STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495179	A. BUILDING _____ B. WING _____	C 12/02/2021

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POTOMAC FALLS HEALTH & REHAB CENTER	46531 HARRY BYRD HIGHWAY STERLING, VA 20164

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E 000	Initial Comments An unannounced Emergency Prepardness survey was conducted on 11/30/21 through 12/02/21. The facility was found to be in substantial compliance with 42 CFR Part 483.73, requirements for Long-Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/30/21 through 12/2/21. 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 VA00053240 was investigated during the survey. The complaint was substantiated without a deficiency. The census in this 150 certified bed facility was 136 at the time of the survey. The survey sample consisted of 45 Resident reviews	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 553		1/11/22

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

Electronically Signed | 12/21/2021

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F 553	Continued From page 1 (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide evidence that two out of 45 residents were invited to attend a care plan meeting, Resident #47 and Resident #120, in the survey sample. The findings included; 1. Resident #47 was originally admitted to the facility 11/26/19 and readmitted 09/23/21 after an acute care hospital stay. The current diagnoses included; Fracture of Upper and Lower End of the Right Fibula and Hypertensive Heart Disease with Heart Valve. The significant change Minimum Data Set (MDS) assessment with an assessment reference date	F 553	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. 1. It is noted that facility staff failed to hold Care Plan Meeting for 2 of 45 residents. Care Plan Meetings for	

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F 553	Continued From page 2 (ARD) of 10/06/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #47 cognitive abilities for daily decision making were intact. In section "G"(Physical functioning) the resident was coded as requiring extensive assistance with one person assistance with bed mobility, dressing eating, toilet use, personal hygiene and bathing. Extensive assistance of two persons with transfers. On 12/01/21 at approximately, 10:33 AM an interview was conducted with Resident #47 concerning care plan meetings. She stated, "No. I don't go." On 12/02/21 at approximately 11:41 AM an interview was conducted with OSM (Other Staff Member) #2 and Corporate Clinical Consultant (Corporate Staff #1) concerning care plan meetings. OSM #2 stated, "She had one care plan meeting on 8/07/21 but chose not to participate. The other care plan meetings are not documented in the record." Corporate Staff #1 stated, "They should complete the care plan documentation in the medical record." On 12/02/21 at approximately, 1:00 PM an interview was conducted with OSM/Social Services Worker #1 concerning care plan meetings. He stated, "She usually don't attend these meetings. He was asked by the surveyor who normally attends the care plan meetings. He stated," Dietary, Director of Activities, The Social Services Coordinator, Therapists, Unit Managers. We've had the meetings. I just can't find any records. I'll find them."	F 553	Residents #47 and #120 have been extended and care plan meetings conducted. 2. Any resident is at risk if not offered an invitation and documented care-plan meeting. The Social Service Care Coordination Specialist or designee will conduct a 30-day review to identify any resident who is at risk for not having been offered a care meeting. 3. The Social Service Director or designee will educate the Social Services staff on Patient Rights requirement to participate in Planning of Care. 4. The Social Service Director or designee will monitor Compliance with Care Plan Meetings weekly x3 weeks; monthly x3 months. Findings will be reviewed in QAPI and variances addressed 5. Compliance date 1/11/22	

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2. Resident #120 was originally admitted to the facility on 11/29/19 after an acute care hospital stay. The current diagnoses included; Personal History of Traumatic Brain Injury and Major Depressive Disorder.

The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/12/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #120 cognitive abilities for daily decision making were intact.

In section "G"(Physical functioning) the resident was coded as requiring supervision of one person with bed mobility, transfers, locomotion, dressing, eating, and toileting. Requiring independence with bathing. Requiring limited assistance of one person with personal hygiene.

On 12/01/21 at approximately 9:45 AM an interview was conducted with Resident #120 concerning care plan meetings. He stated, "I don't know anything about this."

