provided to applicants for employment. The Administrator indicated the Sworn Disclosure Statement form for the 25 reviewed employees was apparently lost or misplaced. The Sworn Disclosure Statement included the following, "Section 63.2-1720 of the Code of Virginia requires that any person desiring work at	F 607	F 607 1. All current employees will have new Sworn Disclosure Statements completed no later than 1.2.22. 2. All current residents do not have the potential to be affected by this. 3. As of 12.8.21, Sworn Disclosure Statements have been placed with all pre-employment paperwork to be completed before new applicant is hired. 4. Facility Administrator will review all new employee files for 6 weeks. Information will be reported at QA and determined if further monitoring will be needed.	1/25/22

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F 607	Continued From page 5 a licensed facility provide the hiring facility with a sworn disclosure statement or affirmation disclosing any criminal convictions or pending criminal charges...." The explanation of the facility's background check process included, "It is the policy of The Company and all applicable subsidiaries, to conduct background checks to include criminal background checks...on all applicants, employees, and volunteers...." The facility's Abuse Prevention Program, under Policy Interpretation and Implementation, included the following: "As part of the resident abuse prevention, the administration will: 2. Conduct employee background checks and will not knowingly employ or otherwise engage any individual who has: a. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law...." The findings were discussed during a meeting at 4:14 p.m. on 12/8/2021, that included the Administrator, DON, Corporate Nurse Consultant, and the survey team.	F 607		
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 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	F 657		

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F 657	Continued From page 6 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, staff interview, clinical record review and facility document review, the facility staff failed to review and revise a comprehensive care plan for 1 of 20 residents in the survey sample, Resident #3. Resident #3's comprehensive care plans were not reviewed and revised for the discontinuation of anticoagulant use. The findings include: Resident #3 was originally admitted to the facility on 04/04/2008 and readmitted on 04/02/2021 with diagnoses that included legal blindness, atrial fibrillation, cerebral palsy, hypertension, dementia without behavioral disturbances, and generalized anxiety disorder. The most recent minimum data set (MDS) dated 12/02/2021 was a quarterly and assessed Resident #3 as rarely/never understood	F 657	F 657 1. 100% audit was completed by clinical IDT of all residents who are on anticoagulation therapy, and care plans corrected if indicated. 2. All current residents receiving anticoagulation therapy have the potential to be affected by this. 3. Physician orders will be reviewed at least five times per week by clinical IDT and any anticoagulation therapy changes will be updated on the care plan as ordered by MDS and/or designee. 4. A weekly audit will be completed by DON and/or designee, of all care plans completed as scheduled for all residents on anticoagulation therapy for six weeks to ensure that compliance is met. Information will be reported at QA and determined if further monitoring will be needed.	1/25/22

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F 657	Continued From page 7 for cognitive function and daily decision making. Under Section N - Medications, Anticoagulants was coded as 0 received. A comparative review of the significant change MDS dated 9/1/2021 was completed. Under Section N - Medications, Anticoagulants was coded as 4 received. On 12/7/2021, Resident #3's clinical record was reviewed. A review of the care plan's documented the following: "(Resident #3) is on Anticoagulant therapy r/t (related to) Atrial fibrillation, hx (history) of DVT (deep vein thrombosis) and CVA (cerebrovascular accident)." A review of the current physician orders did not document anticoagulant use. A review of the medication administration record for the period of July 2021 through December 2021 documented the anticoagulant Warfarin was discontinued on 09/02/2021. On 12/08/2021 at 10:19 a.m., the MDS coordinator (LPN #1) who was responsible for the care plans was interviewed regarding Resident #3's care plans. LPN #1 reviewed Resident #3's electronic clinical record and stated, "[Resident #3] doesn't receive any anticoagulants, they were discontinued on September 2, 2021. Her care plans should have been updated to reflect this change." On 12/08/2021 at 4:45 p.m., the above findings were discussed with the administrator, director of nursing (DON) and corporate consultant. A review of the facility's policy titled "Care Plan Revisions Upon Status Change (Date Implemented: 11/1/2020)" documented the following: "1. The comprehensive care plan will be	F 657		

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F 657	Continued From page 8 reviewed, and revised as necessary, when a resident experiences a status change. "2. Procedure for reviewing and revising the care plan when a resident experiences a status change: a. Upon identification of a change in status, the nurse or any member of the interdisciplinary team will notify the MDS Coordinator, the physician, and the resident representative, if applicable.... d. The care plan will be updated with the new or modified interventions.... f. Care plans will be modified as needed by MDS Coordinator or other designated staff member..." No additional information was received by the survey team prior to exit on 12/09/2021 at 9:45 a.m.	F 657		1/25/22
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 resident interview, staff interview, clinical record review, and in the course of complaint investigation, the facility failed to ensure baths/showers were being provided as scheduled for three of 20 residents, Resident # 48, 7, and 13. The Findings Include: 1. Resident #48 was admitted to the facility on 11/11/2014 with a readmission on 3/5/2020. Diagnoses for Resident #48 included: Diabetes,	F 677	F 677 1. Facility interdisciplinary team implemented combining majority of resident to one unit to increase availability of CNA's for resident care. A CNA will be assigned as a shower aide for each day to ensure showers are completed 2x per week. 2. All residents have the potential to be affected by this. 3. Unit Managers will have shower sheets available and will monitor them. 4. Unit Manager provide shower sheets to the Clinical IDT for review 4 to 5 times per week for 6 weeks. Information will be reported at QA and determined if further monitoring will be needed.	

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F 677	Continued From page 9	F 677		

kidney disease, neuropathy, and dysphagia. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/5/21. Resident #48 was assessed with a cognitive score of 15 indicating cognitively intact.

On 12/07/21 at 12:00 PM Resident #48 was interviewed. Resident #48 stated that she liked to take baths but had not been receiving baths as scheduled and had been told there was not enough staff to give baths.

Resident #48's care plan, current MDS and bathing ADL's (activity of daily living) were reviewed and indicated Resident #48 needed set up and supervision for bathing. The bath schedule for Resident #48 indicated Resident #48 was sheduled for a bath every Tuesday. Resident #48's bath completion form for a 30 day look back period documented Resident #48 received a shower on 11/9/21, bath on 11/10/21, and bath on 11/17/21. No other documentation was provided.

On 12/08/21 at 9:43 AM, certified nursing assistant (CNA) #2 (working on the unit where Resident #48 resided) was interviewed. CNA #2 said the facility was short staffed, sometimes only having 2 CNA's for the entire unit when there should be three CNA's and a CNA giving showers. CNA #2 stated showers are not getting done because they don't have enough help.

The shower schedule for "B" wing was reviewed and indicated the schedule was based on room number and indicated that each resident was only scheduled to receive one shower/bath per week.

