STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0247	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORVIEW HEIGHTS REHABILITATION AND NURSING	827 NORVIEW AVENUE NORFOLK, VA 23509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 10/26/21 through 10/28/21. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 60 certified bed facility was 45 at the time of the survey. The survey sample consisted of 24 current and closed records.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 12VAC5-371-140(E) (3) (B). Based on employee record review, facility document review and staff interviews the facility staff failed to ensure that Virginia State Police criminal background checks were obtained for (1) one current employees within 30 days of their hire date. The findings included: On 10/28/21 twenty-five current employee records were reviewed. The employee record review revealed that 1 current employees did not have a Virginia State Police criminal background check within 30 days of hire. An employee hired 05/04/21 did not have a criminal background check completed until 10/27/21. On 10/27/21 at 10:30 a.m., an interview was conducted with the Business Office Manager (BOM) regarding the (1) one current employee without a Virginia State Police criminal	F 001	**F 001** 1. Facility did not have criminal background check for 1 current employee. Facility will run background check on all employee effective 10/28/21. 2. All residents are at risk when the facility fails to comply with the policy of running background on all potential employees. 100% audit will be conducted on all current employees, to ensure that all employees have a background check in their file. 3. Education provided to BOM on the importance of background checks being conducted on all new hires per facility policy. 4. The Admin or designee will conduct an audit weekly x 2 month of employee records to ensure background checks were completed for all potential employees. Results of audits will be reported monthly to the QAPI Committee. The QAPI committee is responsible for the on-going monitoring for compliance. 5. DOC 12/6/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/26/21

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F 001	Continued From page 1 background check. The BOM stated, "She could not find the criminal background check for this employee and she submitted a new criminal background check on 10/27/21. The facility policy titled "Background Investigations" dated 11/1/20 was reviewed and is documented in part, as follows: Policy: Job reference checks, drug screenings, licensure verifications and criminal conviction record checks are conducted on all personnel making application for employment with this company. 12 12VAC5-371-140(E) (3) (B). 12VAC5-371-150 (A) Resident Rights cross Reference to F-698 VAC5-371-150 (B.1). Resident Rights. Cross-Reference to F-552 12VAC5-371-150 (B.1). Resident Rights. Cross-Reference to F-582 12 VAC5-371-150 (B.1). Resident Rights. Cross-Reference to F-625 12VAC5-371-150 (B.1). Resident Rights. Cross-Reference to F-689 12 VAC 5-371-220 (B) Cross Reference to F684. 12 VAC 5-371-300 (B). Pharmacy Services. Cross Reference to F-761. 12VAC5-371-370 (A). Maintenance and Housekeeping. Cross Reference to F-921 12 VAC 5-371-200 (B.1). Nursing Director Cross-Reference to F-658. 12 VAC 5-371-220 (C.1,C.3, G). Nursing Services Cross-Reference to F-686 and F-690.	F 001		

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/26/21 through 10/28/21. Corrections are required for compliance with 42 CFR Part 483.73, Requirements for Long Term Care Facilities.	E 000		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the ~~emergency plan set forth in paragraph (a) of this~~ section, risk assessment at paragraph (a)(1) of	E 036	**E 036** 1. Facility will schedule annual emergency preparedness training and testing by 12/6/21. 2. All residents are at risk when facility's emergency preparedness training and testing is not completed. 3. Education will be provided by Regional Director of Operations to Admin and Dire of maintenance on the regulations for annual staff training and testing program. 4. Emergency preparedness training and testing will be audited by Administrator or designee 1x	

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

Gary Gray | Administrator | 11/26/21

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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E 036	Continued From page 1 this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have a written training and testing program for staff. The findings included:	E 036	per year to ensure it is completed. Administrator will coordinate with VHASS for implementation and participation in annual emergency preparedness trainings. 5. DOC 12/6/21	

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E 036	Continued From page 2 During an interview on 10/28/21 at 12:36 P.M. with the Administrator, she was asked for documentation that the facility had an annual emergency preparedness plan written training and testing program. The administrator stated, the facility did not have an annual written training and testing program for the year 2021.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and	E 037	1. Facility will schedule annual emergency preparedness training and testing by 12/6/21. 2. All residents are at risk when facility's emergency preparedness training and testing is not completed. 3. Education will be provided by Regional Director of Operations to Admin and Dire of maintenance on the regulations for annual staff training and testing program. 4. Emergency preparedness training and testing will be audited by Administrator or designee 1x per year to ensure it is completed. Administrator will coordinate with VHASS for implementation and participation in annual emergency preparedness trainings. 5. DOC 12/6/21	

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E 037	Continued From page 3 procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 4 procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency	E 037		

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E 037	Continued From page 5 preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected	E 037		

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E 037	Continued From page 6 roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have documentation of the facility's initial and annual emergency preparedness training program and staff have received initial and annual training. The findings included: During an interview on 10/28/21 at 12:49 P.M. with the administrator, she was asked for documentation of the facilities initial and annual (2021) emergency preparedness training program and documentation that staff have received initial and annual training.	E 037		

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E 037	Continued From page 7 The administrator stated, staff have not received annual emergency preparedness training for the year (2021).	E 037		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/26/21 through 10/28/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey, VA00053461-Substantiated, with deficiency. The census in this 60 certified bed facility was 45 at the time of the survey. The survey sample consisted of 22 current Residents (Resident 1 - 21 and 24) reviews and 2 closed record reviews (Resident 22 and 23).	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed	F 552		