On 12/02/21 at approximately 12:50 PM an Interview was conducted with OSM #1 concerning care plan meetings. He stated, "He usually doesn't participate in the meetings. I keep him informed. He doesn't participate in group activities. He should have care plan meetings every quarter or if there's a significant change or an annual review. His last care plan meeting was 6/15/21. He did not attend. According to the OBRA (Omnibus Budget Reconciliation Act). It should be the next quarter. It should have been scheduled in September. unless there was a

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F 553	Continued From page 4 change in condition. I don't have the CP invite or meeting documentation." On 12/02/21 Received care plan invite letters from the administrative staff for Resident #120 dated 6/09/21, 3/16/21 and 11/25/20. On 12/02/21 at approximately 3:20 p.m., the above findings were shared with the Administrator, The Corporate Consultant, The Social Services Coordinator and The Corporate Clinical Services Specialist. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 553		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and clinical record review, the facility staff failed to accommodate the preference of the resident to have showers prior to 6:00 p.m., for 1 of 45 residents (Resident #39), in the survey sample. The findings included: Resident #39 was originally admitted to the facility 4/30/21 and has not been discharged from the facility. The current diagnoses included; postpolio syndrome, chronic pain and multiple rotator cuff	F 558	1. Resident # 39 was interviewed related to shower preferences for time of shower and care plan was revised to reflect the preference. 2. Any resident may be at risk for lack of reasonable accommodations if shower schedule is not discussed and preference not offered. 100% audit will be complete of all residents to ensure the residents preferred shower is followed and any variance will be reflected in residents in plan of care.	1/11/22

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F 558	Continued From page 5 repairs. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/26/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #39's cognitive abilities for daily decision making was intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of two people with bed mobility, transfers, and toileting, extensive assistance of one person with personal hygiene, bathing, and dressing, limited assistance of one person with locomotion and supervision of one person with eating. On 12/1/21 at approximately 5:00 p.m., an interview was conducted with Resident #39. The resident stated approximately two weeks ago during a shower on the stretcher bed she almost slipped off. The resident further stated the males can manage her better on the stretcher bed and she had made it known it was her preference to have her shower during the day shift or prior to 6:00 p.m., yet often the staff comes to take her to the shower after 9:00 p.m., therefore she rejects the shower after the preferred time. At 7:00 p.m., on 12/1/21 Resident #39 hadn't received her shower. An attempt was made to interview the CNA responsible for showering the resident but the response was he is still busy with another resident. An interview was conducted with Certified Nursing Assistant (CNA) #2 on 12/1/21 at approximately 7:15 p.m. CNA #2 stated because	F 558	3. DON or Designee will educate CNAs and licensed staff on shower/ bath scheduling for new admissions, discussion of schedule with resident and preferences incorporated in plan of care to ensure reasonable accommodations related to shower preference. 4. The DON or Designee will review 5 patients per unit to ensure shower preference is being offered and followed 3x week x 2, weekly x 2 then monthly x 2 Findings will be reviewed in QAPI, and variances addressed. 5. Date of compliance 1/11/22	

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F 558	Continued From page 6 resident #39 was in a window bed, her shower was scheduled for evenings on Wednesday and Saturdays. CNA #2 stated she wasn't working with the resident tonight but she was aware the resident preferred her shower prior to 6:00 p.m. An interview was also conducted with the Unit Manager for The Shenandoah Unit on 12/1/21 at approximately 7:45 p.m. The Unit Manager also stated because Resident #39 was in a window bed her shower was scheduled for the evenings. The Unit Manager stated it was possible for a resident to have a bath on the evening shift prior to 6:00 p.m., but that time was usually spent preparing residents for the dinner meal. Review of the shower documentation for November 2021 revealed two days of shower refusals, two days of not applicable and two days of total dependence as well as two days not a Wednesday or Saturday documentation. On 12/2/21 at approximately 11:15 p.m. The Unit Manager for the Shenandoah Unit stated she had spoken with Resident #39 and she stated it remained her preference to receive her shower prior to 6:00 p.m., and the facility would make changes as needed to accommodate the resident. On 12/2/21 at approximately 5:30 p.m., the above findings were shared with the Administrator, Assistant Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		1/11/22

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§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide