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F 677	Continued From page 10 On 12/08/21 at 10:00 AM, license practical nurse (LPN) #3 (unit manager) was interviewed. LPN #3 said the once a week shower was implemented by the previous director of nursing (DON) because of the staffing challenges. LPN #3 said she was aware that showers are not being provided because the facility is still having staffing challenges. On 12/8/21 at 10:40 AM, LPN #3 was interviewed. LPN #3 stated that the once a week shower schedule had been implemented since the end of April 2021. On 12/08/21 at 10:59 AM, the DON was interviewed. The DON stated that she was just hired two weeks ago and was unaware that the shower schedule only allowed for each resident to receive a shower once a week. On 12/08/21 at 11:12 AM, the administrator was interviewed. The administrator reviewed "B" wing shower schedule and was asked why the schedule was for only one bath a week. The administrator said the facility has had some staffing issues and are currently trying to fill positions. No other information was provided prior to exit conference on 12/9/21. 2. Resident # 7 was admitted to the facility 10/3/17 with diagnoses to include, but not limited to: diabetes, peripheral vascular disease, below knee amputation of left leg, muscle weakness, and hypothyroidism. The most recent MDS (minimum data set) was a quarterly review dated 9/9/21 and had Resident # 7 coded as cognitively intact with a total summary	F 677		

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F 677	Continued From page 11 score of 15 out of 15. The annual review documented that Resident # 7 was identified as choosing a shower as "very important" at Section F0400-"Daily Preferences" and "G0120 A.Bathing: 4. total dependence and B.Self Performance 3. One person assist." Section G0400 "Functional Limitation" was assessed as having impairment in the upper and lower extremities. On 12/8/21 beginning at 10:10 a.m. Resident # 7 was interviewed about daily life in the facility. She stated "Well, things are pretty good; however, I am supposed to get a shower on Wednesdays and Saturdays, and I don't get them. I had a visitor this past Sunday, and when she walked in my room, she looked at me and said 'Are you getting your showers?' I said 'no.' She went and talked to them and I got a shower. You see this hair? It's greasy, and I don't like it...if you don't get a shower your hair looks like this." Resident # 7 stated, "They (the facility) don't have enough help. If there was enough help, we could get a shower when we're supposed to..." On 12/8/21 at 10:30 a.m. CNA (certified nursing assistant) # 1 was interviewed about resident showers. CNA # 1 stated "We don't have enough staff to do two showers a week, much less one. There's a lot of 'call outs' and if they can't get anybody, we do the best we can, but if a resident is totally dependant, then giving a shower with just two staff on the unit is very difficult..." On 12/8/21 at approximately 10:45 a.m. the shower sheet documentation was reviewed for September, October, and November 2021, and revealed Resident # 7 had gotten one shower in September, one in October, and one in	F 677		

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F 677	Continued From page 12 November. There was no documentation of the shower the resident stated she had received 12/5/21. The administrator, DON (director of nursing) and the regional nurse consultant were informed of the above findings during a meeting 12/8/21 beginning at 11:12 a.m. No further information was provided prior to the exit conference. 3. Resident # 13 in the survey sample was admitted to the facility on 3/31/2017 with diagnoses that included anxiety disorder, depression, morbid obesity, gastroesophageal reflux disease, lymphedema, slow transit constipation, and hypertrophic osteoarthropathy. According to the most recent Minimum Data Set (MDS), a Quarterly Review, with an Assessment Reference Date (ARD) of 9/23/2021, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. Under Section G (Functional Status), the resident was assessed as totally dependent with one person physical assist for bathing. At approximately 2:30 p.m. on 12/7/2021, Resident # 13 was interviewed regarding her bathing. Asked if there was a scheduled bath day, the resident said, "I have no scheduled bath day. I get one when they have someone to give me one." The resident went on to say she last received a bath "...about five days ago." Resident # 13 also said her personal preference for bathing was a shower. Review of Shower Completion Sheets revealed	F 677		

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F 677	Continued From page 13 Resident # 13 received a shower on 10/3/2021 and 12/1/2021. The resident was scheduled for a shower on 10/7/2021, but did not receive a shower. The Shower Completion Sheet included the following notation next to the residents name for the shower scheduled on 10/7/2021, "Had on 10-3-21." Review of the ADL (Activities of Daily Living) records for October 2021 revealed Resident # 13 received 17 partial baths and six bed baths. The shower the resident received on 10/3/2021 was not included on the October ADL records. Review of the ADL records for November 2021 revealed Resident # 13 received 24 partial baths and two bed baths. There were no showers recorded on the ADL sheets or on the Shower Completion Sheets for November. At 7:45 a.m. on 12/8/2021, the Director of Nursing (DON) was interviewed regarding showers for Resident # 13. Asked if there was a reason why Resident # 13 could not have a shower, the DON said, "There is no reason why she cannot have a shower." The findings were discussed during a meeting at 4:14 p.m. on 12/8/2021, that included the Administrator, DON, Corporate Nurse Consultant, and the survey team.	F 677		
F 684 SS=E	COMPLAINT DEFICIENCY Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		

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F 684	Continued From page 14 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, observation, staff interview and clinical record review, the facility staff failed to follow physician orders for four of 20 residents in the survey sample, Residents # 12, 68, 15, and 46. 1. Resident # 12 was not administered the correct probiotic as ordered by the physician. 2. Resident # 68 did not have weekly weights obtained per physician order. 3. Resident #15 was not administered the medications gabapentin and Eliquis as ordered by the physician. 4. Resident #46 did not have daily weights obtained as ordered by the physician. Findings include: 1. On 12/8/21 beginning at 8:00 a.m. a medication pass and pour observation was conducted with RN (registered nurse) # 1 on A wing. RN # 1 prepared Resident # 12's medications, which included Acidophilus (Lactobacillus) 303 mg 1 tablet. The medications administered were then reconciled with the physician orders. Resident # 12 did not have an order for Acidophilus; rather, he had an order for	F 684	F 684 1. The Nurse obtained the correct medication as ordered for Resident #12. Facility PA reviewed order for weekly weights and is still necessary due to CHF for resident #68. Facility received the correct medications gabapentin and Eliquis for resident #15. Resident #46 was discharged home on 12.9.21 2. All residents have the potential to be affected by this. 3. Education was provided to current nursing employee as well as contracted nursing staff on obtaining residents weight per physician's order, facility process of re-ordering medications timely, and the 5 rights of medication administration. 4. Clinical IDT will review all residents on daily and/or weekly weights, resident who receive probiotic medication 3 to 5 times per week for 6 weeks. Clinical IDT will review all resident on gabapentin and Eliquis 3 to 5 times per week for 6 weeks to ensure medication is available and administer per order. Information will be reported at QA and determined if further monitoring will be needed.	1/25/22

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F 684	Continued From page 15 "Saccharomyces boulardii (Florastor) 250 mg capsule Give 1 capsule by mouth one time a day for probiotic." The order was carried forward from 9/20/21. On 12/8/21 at 8:45 a.m. RN # 1 was asked about the order and if that was what had been given. RN # 1 obtained the bottle of Acidophilus, pulled up Resident # 12's orders on the MAR (medication administration record) and stated "Nope, I did not give the Florastor; this (pointing to the bottle) is not..." RN # 1 stated Resident # 12 had been administered the lactobacillus since the order had been written. The administrator, DON (director of nursing) and the regional nurse consultant were informed of the above findings during a meeting 12/8/21 beginning at 11:12 a.m. No further information was provided prior to the exit conference. 2. Resident # 68 was admitted to the facility 9/2/21 with diagnoses to include, but were not limited to: diabetes, fractured nasal bones, anxiety, congestive heart failure, and atrial fibrillation. The most recent MDS (minimum data set) was significant change assessment dated 11/25/21 and had Resident # 68 as cognitively intact with a score of 15 out of 15. Observed during review of the clinical record 12/7/21 at 3:00 p.m. was an order carried forward from 10/25/21 for "Weights every Monday. Notify MD of weight gain of 5 pounds in a week every day shift Mon for monitoring."	F 684		