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F 552	Continued From page 8 care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: The facility staff failed to ensure one resident (Resident #6) in the survey sample of twenty four residents was allowed the opportunity to formulate an Advance Directive. The Findings included: Resident #6 was admitted to the facility on 04/14/21 with diagnoses which included diabetes, end stage renal disease, failure to thrive, chronic kidney disease, congestive heart failure, hypertension, and a history of sepsis. The facility staff failed to assist Resident #6 with formulating an Advance Directive. A Quarterly Minimum Data Set (MDS) dated 10/13/21 assessed this resident in the area of Cognitive Patterns (Brief Interview for Mental Status) BIMS as a 9. A Care Plan dated 10/26/21 indicated that this resident received dialysis services. A facility form dated 09/03/2021 indicated: "Advance Care Planning Tracking Form" - residents/patients and or their responsible health care decision makers should be provided the opportunity to discuss advance care planning with appropriate staff members and medical providers within the first few days of admission to the facility, at the times of change in condition, and periodically for routine updating of care plans." During an interview on 10/30/21 at 2:30 P.M. with the facility Social Worker, she was asked if	F 552	1. The Advance Directive information was reviewed with resident #6 on September 3, 2021 with signature obtained on November 5, 2021. 2. All residents have the potential to be affected by this deficient practice. Facility reviewed all residents within the facility to ensure advance directive information was offered to resident or resident responsible party. Any identified discrepancies were corrected immediately. 3. Social Worker was educated regarding process of offering and obtaining signature on form stating resident/resident responsible party received the advanced directive information on 10/28/2021. Social Worker will also review advance directives during care plan meetings. 4. Social Worker will audit 100% admissions for documentation that advance directive information was provided to resident or resident's responsible party for 8 weeks. Result of these audits will be reported to the QAPI committee for oversight and any recommended changes. 5. DOC 12/6/21	

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F 552	Continued From page 9 Resident #6 had formulated an Advance Directive. The social worker stated no, and presented the Advance Care Planning Tracking form dated 09/03/2021. When asked for evidence that Resident #6 was provided the opportunity to formulate an Advance Directive, the social worker stated she did not have any other proof. A facility policy dated December 2016 indicated: "Advance Directives- Policy Statement Advance directives will be respected in accordance with state law and facility policy. Policy Interpretation and Implementation 1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so."	F 552		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582		

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F 582	Continued From page 10 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on a medical record review, facility document review and staff interviews the facility staff failed to ensure a Notice of Medicare Non-Coverage was given timely prior to the last	F 582	**F 582** 1. ABN was issued to resident #20 on 11/1/21. 2. All residents discharging from skilled services with covered days remaining are at risk from this deficient practice. 3. Residents discharged from skilled services in the last 30 days have been reviewed to see if any other residents were affected. The BOM was educated on ABN requirements on 11/2/21 4. The Clinical Director will audit all residents DC from skilled level of care weekly x8 weeks to ensure ABN is issued timely. Results of these audits will be reported to the QAPI committee for oversight and any recommended changes 5. DOC 12/6/21	

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F 582	Continued From page 11 covered skilled day of 1/14/21 for one of 24 residents in the survey sample, Resident #20. The findings included: Resident #20 was admitted to the facility on 6/16/2014 and readmitted on 1/15/21 with diagnoses to include but not limited to; Viral Hepatitis and Epilepsy unspecified. Resident #20's Notice of Medicare Non-Coverage (NOMNC) document with Skilled Nursing Services ending on 1/14/21 was reviewed and is documented as follows: I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO (Quality Improvement Organization). The SNF (Skilled Nursing Facility) ABN (Advanced Beneficiary Notice) form CMS-10055 was not provided to the resident due to an oversight. Written on the signature line for patient or representative was the following: POA notified of OT (occupational Therapy) ending. Dated: 1/12/21. On 10/27/21 at approximately 3:10 PM an interview was conducted with the Facility's Social Worker. She stated. "The ABN should have been done because Resident #20 was in long term care." On 10/28/21 at approximately 4:25 p.m., the above findings were shared with the Administrator	F 582		

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F 582	Continued From page 12 and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 582		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: The facility staff failed to provide one resident	F 625	**F 625** 1. The Bed Hold policy was reviewed with resident #22 on November 17, 2021. 2. All discharged residents have the potential to be affected by this deficient practice. Facility reviewed all discharges in the pass 14 days to ensure bed hold policy was provided to resident or resident responsible party. Any identified discrepancies were corrected immediately. 3. Education to license staff including agency on Bed Hold Policy on 11/23/2021. 4. Clinical Manager or designee will audit 100% of all discharges for documentation that bed hold policy was provided to resident or resident's responsible party x 8 weeks. 5. DOC 12/6/21	

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F 625	Continued From page 13 (Resident #22) in the survey sample of twenty four residents with a Bed Hold Policy upon discharge to the hospital. The findings included: Resident #22 was admitted to the facility on 09/22/21 with diagnoses which included type II diabetes, angina, hypertension, deep vein thrombosis, and cocaine/alcohol dependence. Resident #22 was discharged to the hospital on 09/29/21. He was not provided with a bed hold policy. A nursing note dated 09/29/21 indicated: Resident had a fall oob (out of bed) and evaluation of right groin surgical incision - due to increased swelling with purulent drainage. Resident sent to the hospital. A review of the clinical records did not indicate a Bed Hold Policy was provided upon discharge. During an interview on 10/29/21 at 11:15 A.M. with the Social Worker she was asked if Resident #22 received a bed hold policy/notice upon discharge to the hospital. The social worker stated, no. A Bed Hold Policy was requested during the survey but no policy was provided.	F 625		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		

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F 658	Continued From page 14 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on information gleamed during a complaint investigation, resident interview, staff interviews, and clinical record review, the facility staff failed to ensure clinical information and physician orders from specialty provider visits were incorporated to achieve continuity of care for 1 of 23 residents (Resident #9), in the survey sample. The findings included: Resident #9 was originally admitted to the facility 7/12/20, and was discharged from the facility 12/23/20, return not anticipated returning to the facility 9/22/20. Resident #9 diagnoses included; an open wound to the right foot, osteomyelitis of the right foot, amputation of the right fourth toe, spinal cord injury with right side weakness, a-fib and diabetes. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/17/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #9's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with transfers and bathing, extensive assistance of one person with bed mobility and toileting, limited assistance with personal hygiene, supervision of one person with locomotion and	F 658	**F 658** 1. Information was received from podiatrist office regarding all prior visits for resident #9 on October 26, 2021. 2. All residents who have specialty appointments have the potential to be affected by this deficient practice. Facility reviewed all residents within the facility who have attended specialty appointment over the last 30 days to identify any missed information/physician orders and correct them immediately. 3. IDT team was educated regarding process of following up with resident and/or specialty office post appointment to obtain provider notes and validate any new treatment orders on 10/28/21. 4. DON/Designee will audit 100% of residents with specialty appointments to ensure any specialty information has been obtained and scanned into the medical record for 8 weeks. 5. DOC 12/6/21	