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F 578	Continued From page 8 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: 3. The facility staff failed to provide Resident #61 the opportunity to formulate an Advance Directive. Resident #61 was re- admitted to the facility on 10/05/21. Diagnoses for this resident included kidney failure, epilepsy and idiopathic neuropathy. Resident #61 was assessed as having a BIMS score of 13. A Care Plan dated 10/05/21 indicated this resident Focus- was at risk for unresolved pain and multiple medical problems. Goals- Interventions- Assess for side effects of pain medication. observe for constipation: new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls. During an interview on 12/02/21 at 12:36 PM with the Assistant Director of Nursing (ADON) she was asked if Resident #61 or his Representative had been offered the opportunity to formulate an Advance Directive. The ADON stated, not to her knowledge. 4. The facility staff failed to provide Resident #32 with the opportunity to formulate an Advance Directive. Resident #32 was admitted to the facility on 06/11/21. Diagnoses for this resident included dementia, type II diabetes, anxiety, anemia and depression. Resident #32 was assessed as	F 578	1. Residents #61, #45, #33, #32, #72 have been interviewed for the opportunity to formulate Advance Directives and corrections made to the Medical Records. 2.Any resident has the potential to be impacted if not offered advance directives. The Social Service Director or designee will conduct an audit of all residents to ensure residents are provided an opportunity to formulate an Advance Directive. 3. The Social Service Director or Designee will educate the Admissions Department and Social Services Departments of our responsibility to comply with requirements to permit all residents or resident representative an opportunity to formulate an advance directive and to reeducate the Admissions Department and Social Services Department on center Advance Directive Policy. 4. The Social Service Director or Designee will monitor Advance Directives weekly x3 weeks and monthly x3 months. Findings will be reviewed during QAPI and variances addressed 5. Compliance date 1/11/22	

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having a BIMS score of 0.

A Care Plan dated 10/14/21 indicated this resident Focus - psychotropic medication. Goals - Compliant with medication -Goals behavior no agitation - Intervention- GDR - no recent impairment in mood and behavior.

During an interview on 12/02/21 at 12:36 PM with the Assistant Director of Nursing (ADON) she was asked if Resident #32 or his Representative had been offered the opportunity to formulate an Advance Directive. The ADON stated, not to her knowledge.

5. The facility staff failed to provide Resident #72 with the opportunity to formulate an Advance Directive.

Resident #72 was admitted to the facility on 06/19/21. Diagnoses for this resident included COPD, heart failure, hypertension, dementia and anxiety. Resident #72 was assessed as having a BIMS score of 14.

Focus- Antipsychotic Medication- Goal modify behavior- Interventions- Psychiatric team will monitor mood and behavior, performance measures Neuropsychiatric symptoms and supportive therapy provided.

During an interview on 12/02/21 at 12:36 PM with the Assistant Director of Nursing (ADON) she was asked if Resident #72 or her Representative had been offered the opportunity to formulate an Advance Directive. The ADON stated, not to her knowledge.

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Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to afford 5 out of 45 residents (Residents #33, 45, 61, 32, and 72) in the survey sample were given the opportunity to formulate an advance directive.

The findings included:

1. The facility staff failed to execute the opportunity to provide an advance directive for Resident #33.

Resident #33 was originally admitted to the facility 06/26/2021 and readmitted 11/10/2021 after an acute care hospital stay. The current diagnoses included; Unspecified Dementia without Behavioral Disturbance and Displaced Comminuted Fracture of Shaft or Humerus, Right Arm, Subsequent Encounter for Fracture with Routine Healing.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/18/2021 coded the resident coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #33 cognitive abilities for daily decision making were

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severely impaired.

In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of two person for bed mobility, transfers, dressing and toilet use. Requiring Extensive assistance of one person with personal hygiene, bathing and locomotion on the unit. Supervision after set-up with eating.

A review of the clinical record on 12/02/21 revealed there were no advance directives in the clinical record on the above resident.

2. The facility staff failed to execute the opportunity to provide an advance directive for Resident #45.

Resident #45 was originally admitted to the facility 03/24/2020 and readmitted 10/10/2021 after an acute care hospital stay. The current diagnoses included; End Stage Renal Disease and Type 2 Diabetes Mellitus.

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 13 out of a possible 15. This indicated Resident #45 cognitive abilities for daily decision making were intact.