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F 684	Continued From page 16 A review of the TAR (treatment administration record) revealed the weekly weights had not been obtained 10/25, 11/22, and 11/29. The resident was documented as having had refused a weight on 12/6/21. The administrator, DON (director of nursing) and the regional nurse consultant were informed of the above findings during a meeting 12/8/21 beginning at 11:12 a.m. The DON was asked if the weights would be documented anywhere else. She stated she would look and present that information if obtained. No further information was provided prior to the exit conference. 3. Resident #15 was admitted to the facility on 6/21/21 with diagnoses that included kidney cancer with metastasis, hypertension, congestive heart failure, atrial fibrillation, chronic embolism of femoral vein, esophagitis, anxiety, major depressive disorder with psychotic features, chronic lymphocytic leukemia and COPD (chronic obstructive pulmonary disease). The minimum data set (MDS) dated 9/27/21 assessed Resident #15 as cognitively intact. On 12/7/21 at 4:30 p.m., Resident #15 was interviewed about quality of life/care in the facility. Resident #15 stated that at times her medications were not available. The resident stated she had been told the medicines were not ordered in time and that the pharmacy was "slow." Resident #15's medication administration record (MAR) from 11/1/21 through 12/7/21 documented the following medications were not administered:	F 684		

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F 684	Continued From page 17 Gabapentin 100 mg (milligrams) - not administered at 9:00 a.m. on 11/27/21 and at 5:00 p.m. on 11/27/21, 11/28/21 and 11/29/21 Apixaban (Eliquis) 5 mg - not administered at 11:00 p.m. on 11/30/21 and 12/1/21 Resident #15's clinical record documented a physician's order dated 6/22/21 for apixaban 5 mg to be administered two times per day for treatment of atrial fibrillation. The record documented a physician's order dated 11/12/21 for gabapentin 100 mg to be administered two times per day for treatment of neuropathy. On 12/8/21 at 2:00 p.m., the registered nurse (RN #1) that routinely cared for Resident #15 was interviewed about the gabapentin and apixaban not administered as ordered. RN #1 stated the gabapentin was provided by hospice and sometimes hospice did not re-order the medication in time. RN #1 stated the missed doses of apixaban were not given because the supply "ran out." RN #1 stated that gabapentin and apixaban were available in the emergency "stat" supply. RN #1 stated she did not know why the medications were not given because the medications were available in the emergency drug supply. RN #1 went into the medication storage room and verified that doses of gabapentin and apixaban were available in the emergency supply. On 12/8/21 at 2:48 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about Resident #15's missed doses of gabapentin and apixaban. LPN #2 stated the doses should have been given as ordered because they were available in the emergency	F 684		

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F 684	Continued From page 18 supply located in the medication room. LPN #2 stated agency nurses did not have access to the emergency medicines but facility nurses were always available with access to the emergency medications. Resident #15's plan of care (revised 6/21/21) documented the resident was on anticoagulant therapy for the treatment of atrial fibrillation. Interventions to minimize adverse reactions to the anticoagulant included, "Administer anticoagulant medications as ordered by physician..." The care plan documented the resident had chronic pain due to cancer. Interventions to minimize pain included, "Administer analgesia as per orders..." This finding was reviewed with the administrator, director of nursing and regional director of clinical services on 12/8/21 at 4:45 p.m. 4. Resident #46 was admitted to the facility on 10/29/21 with diagnoses that included fractured right tibia, obesity, major depressive disorder, hypertension, cognitive communication disorder, cystitis and hyperlipidemia. The minimum data set (MDS) dated 11/4/21 assessed Resident #46 with severely impaired cognitive skills. Resident #46's clinical record documented a physician's order dated 12/2/21 with start date of 12/3/21 for daily weights. Parameters were listed to notify the physician of a weight gain greater than 3 pounds (lbs.) in a day or more than 5 lbs. in a week. Resident #46's clinical record documented no weights were obtained on 12/3/21, 12/5/21 or 12/6/21.	F 684		

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F 684	Continued From page 19 On 12/8/21 at 2:00 p.m., the registered nurse (RN #1) caring for Resident #15 was interviewed about the missed weights. RN #1 stated the aides usually weighed the residents as needed. RN #1 reviewed the resident's clinical record and stated she did not see weights for 12/3/21, 12/5/21 or 12/6/21. On 12/8/21 at 2:45 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about the missing weights. LPN #2 reviewed Resident #15's record and stated the weights were not obtained as ordered. LPN #2 stated the resident recently had experienced increased edema and the weights were ordered to monitor the edema. This finding was reviewed with the administrator, director of nursing and regional director of clinical services on 12/8/21 at 4:45 p.m.	F 684		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to assess and attempt non-drug interventions prior to the administration of opioid pain medication for one of 20 residents in the survey sample, Resident #15. Resident #15 was administered twenty-two doses of the pain medication hydromorphone	F 697	F 697 1. Facility clinical manager obtained a physician order for pain assessment and to offer non-pharmacological interventions every shift. 2. All residents have the potential to be affected by this. 3. Education was provided to current nursing employee as well as contracted nursing staff on offering non-pharmacological interventions prior to administering opiates. 4. Clinical IDT will review administration of PRN opiates 3 to 5 times per week for 6 weeks to ensure non-pharmacological interventions were offered. Information will be reported at QA and determined if further monitoring will be needed.	1/25/22

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F 697	Continued From page 20 (Dilaudid) without documented pain assessments or prior attempts or offers of non-drug interventions. The findings include: Resident #15 was admitted to the facility on 6/21/21 with diagnoses that included kidney cancer with metastasis, hypertension, congestive heart failure, atrial fibrillation, chronic embolism of femoral vein, esophagitis, anxiety, major depressive disorder with psychotic features, chronic lymphocytic leukemia and COPD (chronic obstructive pulmonary disease). The minimum data set (MDS) dated 9/27/21 assessed Resident #15 as cognitively intact and as experiencing pain almost constantly. Resident #15's clinical record documented a physician's order dated 6/21/21 for the medication hydromorphone 8 mg (milligrams) to be administered every 2 hours as needed (prn) for pain management. Resident #15's medication administration record (MAR) documented the resident was administered 25 doses of hydromorphone 8 mg from 12/1/21 through 12/7/21. Twenty-two of the 25 doses administered had no documented assessment of the resident's pain other than a pain rating (on scale of 0 to 10 with 0 = no pain, 10 = worst pain). The clinical record documented no location or description of the pain, no pain duration or any other symptoms associated with the pain for these twenty-two doses. Offerings and/or attempts at any non-drug interventions to minimize the pain were documented for only three out of the 25 doses of prn hydromorphone administered from 12/1/21 through 12/7/21.	F 697		