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F 658	Continued From page 15 dressing and supervision after set-up with eating. During an interview with Resident #9 on 10/27/21 at approximately 10:30 a.m., the complainant elaborated on the care he had received at the facility since his admission which he felt was neglectful. The resident stated he transferred to the facility because he required intravenous antibiotic therapy and wound care utilizing a wound vacuum to his right plantar foot. Resident #9 stated he wasn't satisfied with application of the wound vacuum (vac) and the number of times it had be removed because he felt the nursing staff weren't competent in use of the wound vac. The resident also stated on 10/5/21 a nurse completed the right foot wound care by spraying it first with peri-fresh. He also reported on 10/7/21 another nurse attempted to remove the old dressing from his right foot but it had adhered to the wound, the nurse applied saline soaked gauze to loosen the dressing but it continued to adhere therefore the nurse pulled the dressing off and removed about 80% of the skin graft. Review of the clinical record revealed no progress notes or orders from the foot and wound specialist provider therefore Registered Nurse (RN) #1 was interviewed for clarification. On 10/27/21, the facility staff received all of the resident's progress notes from the foot and ankle specialty group the resident had seen multiple times since admission to the facility. This was their first time the facility staff had	F 658		

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F 658	Continued From page 16 contacted the provider's office and received the progress notes from visits. August 9, 2021 was the resident's first visit to the foot and ankle providers since admission to the nursing facility. It also was the resident's post-operative visit after the fourth toe amputation, surgical debridement of the right plantar foot wound and diagnosis of osteomyelitis with septic joint of the fourth toe. Review of the recently acquired foot and ankle specialty provider progress notes revealed the wound care orders were not consistent with what was ordered by the provider and they were changed more frequently without the specialty practice notification. An interview was conducted with Registered Nurse (RN) #1 on 10/27/21 at approximately 2:50 p.m. RN #1 stated Resident #9 preferred to arrange his appointments and transportation to all offsite physician appointments and he did. RN #1 further stated the resident faxes information to the staff regarding all appointments after he makes them to ensure they are aware and he attends appointments and returns to the facility. RN #1 stated they had never received any documents from the providers regarding the resident's appointments and they didn't telephone the providers for information they simply relied on details from the resident. RN #1 stated the orders were clearly documented in the progress notes from the specialty provider but because the resident never provided them with documents they managed the wound in-house using what information the resident provided. RN #1 stated she knew now that wasn't what they should have done but as a result the resident didn't suffer any	F 658		

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F 658	Continued From page 17 deterioration in the right plantar foot wound. An interview was conducted with the Director of Nursing on 10/28/21 at approximately 1:40 p.m. The Director of Nursing stated she was aware the resident made his own appointments ad arranged transportation and that he never provided them with documentation of the visit but going forth they would ensure they communicated with the resident and the provider to ensure they had up to date information for their expectation is coordination of care. The Director of Nursing stated they determined continuity of care wasn't established for Resident #9 because he received treatment and orders for the right plantar foot wound from an outside provider and no written information from the provider was given to the facility's staff by the resident or the provider and the facility nurses were not communicating with the outside provider. This allegation was addressed with the Administrator, Director of Nursing and two corporate consultants on 10/28/219 at approximately 5:00 p.m. The Administrator stated she hadn't received any grievances on the resident's behalf but; she would work towards establishing effective communication with the resident and the facility staff. The Administrator also stated it was the expectation of the Licensed Nursing staff to obtain all consultation reports and orders related to the resident visits from the outside provider especially since they knew when each appointment took place and explain to the resident their need to obtain the reports for continuity of care. COMPLAINT RELATED DEFICIENCY	F 658		

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to monitor daily weights and Blood Sugar checks per physician's orders for 1 of 24 residents (Resident #15), in the survey sample. The findings included: Resident #15 was originally admitted to the facility on 06/28/21 and readmitted on 09/06/21 after an acute care hospital stay. The current diagnoses included; Type 2 Diabetes Mellitus without Complications, Moderate Protein Calorie Malnutrition and Dysphagia, Oropharyngeal Phase. The Quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/05/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #15 cognitive abilities for daily decision-making were intact. In section "G"(Physical functioning) the resident	F 684	**F 684** 1. Weight obtained on resident #15 11/17/2021. Weight orders was clarified on 11/17/21. Blood sugars obtained 10/26/21: 10/27/21: 10/28/21 and ongoing with accu-check orders were clarified on 11/24/21 to be check as ordered. 2. All residents are at risk if weights are not completed and blood sugar are not checked as ordered. 3. Identified residents with orders for weekly weights to ensure weekly weights are obtained timely; identify residents with accu-checks to ensure daily blood sugars are obtained timely. Educate nursing staff including agency on obtaining weights and accu-checks as ordered. 4. DON or designee will audit 10% of residents with orders for weekly weights and blood sugar for 8 weeks. Result of Audit will be forwarded to QAPI for oversight and any additional recommendation. 5. DOC 12/6/21.	