In section"G"(Physical functioning) the resident was coded as requiring supervision set-up only with bed mobility, supervision on and off the unit, eating, toilet use and personal hygiene. Requiring one person physical assistance with bathing.

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F 578	Continued From page 12 Requiring limited assistance of one person with bathing and dressing. A review of the clinical record on 12/02/21 revealed there were no advance directives in the clinical record on the above resident. On 12/02/21 at approximately 11:29 AM an interview was conducted with Corporate Staff #1 concerning Advance Directives. She stated, "There were no advance directives. All patients should be at least offered to complete an Advanced Directive on admission, quarterly and annual reviews. It should start with the initial admission contract and then transition to social services." On 12/02/21 at approximately 3:20 p.m., the above findings were shared with the Administrator, The Corporate Consultant, The Social Services Coordinator and The Corporate Clinical Services Specialist. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 578		
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	F 582		1/11/22

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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.

§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

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F 582	Continued From page 14 facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility documentation, the facility staff failed to ensure Medicare Beneficiary Notices in accordance with applicable Federal regulations, were issued to 2 of 3 residents (Resident #7 and Resident #98) in the survey sample. The findings included: 1. The facility staff failed to issue an Advanced Beneficiary Notice (ABN) and Notice of Medicare Provider Non-Coverage (NOMNC) letter to Resident #7 who was discharged from skilled services with Medicare days remaining. Resident #7 was admitted to the nursing facility on 05/28/21. Diagnosis for Resident #7 included but not limited to Cerebral Infarction (stroke) with left hemiplegia (paralysis of one side of the body). Resident #7's Minimum Data Set (MDS) a significant change with an Assessment Reference Date (ARD) date of 08/25/21 coded Resident #7 a 04 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicated severe cognitive impairment. Review of the SNF Beneficiary Notification provided by the facility was noted that Resident #7 was not issued a SNF ABN or NOMNC letter. Resident #7 started Medicare Part A stay on 05/28/21 and the last covered day was on 07/09/21. Resident #7 was discharged from Medicare Part A services when benefit days were not exhausted. Resident #7 had only used 43	F 582	1. Facility failed to ensure notice of discharge (NOMNC) from skilled services for 2 of 45 resident in the facility (#7 and #98). 2.Any resident who resides at the center could be affected if a notice of discharge from Medicare services is not issued. The Social Service Director or designee will audit all residents/patients requiring a NOMNC or ABN in the past 14 days. 3.The Social Service Director or designee will educate the Social Services staff of the requirement to inform Medicaid/Medicare residents when changes in coverage are made as soon as possible through either an Advanced Beneficiary Notice (ABN) or a notice of Medicare Provider Non-Coverage (NOMNC). 4.The Social Service Director or designee will audit all residents/patients requiring a NOMNC or ABN weekly x3 and monthly x3 to identify residents/patients who have been impacted. Findings will be reviewed in QAPI and variances addressed 5. Date of Compliance 1/11/22	

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days of her Medicare Part A services with 57 days remaining. Resident #7 should have been issued a SNF ABN and NOMNC letter.

An interview was conducted with the Social Worker (SW) on 12/01/21 at approximately 11:15 a.m. The SW said Resident #7 should have been issued an ABN and NOMNC letter when discharged from Medicare A services ending on 07/09/21. The SW said he was not able to locate in the resident's clinical record that an ABN or NOMNC letter was every issued when discharged from skill services ending on 07/09/21.

2. Resident #98 was admitted to the nursing facility on 07/19/21. Diagnosis for Resident #98 included but not limited to Cerebral Infarction (stroke) with right hemiplegia (paralysis of one side of the body). Resident #98's Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) date of 11/05/21 coded Resident #98 a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicated no cognitive impairment.

Review of the SNF Beneficiary Notification was noted that Resident #98 was not issued the SNF ABN letter.

Resident #98 started a Medicare Part A stay on 07/09/21, and the last covered day of this stay was 08/16/21. Resident #98 was discharged from Medicare Part A services when benefit days were not exhausted. Resident #98 only used 32 days of her Medicare Part A services with 68 days remaining. Resident #98 should have been issued a SNF ABN and NOMNC. The resident was only issued a NOMNC.