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F 697	Continued From page 21 Resident #15's plan of care (revised 6/21/21) documented the resident had chronic pain due to cancer. Interventions to minimize/manage pain included, "Anticipate (Resident #15's) need for pain relief and respond immediately to any complaint of pain...Evaluate the effectiveness of pain interventions...impact on functional ability and impact on cognition...Offer non-pharmalogical (pharmacological) pain medicaitons (medications) as needed and accepted by (Resident #15) prior to PRN pain medicaiton (medication) administration..." (Sic) On 12/8/21 at 2:00 p.m., the registered nurse (RN #1) that routinely cared for Resident #15 was interviewed about the resident's prn pain medication administration. RN #1 stated the resident had metastatic cancer and frequently complained of pain. RN #1 stated most of the time the resident complained of abdominal pain. RN #1 stated a pain description and attempted non-drug interventions were supposed to be documented. RN #1 stated, "It does get busy. She (Resident #15) asks for it (pain medication) a lot..." RN #1 stated she did not always record an assessment or non-drug interventions offered for each dose of the hydromorphone. On 12/8/21 at 2:50 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about pain assessments and non-drug pain interventions for Resident #15. LPN #2 stated the MAR provided a place to enter the pain rating from the 0 to 10 scale. LPN #2 stated nurses had the ability to enter a note in the MAR providing an assessment and/or any attempted non-drug interventions. LPN #2 stated Resident #15 frequently requested as needed pain medication	F 697		

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F 697	Continued From page 22 and nurses should have documented an assessment including the location of the resident's pain. The Nursing 2017 Drug Handbook on page 734 describes hydromorphone as an opioid analgesic used for the management of moderate to severe pain. Pages 735 and 736 of this reference lists adverse reactions as central nervous system sedation and dizziness and documents, "Patients with any of the following conditions are at increased risk for oversedation and respiratory depression and require close monitoring...opioid habituation or need for increased opioid doses...preexisting pulmonary or cardiac disease...Use with caution in elderly or debilitated patients and in those with hepatic or renal disease..." (1) This finding was reviewed with administrator, director of nursing and regional director of clinical services on 12/8/21 at 4:45 p.m. (1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 697		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 725		

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F 725	Continued From page 23 diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and in the course of complaint investigation, the facility failed to ensure sufficient nursing staff were available to provide nursing care for three of 20 residents, Residents #48, #7, and #13; and failed to promptly respond to call bells for one of 20 residents, Resident #13. The Findings Include: Resident #48 was admitted to the facility on 11/11/2014 with a readmission on 3/5/2020. Diagnoses for Resident #48 included: Diabetes, kidney disease, neuropathy, and dysphagia. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/5/21. Resident #48 was assessed with a cognitive score of 15 indicating	F 725	F 725 1. Facility interdisciplinary team implemented combining majority of resident to one unit to increase availability of CNA's for resident care, to ensure more timely call bell response, and sufficient ADL care. 2. All residents have the potential to be affected by this. 3. Clinical IDT have reviewed and revised staffing assignment sheets for unit. 4. Unit Manager will provide assignment sheets to the Clinical IDT for review 4 to 5 times per week for 6 weeks to ensure sufficient staffing availability were met. Information will be reported at QA and determined if further monitoring will be needed.	1/25/22

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F 725	Continued From page 24 cognitively intact. On 12/07/21 at 12:00 PM Resident #48 was interviewed. Resident #48 stated that she liked to take baths but had not been receiving baths as scheduled and had been told there was not enough staff to give baths. Resident #48's care plan, current MDS and bathing ADL's (activity of daily living) were reviewed and indicated Resident #48 needed set up and supervision for bathing. The bath schedule for Resident #48 indicated Resident #48 was scheduled for a bath every Tuesday. Resident #48's bath completion form for a 30 day look back period documented Resident #48 received a shower on 11/9/21, bath on 11/10/21, and bath on 11/17/21. No other documentation was provided. On 12/08/21 at 9:43 AM, certified nursing assistant (CNA) #2 (working on the unit where Resident #48 resided) was interviewed. CNA #2 said the facility was short staffed, sometimes only having 2 CNA's for the entire unit when there should be three CNA's and a CNA giving showers. CNA #2 stated showers are not getting done because they don't have enough help. CNA #2 also said today was first day they have had 4 CNA's on the floor in a long time. The shower schedule for "B" wing was reviewed and indicated the schedule was based on room number and indicated that each resident was only scheduled to receive one shower/bath per week. On 12/08/21 at 10:00 AM, license practical nurse (LPN) #3 (unit manager) was interviewed. LPN #3 said the once a week shower was	F 725		

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implemented by the previous director of nursing (DON) because of the staffing challenges. LPN #3 said she was aware that showers are not being provided because the facility is still having staffing challenges.

On 12/8/21 at 10:40 AM, LPN #3 and LPN #4 were interviewed. Both nurses expressed concerns over staffing shortages. LPN #3 stated that the once a week shower schedule had been implemented since the end of April 2021 and that the administrator, DON and corporate was made aware of the nurses concerns of staff shortages. LPN #3 stated the facility did have mandatory overtime, but staff were getting mandated so much that several people quit. Agency nurses were brought in, but would call off work or didn't show up.

On 12/08/21 at 10:59 AM, the DON was interviewed. The DON stated that she was just hired two weeks ago and was unaware that the shower schedule only allowed for each resident to receive a shower once a week. The DON stated that she was aware of the staffing issues, was trying to fill positions, and was currently using agency staff to fill vacancies.

On 12/08/21 at 11:12 AM, the administrator was interviewed. The administrator reviewed "B" wing shower schedule and was asked why the schedule was for only one bath a week. The administrator said the facility has had some staffing issues and are currently trying to fill positions. The facility is using multiple staffing agencies but are still having problems with staffing. The administrator stated she has cut off admitting if the census gets to 68 and has a plan to move all but a few residents to "A" wing and

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have most the staff on that wing, which should help with the staffing issues.
2. Resident # 7 was admitted to the facility 10/3/17 with diagnoses to include, but not limited to: diabetes, peripheral vascular disease, below knee amputation of left leg, muscle weakness, and hypothyroidism.

The most recent MDS (minimum data set) was a quarterly review dated 9/9/21 and had Resident # 7 coded as cognitively intact with a total summary score of 15 out of 15. The annual review documented that Resident # 7 was identified as choosing a shower as "very important" at Section F0400-"Daily Preferences" and "G0120 A.Bathing: 4. total dependence and B. Self-Performance 3. One person assist." Section G0400 "Functional Limitation" was assessed as having impairment in the upper and lower extremities.

On 12/8/21 beginning at 10:10 a.m. Resident # 7 was interviewed about daily life in the facility. She stated "Well, things are pretty good; however, I am supposed to get a shower on Wednesdays and Saturdays, and I don't get them. I had a visitor this past Sunday, and when she walked in my room, she looked at me and said 'Are you getting your showers?' I said 'no.' She went and talked to them and I got a shower. You see this hair? It's greasy, and I don't like it...if you don't get a shower your hair looks like this." Resident # 7 stated, "They (the facility) don't have enough help. If there was enough help, we could get a shower when we're supposed to..."