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F 684	Continued From page 19 was coded as requiring limited assistance of two persons for bed mobility, transfers and dressing. Requiring extensive assistance with eating and toileting. Requires supervision with personal hygiene.	F 684		
	The Care plan dated 7/28/21 reads: Resident has a history of Diabetes Mellitus. Goal: Resident will have no complication through the review date. Interventions: Fasting serum blood sugar as ordered by the doctor. The Care plan dated 10/21/21 reads: Resident #15 requires tube feedings r/t (relating/to) Dysphagia and chewing problems. Goals: Resident will be free of aspiration through the review date. Interventions: Discuss with resident/family /caregivers any concerns about tube feeding. The Care plan dated 9/28/21 reads: Resident #15 has a swallowing problem r/t swallowing assessment results. Goal: The resident will maintain weight and nutritional balance through the review date. Interventions: Refer to Speech Therapist for swallowing evaluation. The October 2021 MAR (Medication Administration Record) Reads: Weekly weights every Wednesday Day shift. Start date 9/15/21 at 7:00 AM. A review of Resident's weight summary in the clinical record show that Resident #15 was weighed only on Wednesday 9/15/21. A review of the September 2021 MAR reveal on 9/22/21 that resident was weighed (111.6 lbs). No additional recorded after 9/22/21. The MAR for			

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F 684	Continued From page 20 September was initialed by staff on 9/22/21 and 9/29/21 but no weight recordings were found in the clinical record. A review of the October 2021 MAR reveal that Resident was only weighed on 10/13/21 (118.6 lbs.) The staff initialed the MAR on 10/06/21, 10/20/21 and 10/27/21 but no weight recordings were found in the clinical record. The October 2021 POS (Physician Order Summary) reads: Weekly weighs on Wednesdays every day shift every Wednesday. Dated 9/10/21. Start date: 9/15/21. The October 2021 POS (Physician Order Summary) reads: Check BS (Blood Sugar) before meals. Dated 7/03/21. A review of the September 2021 MAR reveal that Resident #15 did not receive any Blood Sugar Checks on the following dates at 6:30 AM: 9/04/21, 9/09/21 and 9/10/21. At 11:30 AM and at 4:30 PM. No Blood Sugar Checks were conducted on 9/06/21. On 10/26/21 at approximately 12:12 PM. Resident was seen resting in bed. He stated that he receives tube feedings sometimes but is allowed to eat pureed foods. On 10/27/21 at approximately 4:10 PM an interview was conducted with Resident #15 concerning his weight. He stated. If I eat more than 50% of my meals "I don't get any tube feedings. They check my weight sometimes. My appetite is pretty good." On 10/28/21 at approximately 2:25 PM an	F 684		

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F 684	Continued From page 21 interview was conducted with RN (Registered Nurse) #1. Concerning Resident #15 weights and Blood Sugar checks. She stated. "We have issues with our scales. He should have receive weekly weights. The resident was here so he should have received blood sugar checks."	F 684		
	On 10/28/21 at approximately 4:25 p.m., the above findings were shared with the Administrator and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.			
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews and clinical record review, the facility staff failed to provide necessary care and services to prevent development of pressure injuries for 2 of 23 residents (Resident #8), in the survey sample.	F 686		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (~~EACH DEFICIENCY MUST BE PRECEDED BY FULL~~ REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 22 The findings included: 1. Resident #8 was originally admitted to the facility 8/29/20 and had never been discharged from the facility. The current diagnoses included; a neurogenic bladder, urinary retention with voiding trial failures, renal failure and morbid obesity. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/11/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #8's cognitive abilities for daily decision making were intact. In section "H0100" the resident was coded for having an indwelling catheter. In section "M0100" was coded resident had no pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. The last Braden Scale completed on behalf of the resident was dated 5/11/21 and it indicated she had a moderate risk for a pressure injury. The weekly skin assessment were very inconsistent and there was no weekly documentation. The 8/6/21, skin assessment indicated the resident had open areas to the right hip and groin; 9/16/21 open areas to the right hip and groin; 9/23/21 right thigh opening; 10/14/21, skin intact; 10/21/21, peripheral intravenous to left forearm; 10/28/21, skin intact. Review of the clinical record revealed a progress note dated 9/2/2021 which read; No dressing to	F 686	**F 686** 1. Bolster device was placed on Resident #10 to stop heal from rubbing against coccyx area on 10/24/21 and foley catheter stat-lock was applied on Resident #8 on 10/27/21 2. All residents have the potential to be affected when facility protocols on preventing/healing pressure ulcers and applying foley catheter stat-locks are not followed. 3. 100% audit of all residents with foley to ensure foley stat-locks are in place and residents with contractures had appropriate prevention devices in place. Educate RN/LPN/CNAs on ensuring stat-locks are applied for residents with foley catheter and pressure injury prevention devices are in place on all residents who are contracted. 4. DON or designee will complete audit on residents with foley's to ensure stat-locks are in place and pressure relieving devices on contracted residents weekly x 8 weeks. Results of audits will be forwarded to QAPI for oversight and any additional recommendations. 5. DOC 12/6/21	

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	495309	A. BUILDING _____ B. WING _____	C 10/28/2021

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F 686	Continued From page 23 the right inner thigh applied, area resolved. Area cleaned and dried. Review of the clinical notes revealed a noted dated 10/18/21 at 19:02 which read; New area noted by Certified Nursing Assistant to resident's right inner leg, physician on call notified no feedback or new treatment ordered as yet. Physician notified and Power Of Attorney notified. A physician's ordered dated 10/18/21 at 17:13 read; Clean the right inner leg wound with dermal wound cleanser, pat dry, apply Medi-honey and cover with a dry dressing, as needed every day shift. Review of the treatment administration record revealed the treatment had not been signed off as completed since the order was obtained. Another physician's order dated 10/21/21 read; Check placement of catheter strap every shift. A 10/26/21 care plan problem read; (name of resident) has a Pressure Ulcer. The goal read; Pressure Ulcer will decrease in size by the next review date 12/19/2021. The interventions included; Followed by wound NP. Assess for signs and symptoms of worsening, of infection or complications daily. Treatment as ordered by physician to the wound care area. An interview was conducted with Registered Nurse (RN) #1 on 10/27/21 at approximately 11:50 a.m. RN #1 stated the resident's catheter should be anchored because she had developed a pressure injury before because of positioning problems with the catheter tubing. After observation of the resident's catheter and tubing;	F 686		