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F 582	Continued From page 16 An interview was conducted with the Social Worker (SW) on 12/01/21 at approximately 11:15 a.m. The SW said only the NOMNC was issued when Resident #98 was discharged from Medicare A services ending on 08/16/21. He said Resident #98 should have been issued an ABN letter along with the NOMNC letter when discharged from skill services ending on 08/16/21. The Administrator, Clinical Service Specialist, Regional RAI Consultant and Clinical Service Specialist were informed of the above findings during the debriefing on 12/01/21 at approximately 1:25 p.m. The facility did not have any further questions or present any further information about the findings. The facility did not have a policy on issuing an ABN or NOMNC letter.	F 582		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623		1/11/22

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(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in

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completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §

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F 623	Continued From page 19 483.70(l). This REQUIREMENT is not met as evidenced by: Based on resident record review, staff interviews and facility document review, the facility failed to notify the Office of the State Long-Term Care Ombudsman in writing of hospital discharges for 2 of 45 residents (Resident #45 and 106) in the survey sample. The findings included; Resident #45 was originally admitted to the facility on 03/24/2020 and readmitted on 10/10/2021 after an acute care hospital stay. The current diagnoses included; End Stage Renal Disease and Type 2 Diabetes Mellitus. 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 13 out of a possible 15. This indicated Resident #45 cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring supervision set-up only with bed mobility, supervision on and off the unit, eating, toilet use and personal hygiene. Requiring one person physical assistance with bathing. Requiring limited assistance of one person with bathing and dressing. On 12/02/21 at approximately 12:23 PM an interview was conducted with OSM (Other Staff Member) #1 concerning The Ombudsman Notification. He stated, "The ombudsman notification was not sent."	F 623	1. It is noted that the Facility failed to send notice to Office of State LTC Ombudsman of hospital transfer or discharge for 2 of 45 residents (#45 and #106). 2. Any resident who resides at the center could be affected if written notification of hospital transfer is not provided to the ombudsman. The Social Services Director or other designee will perform a facility audit of last 14 days to identify other notices that may be impacted. Notice was sent to the state Ombudsman on 12/20/2021 for residents #45 and #106. 3. The Social Services Consultant or other designee will educate the Social Services department of the Policy entitled Notice of Discharge and the Monthly Notice Requirements for Transfer or Discharge to the State LTC Ombudsman. 4. The Social Services Director or designee will complete audits weekly x 3 weeks and monthly x 3 months and will be reviewed in QAPI with variances addressed 5. Date of Compliance 1/11/22.	

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The Discharge MDS assessments was dated for 10/08/21 - discharged with return anticipated. According to the facility's documentation, on 10/08/21 Resident #45 was transported from dialysis to the local hospital.

On 12/02/21 at approximately 3:20 p.m., the above findings were shared with the Administrator, The Corporate Consultant, The Social Services Coordinator and The Corporate Clinical Services Specialist. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.

2. The facility staff failed to ensure the local State Long-Term Care Ombudsman was notified that Resident # 106 was discharged to the hospital on 9/27/21.

Resident #106 was admitted on 7/9/21 with diagnoses to include but not limited to Dementia, Diabetes Mellitus and Anxiety Disorder.

Resident #106's most recent Minimum Data Set (MDS) was a significant change with an Assessment Reference Date (ARD) of 10/14/21. Resident #106's Brief Interview for Mental Status (BIMS) was coded as a 10 out of 15, indicating the resident had mild cognitive impairment but was able to perform some daily decision making.

Resident #106's Clinical Census was reviewed and revealed the resident was discharged on 9/27/21.

Resident #106's Nursing Progress Notes were reviewed and are documented in part, as follows:

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9/27/2021 13:52 (14:52 p.m.)Transfer Out (Acute/Emergency) Reason for transfer: Evaluation of left toes.

9/28/2021 02:15 a.m. Discharge Summary Note Text: A F/U (follow-up) call made to Name (hospital) to check on patient status, Nurse noted patient is admitted to Room 458 for observation pending a surgical procedure.