On 12/8/21 at 10:30 a.m. CNA (certified nursing assistant) # 1 was interviewed about resident showers. CNA # 1 stated "We don't have enough

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F 725	Continued From page 27 staff to do two showers a week, much less one. We usually have only two aides working this entire unit (B unit) and if we're lucky, sometimes we have three. There's a lot of 'call outs' and if they can't get anybody, we do the best we can, but if a resident is totally dependent, then giving a shower with just two staff on the unit is very difficult..." On 12/8/21 at approximately 10:40 a.m. interviews with LPN (licensed practical nurse) # 3 and LPN # 4 revealed residents had not received two showers per week since the end of April 2021. When asked the reason, both LPN's stated "There's not enough staff. The shower aide was getting pulled to the floor all the time due to call outs and no one coming in to fill the slot. The former DON (director of nursing) had made a new shower sheet with residents being given once per week, but not sure that ever even happened either..." On 12/8/21 at approximately 10:45 a.m. the shower sheet documentation was reviewed for September, October, and November 2021, and revealed Resident # 7 had gotten one shower in September, one in October, and one in November. There was no documentation of the shower the resident stated she had received 12/5/21. The administrator, DON, and the regional nurse consultant were informed of the above findings during a meeting 12/8/21 beginning at 11:12 a.m. No further information was provided prior to the exit conference. 3. Resident # 13 in the survey sample was admitted to the facility on 3/31/2017 with	F 725		

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F 725	Continued From page 28 diagnoses that included anxiety disorder, depression, morbid obesity, gastroesophageal reflux disease, lymphedema, slow transit constipation, and hypertrophic osteoarthropathy. According to the most recent Minimum Data Set (MDS), a Quarterly Review, with an Assessment Reference Date (ARD) of 9/23/2021, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. Under Section G (Functional Status), the resident was assessed as independent with set-up help only for eating; as needing limited assistance with one person physical assist for transfers; as needing extensive assistance with one person physical assist for dressing and personal hygiene; and as totally dependent with one person physical assist for bathing. At approximately 2:30 p.m. on 12/7/2021, Resident # 13 was interviewed regarding her bathing. Asked if there was a scheduled bath day, the resident said, "I have no scheduled bath day. I get one when they have someone to give me one." The resident went on to say she last received a bath "...about five days ago." Resident # 13 also said her personal preference for bathing was a shower. Asked if she had to wait for an extended period of time after ringing her call bell, Resident # 13 said she had waited up to two hours for someone to come. "When you need help, you need help," the resident said. Comments elicited from five residents during a Group Interview at 10:30 a.m. on 12/8/2021 brought the same comments about the delay in	F 725		

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F 725	Continued From page 29 call bell response. Several residents indicated waits up to 45 minutes were common. Review of the ADL (Activities of Daily Living) records for October 2021 revealed Resident # 13 received 17 partial baths and six bed baths. Resident # 13 received one shower in October, on 10/3/2021, The shower was not included on the October ADL records. Review of the ADL records for November 2021 revealed Resident # 13 received 24 partial baths and two bed baths. There were no showers recorded on the ADL sheets or on the Shower Completion Sheets for November. At 11:00 a.m. on 12/8/2021, the DON was interviewed regarding staffing and showers for residents. The DON indicated that staffing was a problem. Asked who monitors resident showers, the DON said, "The unit managers monitor showers. They have not brought any problems to my attention. I was not aware residents were not getting showers." The DON was also asked about call bell response. Asked what her expectation was for call bell response, the DON said, "My expectation is that all staff should respond to call bells." Asked how soon call bells should be answered, the DON said, "Immediately."	F 725		
F 727 SS=D	COMPLAINT DEFICIENCY RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under	F 727		

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F 727	Continued From page 30 paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to provide RN (registered nurse) coverage for two of fourteen days reviewed. Findings were: On 12/08/2021 at approximately 1:30 p.m., the "as worked" schedule for two weeks (11/21/2021-12/06/2021) was reviewed. On 11/21/2021, 12/04/2021 and 12/05/2021, there was no RN on the schedule. The administrator was interviewed at approximately 2:00 p.m., regarding the lack of RN coverage. She stated, "That is correct. We had a nurse scheduled and she went out on FMLA (family medical leave) right before Thanksgiving. We tried to get it covered but I couldn't get anyone here...we have 6 agencies that we work with to try to get the shifts covered, no one would work it. I am working right now with someone who is interested in doing it." The above information was discussed during an	F 727	F 727 1. Facility failed to provide RN covered for 2 days out of 14 days. 2. No residents were affected by this. 3. Administrator and/or designee will work to ensure RN coverage provided daily either with contracted nurse, facility nurse, and/or PRN nurse. 4. Clinical IDT and Administrator to review staffing plans 3 to 5 times per week to ensure sufficient RN coverage 7days per week for 8 hours per day per regulation. Information will be reported at QA and determined if further monitoring will be needed.	1/25/22

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F 727	Continued From page 31 end of the day meeting on 12/08/2021 with the DON (director of nursing), the administrator, and the corporate nurse consultant. On 12/09/2021 at approximately 8:00 a.m., the administrator came to the conference room. She stated, "I never wrote her down, but here is her timecard. I had an RN that agreed to come in and be here to cover the facility. She didn't take an assignment but she was here to assist. I actually paid her a two hundred dollar bonus on top of her salary to get her to come in on November twenty-first for an eight hour shift." The time card was reviewed and showed the nurse worked on 11/21/2021, leaving two days without coverage, 12/04/2021 and 12/05/2021. No further information was received prior to the exit conference on 12/09/2021.	F 727		
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 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	F 755	F 755 1. Facility received the correct medications gabapentin and Eliquis for resident #15. 2. All residents have the potential to be affected by this. 3. Education was provided to current nursing employee as well as contracted nursing staff on facility process of re-ordering medications. 4. Clinical IDT will review all resident on gabapentin and Eliquis 3 to 5 times per week for 6 weeks to ensure medication is available and administer per order. Information will be reported at QA and determined if further monitoring will be needed.	1/25/22

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F 755	Continued From page 32 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 resident interview, staff interview and clinical record review, the facility staff failed to ensure medications were available for administration for one of twenty residents in the survey sample, Resident #15. Doses of the medications gabapentin and apixaban (Eliquis) for Resident #15 were not provided from the pharmacy in a timely manner. The findings include: Resident #15 was admitted to the facility on 6/21/21 with diagnoses that included kidney cancer with metastasis, hypertension, congestive heart failure, atrial fibrillation, chronic embolism of femoral vein, esophagitis, anxiety, major depressive disorder with psychotic features, chronic lymphocytic leukemia and COPD (chronic obstructive pulmonary disease). The minimum data set (MDS) dated 9/27/21 assessed Resident #15 as cognitively intact.	F 755		