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F 686	Continued From page 24 RN #1 stated the resident's catheter tubing wasn't anchored and she would be back to secure the catheter as ordered, as well as assess the open area to the resident's right inner leg. RN #1 stated Resident #8 had previously had an open area to the right inner leg which had been assessed by the wound care Nurse Practitioner as a stage three pressure injury for it was caused by pressure from the catheter tubing. RN #1 further stated the right inner leg pressure injury had healed approximately two months ago. RN #1 also stated the wound care Nurse Practitioner was scheduled to see the newly opened area to the resident's right inner leg today but she learned she wasn't coming to the facility today therefore she would make the assessment. An interview was conducted with An interview was conducted with Licensed Practical Nurse (LPN) #1 on 10/28/21 at approximately 3:45 p.m. LPN #1 stated a Certified Nursing Assistant notified her at the end of her shift that Resident #8 had an open area to her right inner leg and she made an observation, contacted the on call physician and treated the open area as well as documented it for that was her responsibility. LPN #1 further stated the facility doesn't allow LPN's to assess and stage open areas therefore when the next RN was on duty the wound was to be assessed, measured and thoroughly documented on. On 10/28/21, at approximately 5:00 p.m., the above information was shared with the Administrator, Director of Nursing and two corporate consultants. The Director of Nursing stated the assessment of Resident #8's open area to the right inner leg should have been conducted prior to today and the indwelling catheter should have been secured at all times to	F 686		

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F 686	Continued From page 25 prevent further opportunities for skin breakdown. 2. Resident #10 was originally admitted to the facility 10/11/2017 and readmitted 10/30/2017 after an acute care hospital stay. The resident's current diagnoses included; cerebral palsy, chronic pain, adult failure to thrive, severely contractured upper and lower extremities and pressure injuries. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/30/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making abilities. In section "G" (Physical functioning) the resident was coded as requiring total care of two people with bed mobility and transfers, total care of one person with locomotion, dressing, eating, toileting, personal hygiene and bathing. In section "M" the resident was coded for having one stage 3 pressure injury and one stage 4 pressure injury. During the initial tour on 10/26/21 at approximately 2:00 p.m., Resident #8 was identified as a vulnerable resident; unable to express herself verbally or non-verbally and ill-positioned in bed. No Braden scales could be located in the clinical record as completed for the resident.	F 686		

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F 686	Continued From page 26 The clinical record revealed the following note; Resident seen by wound nurse 4/13/21;Unstageable wound to right lower buttocks noted to be resolved as of 4/13/21; no skin issues currently noted. A weekly skin assessed completed 7/23/21 read; 0.5 x 0.5 area to the buttock reopened. The 7/30/21, weekly skin assessment indicated all skin was intact; the 8/16/21, weekly skin assessment indicated all skin was intact; 8/23/21, weekly skin assessment indicated all skin was intact; 8/30/21, weekly skin assessment indicated all skin was intact; on 9/6/21, the weekly skin assessment indicated all skin was intact. On 9/13/21, the weekly skin assessment revealed a open area to the right gluteal fold with a treatment in place; on 9/20/21, the weekly skin assessment revealed a opening to the right buttock and a skin tear (site not identified); the weekly skin assessment dated 9/26/21 a stage 2 to the right buttock and a progression of the right heel pressure injury from a stage 1 to a stage 2, with an update to the treatment orders. The next weekly skin assessment was dated 10/13/21, indicated the resident had pre existing wounds to the right buttock and right heel, and treatments were in place for both and they were showing signs improvement; the 10/20/21, weekly skin assessment indicated the resident had pre existing wounds to the right buttock and right heel, and the 10/27/21, weekly skin assessment indicated the resident had open areas to the right gluteal fold and the left heel and to continue treatment as ordered; the current dressing was clean, dry and intact. Further review of the resident's clinical record	F 686		

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F 686	Continued From page 27 revealed the resident was identified on 7/23/2021, with a 0.5 x .05 centimeter opening of the right buttocks. The area was cleansed with normal saline, medihoney was applied and a border dressing. Notation was made for the Nurse Practitioner (NP) to follow-up. On 7/28/21 the NP assessed the right buttock pressure injury as a stage 3 which had reopened. Recommendations included pressure reduction and turning precautions and use of heel protection and pressure reduction to bony prominence's. The clinical record further revealed on 9/15/2021 and a right posterior ankle, stage I pressure injury. Another clinical record note dated 9/26/2021 at 17:36 read; during wound care, this nurse noted that the stage I pressure injury on right heel has progressed to a stage II with slight necrosis. No drainage, no odor. The treatment order was changed to clean with dermal wound cleanser (DWC), apply Santyl and cover daily. A new order was also written to ensure the resident always had a protective barrier between contracted points, and cushioning/repositioning to prevent breakdown of bony prominence's. A message was left with on the on call physician, and notification was put in the in physician's communication book for follow-up with the NP on Monday. The resident's sister was notified. On 9/29/21 the right heel pressure injury was assessed by Registered Nurse #1. The Weekly Pressure Wound Observation Tool revealed the resident had a stage 3 pressure injury to the right heel measuring 1.09 by 1.17 by 0.2 centimeters. A new order was obtained as follows; cleanse with normal saline, apply Iodosorb to wound bed followed by a dry dressing daily.	F 686		

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F 686	Continued From page 28 A care plan problem dated 9/21/2021 read; (name of resident) has actual skin impairment to her right buttocks. The goal read; will have intact skin, free of redness, blisters or discoloration by/through review date, 12/19/2021. The interventions included; administer treatments as ordered and monitor for effectiveness. Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. A care plan problem dated 10/7/21 read; (name of resident) has a stage 3 pressure ulcer to the right heel related to contractures. The goal read; Pressure injury will show signs of healing and remain free from infection by/through review date, 12/19/2021. The interventions included; reposition at least every 2 hours, more often as needed or requested. Resident has bolster to be used while in bed to prevent heel from applying pressure to her buttocks. An interview was conducted with Registered Nurse (RN) #1 on 10/28/21 at approximately 1:20 p.m. RN #1 also stated had she was aware of the inconsistencies in weekly skin reviews, assessment of new areas identified and institution of treatments. RN #1 further stated the process is for LPN's not to make wound care assessments but to complete a change in condition form indicating the location, appearance, drainage if any and size of the identified area and put a referral in to have her and the NP assessment the area further. RN #1 stated the wound care NP didn't assess the Resident #8's pressure injury until 9/29/21,	F 686		