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F 755	Continued From page 33 On 12/7/21 at 4:30 p.m., Resident #15 was interviewed about quality of life/care in the facility. Resident #15 stated during this interview that at times her medications were not available. The resident stated she had been told the medicines were not ordered in time and that the pharmacy was "slow." Resident #15's clinical record documented a physician's order dated 6/22/21 for apixaban 5 mg (milligrams) to be administered two times per day for treatment of atrial fibrillation. The record documented a physician's order dated 11/12/21 for gabapentin 100 mg to be administered two times per day for management of neuropathy. Resident #15's medication administration record (MAR) from 11/1/21 through 12/7/21 documented the following medications were not administered: Gabapentin 100 mg - not administered at 9:00 a.m. on 11/27/21 and at 5:00 p.m. on 11/27/21, 11/28/21 and 11/29/21 Apixaban (Eliquis) 5 mg - not administered at 11:00 p.m. on 11/30/21 and 12/1/21 A MAR note dated 11/27/21 documented the gabapentin 100 mg was "on order." Another MAR note dated 11/29/21 documented the gabapentin 100 mg was "not available not given on order from pharmacy." A MAR note dated 11/30/21 documented concerning the apixaban, "medication not on hand, pending arrival from pharmacy." A MAR note dated 12/1/21 documented, "...Apixaban...on order awaiting pharmacy..." On 12/8/21 at 2:00 p.m., the registered nurse (RN	F 755		

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F 755	Continued From page 34 #1) that routinely cared for Resident #15 was interviewed about the unavailable gabapentin and apixaban. RN #1 stated the gabapentin was provided by hospice and sometimes they did not re-order medications in time. RN #1 stated the missed doses of apixaban were not given because the supply "ran out." RN #1 stated she did not know if the medications were not reordered in time or if pharmacy was slow to deliver. RN #1 stated she frequently experienced problems with the pharmacy delivering medications timely. RN #1 stated, "Sometimes we reorder and we just don't get it [medication]." On 12/8/21 at 2:48 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about Resident #15's supply of gabapentin and apixaban. LPN #2 stated the pharmacy was not always prompt with medication deliveries. LPN #2 stated, "Even when we order, we don't always get it [medication] timely." This finding was reviewed with the administrator, director of nursing and regional director of clinical services on 12/8/21 at 4:45 p.m.	F 755		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		

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F 758	Continued From page 35 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 758	F 758 1. Facility clinical manager obtained a physician order for administering anti-psychotic medication and documentation of non-pharmacological interventions. Facility obtained a discontinuation date for Ativan for resident #15. 2. All residents have the potential to be affected by this. 3. Education was provided to current nursing employee as well as contracted nursing staff on offering non-pharmacological interventions prior to administering anti-psychotics and ensure a discontinuation date for PRN anti-psychotics. 4. Clinical IDT will review new orders 3 to 5 times per week for 6 weeks to ensure a discontinuation date is provided for PRN anti-psychotic medication. Clinical IDT will review administration of PRN anti-psychotics 3 to 5 times per week for 6 weeks to ensure non-pharmacological interventions were offered. Information will be reported at QA and determined if further monitoring will be needed.	1/25/22

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F 758	Continued From page 36 review, the facility staff failed to ensure one of twenty residents was free from unnecessary medications, Resident #15. Resident #15 was administered multiple doses of the anti-anxiety medication lorazepam without a documented assessment of the need for the medication or of any prior attempts or offers of non-drug interventions. The findings include: Resident #15 was admitted to the facility on 6/21/21 with diagnoses that included kidney cancer with metastasis, hypertension, congestive heart failure, atrial fibrillation, chronic embolism of femoral vein, esophagitis, anxiety, major depressive disorder with psychotic features, chronic lymphocytic leukemia and COPD (chronic obstructive pulmonary disease). The minimum data set (MDS) dated 9/27/21 assessed Resident #15 as cognitively intact. Resident #15's clinical record documented a physician's order dated 8/19/21 for the anti-anxiety medication lorazepam 1 mg (milligram) with instructions to give 1.5 tablets every 4 hours as needed (prn) for anxiety for 180 days. Resident #15's medication administration record (MAR) documented twenty-one doses of prn lorazepam administered from 12/1/21 through 12/7/21. There were no documented assessments, indications for use or offered and/or attempted non-drug interventions prior to the administration of twenty out of the twenty-one doses administered. There was no mention of the resident's behavior, presenting symptoms or reason the resident required and/or requested the	F 758		

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F 758	Continued From page 37 medication. Resident #15's MAR listed behavior monitoring each shift. Nurses documented the resident had no behaviors from 12/1/21 through 12/7/21. Resident #15's plan of care (revised 6/21/21) documented the resident used psychotropic medications and had mood problems due to terminal illness, anxiety, psychosis and depression. Interventions to minimize anxiety and improve mood included, "Administer psychotropic medications as ordered by physician...Discuss with MD, family re [regarding] ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness..." On 12/8/21 at 2:00 p.m., the registered nurse (RN #1) that routinely cared for Resident #15 was interviewed about the prn lorazepam administration. RN #1 stated Resident #15 frequently requested the lorazepam for "anxiety." RN #1 stated she did not always record an assessment describing the resident's symptoms of anxiety and did not see any non-drug interventions listed. On 12/8/21 at 2:50 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about any assessment associated with the twenty doses of prn lorazepam for Resident #15. LPN #2 stated the resident requested the as needed lorazepam but she did not see assessments documented regarding her symptoms or non-drug interventions offered and/or attempted. The Nursing 2017 Drug Handbook on page 902 describes lorazepam as an anxiolitic benzodiazepine used for the treatment of anxiety,	F 758		

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F 758	Continued From page 38 insomnia and situational stress. Page 903 of this reference documents adverse reactions to lorazepam include central nervous system sedation, drowsiness, dizziness and states, "...Use cautiously in patients with pulmonary, renal, or hepatic impairment, or history of substance abuse...Use cautiously in elderly, acutely ill or debilitated paitents..." (1) This finding was reviewed with the administrator, director of nursing and regional director of clinical services on 12/8/21 at 4:45 p.m. (1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761	F 761 1. LPN Unit Manager discarded the unopened bottle of Tuberculin PPD solution as it was not dated nor refrigerated. 2. All residents have the potential to be affected by this. 3. Education was provided to current nurses regarding the storage of medication, dating of medication, and discarding medication. 4. Clinical IDT will audit medication storage areas 2 times per week for 6 weeks to ensure medication is stored, dated, and discarded properly. Information will be reported at QA and determined if further monitoring will be needed.	1/25/22

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F 761	Continued From page 39 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure Tuberculin PPD (purified protein derivative) solution was dated when opened, in one of two medication rooms. One multi-dose vial of PPD solution was observed opened, not dated and available for administration on the A wing. Findings were: On 12/08/2021 at approximately 2:30 p.m., the refrigerator on the A wing was inspected with LPN (licensed practical nurse) # 2. Observed in the refrigerator was an opened multi-dose vial of Tuberculin PPD solution. The vial was not dated. LPN #2 was asked when the vial had been opened. She stated, "I don't know, I will throw it away." She was asked how long the vial should be kept after opening. She stated, "Thirty days." At approximately 3;00 p.m., LPN #2 came to the conference room with a paper from the pharmacy titled "Medication Storage..List is not all-inclusive and subject to change. Information is from package inserts." The document listed medications, how to store them, and the expiration date. Per the document, PPD (Tubersol) should be stored in the refrigerator with an expiration time of 30 days after opening. LPN #2 was asked if the document presented was what the facility used to determine storage	F 761		

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F 761	Continued From page 40 times. She stated, "Yes." The above information was discussed during an end of the day meeting on 12/08/2021 with the DON (director of nursing), the corporate nurse consultant and the administrator. No further information was obtained prior to the exit conference on 12/09/2021.	F 761		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition	F 801	F 801 1. As of 12/11/2021, the facility Dietary Manager completed his ServSafe Certification. 2. All residents have the potential to be affected by this. 3. Education was provided to facility dietary manager regarding keeping current with his ServSafe credentials long with his staff employees. 4. Dietary manager will maintain a log of employee ServSafe Certifications and their expiration date to ensure all certifications are current. Information will be reported at QA and determined if further monitoring will be needed.	1/25/22

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F 801	Continued From page 41 professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers,	F 801		

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F 801	Continued From page 42 meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to employee a qualified dietary manager. The facility's dietary manager had no certifications or education in food service management or food safety. The findings include: On 12/7/21 at 2:25 p.m., a follow-up inspection of the kitchen was conducted accompanied by the dietary manager (other staff #1). The dietary manager was interviewed at this time about his qualifications as the food services manager. The dietary manager initially stated he was not certified but had ServSafe training regarding food service/safety. A copy of the certification was requested. The dietary manager then stated that he used to have a food safety certificate but it had expired. The dietary manager stated he previously worked in the restaurant business but did not currently have a degree or any training certifications in food safety. The dietary manager stated he had been employed in the facility for approximately two months. The certifications for three dietiary employees were reviewed. The dietary employees had current ServSafe certificates regarding food safety. The dietary manager had no certificate regarding food service/safety. On 12/7/21 at 3:06 p.m., the administrator was	F 801		

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F 801	Continued From page 43 interviewed about the dietary manager's qualifications. The administrator stated the facility employed a part-time registered dietitian and the dietary manager had no current certifications in food safety. The administrator stated the dietary manager transferred from another facility, previously had ServSafe certification but the certification had expired prior to his start at the facility. The administrator stated, When he (dietary manager) transferred here he did not have it (certification)." This finding was reviewed with the administrator, director of nursing and regional director of clinical services on 12/8/21 at 4:45 p.m. On 12/9/21 at 9:15 a.m., the facility provided the dietary manager's hire date as 10/6/21.	F 801		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812	F 812 1. Employee #1 was educated on the proper procedure for food temperatures and sanitation. Employees immediately removed their personal food items and placed them in the breakroom fridge. The opened/ not dated food in the kitchenettes were discarded immediately. The can opener and back splash/top of stove were cleaned. 2. All residents have the potential to be affected by this.	1/25/22

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F 812	Continued From page 44 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review and staff interview, the facility staff failed to prepare, store and serve food in a sanitary manner in the main kitchen and on one of two nursing units. The findings include: 1. On 12/7/21 at 11:20 a.m., an initial tour of the kitchen was conducted. The cook (other staff #2) stated the dietary manager was not working and she was currently serving lunch from the steam table. On 12/7/21 at 11:25 a.m., the cook was requested to check the temperature of the food items currently stored on the steam table. The cook, using a digital thermometer, checked the temperature of ground turkey and then the pureed turkey. The cook then dipped the thermometer tip into a bucket of solution she identified as sanitizer. Without wiping the thermometer tip, the cook inserted the thermometer into a pan of green beans. The cook dipped the thermometer tip into the bucket of sanitizer solution and without wiping or drying the tip, inserted the thermometer into beef patties, then crab cakes and then into baked potatoes. The cook then dropped the thermometer on the floor, picked it up, and dipped the thermometer tip again in the sanitizing solution. Without wiping off or drying the thermometer tip, the cook placed the thermometer into a pan of gravy for a temperature check. The cook continued to serve	F 812	3. Education was provided to current dietary employees regarding proper procedure for checking food temperatures and sanitation of the thermomotor in between each food item. Also, current dietary employees were educated on where they are to store personal food items. Current employees were educated all food items in the Kitchenette on the units are to be label and dated. Any food item passed 3 days will be thrown out and/or if the items is not labeled. Employees were educated on the cleaning schedules for the back splash/stove top and the can opener. 4. Dietary Manager and/or designee, will observe 2 food temperatures and sanitation process 2 times per week for 6 weeks. Dietary Manager and/or designee will monitor the kitchen walk-in fridge to ensure employee personal food items are not in there 2 times per week for 6 weeks. The dietary manager and/or designee will check both units' kitchenette 2 times per week for 6 weeks to ensure resident food is stored properly and within date range. The dietary manager and/or designee will monitor the	

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F 812	Continued From page 45 the food items from the steam table for completion of the lunch service. On 12/7/21 at 11:28 a.m., the cook was interviewed about dipping the thermometer into the sanitizer solution. The cook stated the solution was the same as used on the three-compartment sink to sanitize pots/pans/utensils. The cook stated she dipped the thermometer tip to sanitize the thermometer and also used the sanitizer solution to wipe off countertops after food preparation. On 12/7/21 at 11:30 a.m., the walk-in refrigerator was inspected accompanied by a dietary employee (other staff #3). There was a tray with the following out of date or undated food items: commercial can of cinnamon rolls with use-by date of 11/20/21, a bag of shredded cheese with a sell-by date of 10/14/21, a commercially prepared beef turnover with no date, a Styrofoam cup of soup with no label or date and a bag of 12 egg/sausage/cheese burritos with no expiration date. The dietary employee was interviewed at this time about the out of date or undated food items. The dietary employee stated the food items were for staff members and not residents. The dietary employee stated, "We sometimes make food for employees in the kitchen." On 12/7/21 at 11:35 a.m., accompanied by the cook, the counter-mounted can opener was observed. The blade and bracket of the can opener had an accumulation of black/brown debris. The cook was interviewed at this time about the can opener. The cook stated she was not sure if the can opener went through the dishwasher.	F 812	cleanliness of the back splash/ stove top as well as the can opener. Information will be reported at QA and determined if further monitoring will be needed.	

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F 812	Continued From page 46 On 12/7/21 at 11:37 a.m., the back splash and top of the kitchen stove were observed dirty with an accumulation of black/brown splatter and debris. On 12/7/21 at 2:25 p.m., the dietary manager (other staff #1) was interviewed about the cook's method of checking food temperatures and the out of date and undated food items in the refrigerator. The dietary manager stated the cook was supposed to use an alcohol pad to clean the thermometer probe between each food item. The dietary manager identified the sanitizing solution used as Santec eight disinfectant/sanitizer. The dietary manager stated the sanitizer solution in the bucket was used for counter wipe downs and was the same product used in the three-compartment sink to sanitize pots/pans/utensils. The dietary manager stated there was no protocol to use the sanitizing solution with the thermometer during temperature checks. The dietary manager stated the thermometer should have been cleaned, sanitized with an alcohol wipe, and dried/wiped off after it was dropped in the floor. The dietary manager stated the thermometer should be cleaned/wiped after each food item to prevent mixing foods in case of resident allergies. The dietary manager stated the food items identified as employee food should not have been stored in the kitchen refrigerator. The dietary manager stated only resident food was supposed to be stored in the walk-in refrigerator and/or freezer and a refrigerator was available in the employee lounge area for employee food storage. The dietary manager stated the can opener was supposed to be routinely cleaned in the dishwasher to prevent build-up.	F 812		