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F 686	Continued From page 29 fourteen days after the initial observation of skin changes identified by the LPN and during the NP assessment the wound was determined to be a stage 3 pressure injury not a stage I. RN #1 stated they instituted use of a pillow between the resident's right heel and right buttock to reduce the pressure from the right leg contracture to reduce the opportunity for increased skin breakdown but it was ineffective therefore; therapy was asked to evaluate and develop a plan for pressure relief. They instituted use of a wedge designed for Resident #8. On 10/28/21, at approximately 5:00 p.m., the above information was shared with the Administrator, Director of Nursing and two corporate consultants. The Director of Nursing stated the plan was to have more education on pressure ulcer prevention, treatment and promotion of healing.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to monitor one resident after sustaining an injury	F 689		

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F 689	Continued From page 30 after falling by obtaining neurological checks. For 1 of 24 residents (Resident #16), in the survey sample. The findings included: Resident #16 was originally admitted to the facility on 10/06/21 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Cerebral Infarction Unspecified and Muscle weakness. The admissions Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/13/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #16 cognitive abilities for daily decision making were intact. In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of one person for bed mobility, transfers, dressing, eating and personal hygiene. Requiring total assistance with toileting. The care plan dated 10/27/21 reads: Resident #16 is at risk for falls r/t (related/to) Incontinence, Hemiplegia, Seizure, Medications and history of CVA (Cerebral Vascular Accident). Goal: The resident will not sustain serious injury through the review date (12/27/21). Interventions: Every 1 hour checks, Follow facility fall protocol (10/27/21). During the initial tour on 10/26/21 at approximately 11:55 AM., Resident #16 stated that he fell recently injuring his right inner eye and had another fall scratching his left elbow. (An	F 689	**F689** 1. No immediate correction can be initiated for this area. 2. All residents who fall and hit their head have the potential to be affected by this deficient practice. Facility reviewed all residents who have fallen and hit their head within the facility within the last 60 days. Any identified discrepancies will be notified to the staff member and staff member will be educated on the fall policy. 3. Nursing facility and agency staff members were educated regarding the fall policy (including neuro-checks on 11/4/21. 4. DON or designee will audit 100% of falls with injury for 8 weeks to ensure fall process is occurring per policy. Results of these audits will be reported to the QAPI committee for oversight and any recommended changes. 5. DOC 12/6/21	

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F 689	Continued From page 31 area on Resident's left elbow was observed by the said surveyor. Appears to be healed). A review of the progress notes dated 10/15/21 at 11:07 PM., Reads: Resident found on floor in room. Patient was face up and had skin tear to right elbow. Vital signs were taken. Small reddened area noted under the right eye. Arm was cleaned and bandage applied. MD was notified and wife was called and a message was left. On 10/28/21 at approximately 2:10 PM RN (Registered Nurse/Unit Manager) #1 was asked to provide neuro checks (Neurological Checks) documentation for Resident #16. On 10/28/21 at approximately 2:15 Pm., an interview was conducted with RN #1 concerning Resident #16 neuro checks documentation concerning fall with an injury sustained on 10/15/21. She stated. "No neuro checks were not done. He should have had them done. Neuro checks are done initially then every 15 minutes x 4, then every 30 minutes x 2. Then hourly for 4 hours then every 4 hours x 6 then every shift. We have a check list for neuro checks. Residents should have a full set of vital signs done after falling to make sure they don't have brain injury of have suffered any kind of injury after a fall. His falls occurred while he was on the quarantine unit. We have measures in place on this unit. Fall mats, frequent rounding, resident is placed next to the nurses station." On 10/2821 at approximately, 2:55 PM., RN #1 presented surveyor with The Facility's Fall Expectations Document. The document reads: Date of Incident, Time of Incident, Name of resident. Initial Risk management, Change of	F 689		

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F 689	Continued From page 32 Condition, MD (Medical Doctor) notification, RP (Responsible Party) notification, Care Plan Update, Fall assessment, Pain assessment, Initiate neuro checks, Any Injuries, Treatment Orders if applicable. If head injury or major injury notify Unit Manager ASAP if no injury can notify in the morning. On 10/28/21 at approximately 4:25 p.m., the above findings were shared with the Administrator and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		

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F 690	Continued From page 33 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility's staff failed to ensure appropriate care and services were provided to prevent/reduce trauma to the urethra and bladder, and other complications such as pressure ulcer development while utilizing an indwelling catheter for 1 of 32 residents (Resident #8), in the survey sample. The findings included: Resident #8 was originally admitted to the facility 8/29/20 and had never been discharged from the facility. The current diagnoses included; a neurogenic bladder, urinary retention with voiding trial failures. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/11/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #8's cognitive abilities for daily decision making were intact.	F 690	**F 690** 1. Foley catheter stat-lock was applied on 10/27/21. 2. All residents are at risk when foley catheter stat-lock are not applied. 3. 100% audit of all residents with foley to ensure foley stat-locks are in place. 4. Educate RN/LPN/CNAs on ensuring stat-locks are applied for residents with foley catheter. Results of audit will be forwarded to QAPI for oversight and any additional recommendations. 5. DOC 12/6/21.	

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F 690	Continued From page 34 In section "H0100" the resident was coded for having an indwelling catheter. Resident #8 had a physician's order for an indwelling urinary Foley catheter to straight drainage 16 French with a 10 milliliter balloon secondary to a diagnosis of urinary retention Resident #8 also had a physician order dated 10/21/2021 to check placement of the indwelling catheter strap every shift. The current care plan had a problem dated 6/15/21 read; (name of the resident) has Indwelling Foley Catheter: failed voiding trials after catheter removal, diagnosis urinary retention. The goal read; (name of the resident) will not develop any complications associated with catheter use through next review, 12/19/2021. The interventions included; Position catheter bag and tubing below the level of the bladder and away from entrance room door. Change catheter and bag as per policy. Observe/record/report to MD for signs/symptoms of a UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. On 10/26/21 at approximately 3:50 p.m., a bedside drainage bag was observed attached to the bed frame. The resident state she was unable to pass her water without the catheter and she was told approximately five days ago the catheter tubing had cause another open area to the groin. The resident further stated she wasn't aware of it because she can't feel the tubing	F 690		

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F 690	Continued From page 35 when it rolls in to the groin area. The resident further stated it had happened before and healed but Resident #8 stated "take a look yourself" as she pushed the bed linens back. The catheter tubing was not anchored and it was lodged between the folds of skin under her stomach and right thigh. An interview was conducted with Registered Nurse (RN) #1 on 10/27/21 at approximately 11:50 a.m. RN #1 stated the resident's catheter should be anchored because she had developed a pressure wound when it's wasn't. After observation of the resident's catheter and tubing; RN #1 stated the resident's catheter tubing wasn't anchored and she would be back to secure the catheter as ordered as well as assess the open area to the resident's right inner leg. Taping the catheter is a frequent method used for stabilization. The drainage tube attached to the catheter is taped to the person's thigh or abdomen. The area of the thigh is the best site for taping with women. Men to secure the catheter use the site of the thigh or lower abdomen. (http://www.public.asu.edu/) On 10/28/21, at approximately 5:00 p.m., the above information was shared with the Administrator, Director of Nursing and two corporate consultants. The Director of Nursing stated the resident's indwelling catheter should have been secured and it had since been secured.	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		

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F 698	Continued From page 36 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility staff failed to ensure ongoing communication and collaboration with the dialysis facility for one resident (Resident #6) in the survey sample of twenty four residents. The findings included: Resident #6 was admitted to the facility on 04/14/21 with diagnoses which included diabetes, end stage renal disease, failure to thrive, chronic kidney disease, congestive heart failure, hypertension, and a history of sepsis. The facility staff failed to ensure Resident #6 daily dialysis communication book was available. A Quarterly Minimum Data Set (MDS) dated 10/13/21 assessed this resident in the area of Cognitive Patterns (Brief Interview for Mental Status) BIMS as a 9. A Care Plan dated 10/26/21 indicated that this resident received dialysis services. "Dialysis - AV fistula shunt- palpate gently over area with fingertips or palm of hand. Check complete dialysis communication log record on return from dialysis appointments for any reports. Collaborate with RD at dialysis center about weights, outcomes of biochemical tests, nutrition education and nutrition counseling."	F 698	**F 698** 1. Dialysis book that did not return with Resident #6 was obtained on 10/27/21. 2. All residents receiving dialysis services are at risk from this deficient practice. Residents receiving dialysis from outside facility will be reviewed from last 30 days to see if other residents were affected. 3. The interim DON and nursing staff were educated regarding ensuring dialysis book was returned with resident post dialysis treatment on 10/27/21. 4. DON or designee will audit all residents returning from dialysis weekly x 8 weeks to ensure communication book returns with individual and any new physician orders are implemented timely. Results of audits will be reported to the QAPI committee for oversight and any recommended changes. 5. DOC 12/6/21.	

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F 698	Continued From page 37 A Physician order dated 10/28/21 indicated: "Hemodialysis (T) Tuesday, (Th) Thursday, and (Sat) Saturday. On 10/27/21 at 3:45 P.M. during an interview with the Unit Manager, she was asked for Resident #6's dialysis communication book. The Unit Manager stated, the communication book was not returned from dialysis following his Tuesday appointment. A request was made to the Unit Manager and the Administrator for a Dialysis communication policy. No policy was provided during the survey.	F 698		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		

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F 761	Continued From page 38 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 the facility's medication storage review of 1 medication cart and 1 medication room; the facility staff failed to ensure two opened containers of eye drops included the opened date. The findings included; On 10/26/21 at approximately 1:15 PM a medication cart audit was conducted with LPN (Licensed Practical Nurse) #1. Stored inside of the medication cart were two opened bottles of eye drops without open dates written on the bottles. (Latanoprost 0.095% expires 7/20/22 and Opthalmic Ultra eye drops expire 7/20/22). LPN #1 stated. "They should put a date on them." On 10/26/21 at approximately 2:00 PM an interview was conducted with RN (Registered Nurse/Unit Manager) #1 concerning the above eye drops. She stated. "When they open a bottle they should put a date on them. If no date they should discard and reorder the medications." On 10/28/21 at approximately 4:25 p.m., the above findings were shared with the Administrator and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 761	**F 761** 1. All medication carts in the facility were assessed for any undated opened eye drop containers, any undated open containers were disposed of and replaced with new labeled containers. Completed on 10/27/2021. 2. All residents using eye drops are at risk from this deficient practice. 3. The nursing staff and agency staff members were educated on the dating of open medication containers to include eye drops on 10/27/21. 4. DON/Designee will audit all resident eye drop bottles weekly x 8 weeks to ensure bottles are dated when opened per policy. Results of these audits will be reported to the QAPI committee for oversight and any recommended changes. 5. DOC 12/6/21.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921		