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F 812	Continued From page 47 The manufacturer's label on the Santec eight disinfectant/sanitizing solution included no use of the solution with thermometers and required wet/soak/dry times prior to contact with foods. The Santec eight manufacturer's label documented, "To disinfect inanimate, hard non-porous surfaces apply use-solution with mop, cloth, sponge, low pressure coarse sprayer or hand pump trigger sprayer so as to wet all surfaces thoroughly. Allow to remain wet for 10 mins. [minutes], then remove excess liquid...NOTE: For spray applications, cover or remove all food products...To sanitize pre-cleaned mobile items in public eating establishments (drinking glasses, dishes, eating utensils) immerse in a 200-400 ppm active quaternary solution for at least 60 sec. [seconds] making sure to immerse completely. Remove items, drain the use-solution from the surface and air dry. Do not rinse..." 2. On 12/8/21 at 10:35 a.m., the nourishment refrigerator on A wing was inspected. Stored in the refrigerator were the following: a foil covered foam platter with leftover food (ham, dressing, mac/cheese, green beans, potatoes) with no name and/or date, two foil covered plates of leftover food with no date label, and two undated boxes of fried chicken meals. On 12/8/21 at 10:40 a.m., accompanied by the licensed practical nurse unit manager (LPN #2), the undated, leftover food items were observed. LPN #2 was interviewed at the time about the leftovers. LPN #2 stated any leftover food items or food brought in by families was supposed to be dated and kept for maximum of three days. The facility's policy titled Environment (October	F 812		

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F 812	Continued From page 48 2019) documented, ,"It is the center policy that all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition...The Dining services Director (dietary manager) will insure that all employees are knowledgeable in the proper procedures for cleaning all food services equipment and surfaces...will insure that all food contact surfaces are cleaned and sanitized after each use...will insure that a routine cleaning schedule is in place for all cooking equipment..." The facility's policy titled Food: Preparation (October 2019) documented, "It is the center policy that all foods are prepared in accordance with the guidelines of the FDA Food Code...The Dining Services Director or Cook(s) is responsible to ensure that all utensils, food contact equipment, and food contact surfaces are cleaned and sanitized after every use...All staff will use serving utensils appropriately to prevent cross contamination...All Time/Temperature Control for Safety (TCS) foods that are to be held more than 24 hours at a temperature of 41 [degrees] F or less, will be labeled and dated with a 'prepared date' (Day 1) and a 'use by date' (Day 7)." The facility's policy titled Use and Storage of Food Brought in by Family or Visitors (copyright 2020) documented, "...All food items that are already prepared by the family or visitor brought in must be labeled with content and dated...The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator...The prepared food must be consumed by the resident within 3 days...If not consumed within 3 days, food will be thrown away by facility staff..."	F 812		

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	495146	A. BUILDING _____ B. WING _____	C 12/09/2021

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F 812	Continued From page 49 These findings were reviewed with the administrator, director of nursing and regional director of clinical services on 12/8/21 at 4:45 p.m.	F 812		
F 849 SS=E	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining	F 849	F 849 1. Facility contacted the Hospice services provider to get records of resident #15 plan of care and records of visits. 2. All residents have the potential to be affected by this. 3. Education was provided current Nursing Admin team and Social Worker for the importance of having the hospice plan of care as well as the visit notes to ensure compliance. 4. Social Worker and/or designee will review facility hospice residents 1 time per week for 6 weeks to ensure the facility has copies of the hospice residents plan of care and visit notes. Information will be reported at QA and determined if further monitoring will be needed.	1/25/22

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F 849	Continued From page 50 the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related	F 849		

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F 849	Continued From page 51 conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following:	F 849		

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F 849	Continued From page 52 (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice	F 849		

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F 849	Continued From page 53 care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to coordinate services with a hospice provider for one of twenty residents in the survey sample, Resident #15. Resident #15, on hospice services since her admission on 6/21/21, had no hospice plan of care and no evidence of services provided for the resident by hospice personnel. The findings include: Resident #15 was admitted to the facility on 6/21/21 with diagnoses that included kidney cancer with metastasis, hypertension, congestive heart failure, atrial fibrillation, chronic embolism of femoral vein, esophagitis, anxiety, major depressive disorder with psychotic features, chronic lymphocytic leukemia and COPD (chronic obstructive pulmonary disease). The minimum data set (MDS) dated 9/27/21 assessed Resident #15 as cognitively intact. Resident #15's clinical record documented a physician's order dated 6/21/21 for hospice services due to terminal condition related to metastatic kidney cancer and leukemia. Resident #15's clinical record documented no hospice plan of care. There were no documented assessments and/or progress notes from the	F 849		

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F 849	Continued From page 54 hospice provider, hospice nurses or hospice aides. There was no documentation of what services were provided by hospice, when they were provided or of staff names providing the service. The resident's plan of care (revised 6/21/21) documented the resident was enrolled in hospice, had a terminal prognosis and experienced chronic pain and mood problems due to metastatic cancer. The only intervention about hospice stated, "Consult with physician and Social Services to have Hospice care for [Resident #15] in facility." The clinical record included no progress notes, nursing notes or any record of service from the hospice provider. On 12/8/21 at 2:00 p.m., the registered nurse (RN #1) that routinely cared for Resident #15 was interviewed about hospice. RN #1 stated the hospice nurse and aide came at least weekly to provide care for the resident. RN #1 stated that hospice provided orders for pain medications for the resident. When asked about their assessments and documentation of care provided, RN #1 stated, "They [hospice] have their own documentation." RN #1 reviewed the clinical record and stated she did not find notes or assessments from hospice. On 12/8/21 at 2:50 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about hospice services for Resident #15. LPN #2 stated the hospice nurse came once or twice per week to assess the resident and hospice aides provided some of the daily care. LPN #2 stated hospice communicated verbally but did not provide any documentation of their visits. LPN #2 stated she did not find any hospice notes or	F 849		

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F 849	Continued From page 55 assessments in the clinical record. The facility's policy titled Hospice Program (revised Dec., 2019) documented, "...Hospice providers who contract with this facility...are held responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility...it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness...including...Determining the appropriate hospice plan of care...Our facility nursing staff...is to coordinate care provided to the resident by our facility staff and the hospice staff...Obtaining the following information from the hospice...The most recent hospice plan of care specific to each resident...Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility..." Resident #15's hospice provider's agreement with the facility documented, "...Hospice shall furnish to Home [nursing facility], at the time of the patient's admission, a copy of the patient's plan of care, an assessment of the patient and family's needs, a current physical examination...Hospice shall promptly communicate orally or in writing any changes in the plan of care to Home...Home shall prepare and maintain medical records for each Hospice patient...in accordance with Home's routine record keeping procedures; provided, however, that in any event the medical record shall be complete, promptly and accurately documented, readily accessible and systematically organized. The medical records shall consist of clinical notes describing all inpatient services and events..."	F 849		

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F 849	Continued From page 56 This finding was reviewed with the administrator, director of nursing and regional director of clinical services on 12/8/21 at 4:45 p.m.	F 849		