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F 921	Continued From page 39 §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review the facility staff failed to provide a safe, functional, sanitary, and comfortable environment for residents by not removing debris from two storage shed fires. The findings included; On 10/26/21 at approximately 1:15 PM an observation of the facility's dumpster area was conducted with the Food Service Director (FSD). Located near the dumpsters were the charred remains from two storage sheds. The first storage shed was completely burned to the ground and the second storage shed was partially burned. Located on the grounds were charred medical equipment, binders, scattered papers, Wheel chairs, several gallon jugs of water. An existing tree was located near the charred remains of the first shed with charred marks about 100 feet high upon it. There were two separate piles of wooden pallets near the charred remains. Some of the Charred debris was scattered beyond the parameters of the storage sheds near the sidewalk and building. The Food Service Director stated that the first shed was burned completely down on one day and that the second shed was partially burned on the next day. She stated that she found out about the fires when she returned to work. On 10/26/21 at approximately 3:30 PM a second observation of the grounds near the storage	F 921	**F 921** 1. Tree limb in the back of facility and storage shed debris was removed on 11/11/21. 2. All residents may be at risk when environment is not clear of potential safety hazards. 3. Director of Maintenance will perform walking rounds on 100% of grounds and communicate environmental needs to administrator. 4. Director of Maintenance was educated on ensuring property was free from debris on 10/28/21. 100% grounds audit on facility outdoors will be completed for 60 days. Results of audit will be forwarded to QAPI committee for oversight and any additional recommendations. 5. DOC 12/6/21	

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F 921	Continued From page 40 sheds were made. The area remains unchanged. Debris still scattered on the grounds. Debris located inside or near the storage sheds. On 10/26/21 at approximately 3:40 PM an interview was conducted with the Administrator concerning the two storage sheds. She stated, "We're doing surveillance for four weeks. We asked for increased surveillance after the fires. We're trying to get a security system for the front and back of facility for additional lighting. A Pad lock was placed on the kitchen door. We have not gotten the police report but have secured the gate. The investigation is ongoing. It May be an arsonist in the area. One suspect is in custody. I have the name of the fire investigator. The fire department inspector is conducting the investigation. They wouldn't give me anything. They were old sheds that haven't been used for years. We didn't use them actively now. Water bottles, some debris, wheel chairs, files remnants of papers. I don't know of patient or employee information. Corporate reported it to the insurance. We are going to have it cleaned up. I think the insurance adjuster came out but I don't have anything to do with it. I will certainly ask Regional to give you the information. On 10/27/21 at approximately 9:13 AM., a telephone interview was conducted with the Norfolk Fire Inspector. He was asked about the fire reports for two fire incidents. He stated, "The first fire incident occurred on 9/24/21 around 3:00 A.M. The second fire incident occurred on 9/25/21 around 10:00 P.M. The Fire Inspector stated a report could be issued to the facility if they requested one. The Fire Inspector stated the facility had a private	F 921		

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F 921	Continued From page 41 insurance investigator looking into the matter but had since stopped all pursuit due to the deductible of the insurance policy. The Fire Inspector stated there is an ongoing investigation of arson for both incidents. The Fire Inspector stated the fire scene has been released back to the facility. All evidence regarding the arson suspicion has been collected. The scene was released over to the facility several weeks ago." No specific time frame was given. On 10/27/21 at approximately, 3:45 PM a third observation of the grounds near the storage sheds were made. The area remains unchanged. (Still with debris scattered throughout the grounds). On 10/28/21 at approximately 10:50 AM an interview was conducted with the maintenance Director concerning the sheds. He stated, "I came in 2 weeks ago (Started Employment). I went out to see what was going on. I tried to figure out how I could clean it up. The administration said the fire department will come out. Wait until the investigation is over before you clean up. There's pallets, different papers are burnt up." On 10/28/21 at approximately 12:30 PM an interview was conducted with the Acting Director of Nursing (ADON) concerning the incident involving the sheds. She stated, "On 9/24/2, I received a phone call from the staff saying there was a fire. I asked them if they had called the Fire Department (FD). They had called 911. I arrived fifteen minutes later. The back shed was being put out by the FD. The FD interviewed me. I made sure the residents were ok. They evacuated two patients on the green Hall (Near the kitchen). They were brought to the main	F 921		

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F 921	Continued From page 42 nurses' station. Fire safety precautions were followed by the staff. The FD stated there was an arsonist in the area. A gentleman came to the door and said your building is on fire. I got my phone call at 2 am. The first shed had items like bedside tables, storage containers. There wasn't anything of value. I tried to do an incident report but couldn't put them in PCC (Point Click Care). The fire re-ignited. I called the FD back and they put out the fire. On the next night (9/25/21) I got a call about 10:00 PM., from the nurse saying the second shed is burning but contained by the FD. I didn't come out this time. The second shed contained old furniture. The papers on the ground may be old maintenance receipts, buckets. Those pallets are there because of a shipment of beds that came in. This was after the fire." On 10/28/21 at approximately 1:15 PM a phone call was made to Certified Nursing Assistant (CNA) #1. A message was left for staff to return call. On 10/28/21 at approximately, 1:20 PM an interview was conducted with CNA #2 concerning the incident involving the two sheds. He stated, "I was working the 7:00 PM to 7:00 AM shift. When a man was at the front door, ringing the door bell, yelling, "Fire." We got the patients safe and secure. I didn't see but smelled the smoke at first because I was busy getting the patients. I saw the flames from the unit closest to the kitchen. This was the first fire on September 24th." On 10/28/21 at approximately 1:25 PM a telephone interview was conducted with CNA #3. Concerning the shed incidents. She stated, "I was rounding. We got a knock at the front door from policemen and the FD were here. They said they had an arson in the area. The residents were	F 921		

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F 921	Continued From page 43 safe. The residents were located in the front. I saw some wheel chairs and other personal items outside on the ground." On 10/28/21 at approximately 2:00 PM a returned phone call was received from CNA #1 concerning the storage shed incidents. She stated, "On the first night (9/24/21), we were at the nurses' station when someone rang the bell and stated there's a fire out back. I called 911. I went to the recreation room to get help. I saw the fire. I called code red. You could see it through the window. We closed the doors. I grabbed the fire extinguisher." On 10/28/21 at approximately 4:25 p.m., the above findings were shared with the Administrator and Corporate Consultant. The administrator stated, "We will have the outside cleaned up, storage barn demolished and tree limbs removed."	F 921		