On 12/2/21 at 11:00 a.m., the facility Social Worker was asked for documentation to show that the local State Long-Term Care Ombudsman was notified that Resident #106 was discharged to the hospital on 9/27/21. The Social Worker was unable to locate any documents that the Ombudsman had been notified of Resident #106's discharge on 9/27/21.

On 12/2/21 at 12:00 p.m. an interview was conducted with the facilities Social Services Care Coordination Specialist regarding documentation that the State Long-Term Care Ombudsman was notified by the facility that Resident #106' was discharged to the hospital on 9/27/21. The Social Services Care Coordination Specialist stated, "We have no documentation to support that the Ombudsman was notified of Name (Resident #106) hospital discharge on 9/27/21. The notifications should be sent monthly. Both of our social workers are new."

The facility policy titled "Notice of Discharge" dated 9/21 was reviewed and is documented in part, as follows:

Policy: Copies of notices for emergency transfers must be sent to the ombudsman, but they may be

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F 623	Continued From page 22 sent when practicable and may be provided in the form of a list of residents on a monthly basis. On 12/2/21 at 3:00 p.m., a pre-exit debriefing was conducted with the Administrator and the acting Director of Nursing where the above information was shared. Prior to exit no further information was shared.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (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	F 625		1/11/22

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F 625	Continued From page 23 described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to offer a bed hold for 1 of 45 Residents, Resident #45. The findings included: For Resident #45 the facility failed to offer the Resident a bed hold when they were discharged to a local hospital. Resident #45 was originally admitted to the facility on 03/24/2020 and readmitted on 10/10/2021 after an acute care hospital stay. The current diagnoses included; End Stage Renal Disease and Type 2 Diabetes Mellitus. 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 13 out of a possible 15. This indicated Resident #45 cognitive abilities for daily decision making were intact. In section "G"(Physical functioning) the resident was coded as requiring supervision set-up only with bed mobility, supervision on and off the unit, eating, toilet use and personal hygiene. Requiring one person physical assistance with bathing. Requiring limited assistance of one person with bathing and dressing. The Discharge MDS assessments was dated for 10/08/21 - discharged with return anticipated. According to the facility's documentation, on 10/08/21 Resident #45 was transported from	F 625	1. The facility failed to extend the Bed Hold Notice to 1of 45 residents #45. 2. Any resident who transfers to the hospital is at risk for not receiving a Bed Hold policy notification. 3. The Director of Admissions or other Designee will audit discharges for the last 14 days of all other residents who may have been impacted by the failure to submit a Bed Hold Notification. Thereafter, audits for Bed Hold Notification will be complete weekly x3 weeks, monthly x 3 months for all discharges and bed hold notices. 4. The Administrator or designee will educate the Admissions Department on the Policy for Bed Hold Notification. Bed hold policy will be reviewed during QAPI and variances addressed 5. Date of Compliance 1/11/22	

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F 625	Continued From page 24 dialysis to the local hospital. The surveyor was unable to locate any information in the Resident's clinical record to indicate a bed hold had been offered. On 12/02/21 at approximately 11:32 AM an interview was conducted with corporate staff #1 concerning the bed hold notice. She stated," No bed hold was sent. It would be expected to be given. Our admissions department would call and offer the bed hold." On 12/02/21 at approximately 3:20 p.m., the above findings were shared with the Administrator, The Corporate Consultant, The Social Services Coordinator and The Corporate Clinical Services Specialist. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 625		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 640		1/11/22

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F 640	Continued From page 25 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to complete the required discharge Minimum Data Set (MDS) assessment within the required timeframe after a	F 640	1. Resident # 2□s MDS with assessment reference date (ARD) of 8/25/2021 was encoded, transmitted and accepted by the CMS databank on	

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F 640	Continued From page 26 planned discharge from the facility for 1of 45 residents (Resident #2), in the survey sample. The findings included; Resident #2 was originally admitted to the facility 7/7/21 and had never been discharged from the facility. The current diagnoses included; gastrointestinal upset related Pancolitis new cardiomyopathy, and heart failure. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/13/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were intact On 12/1/21, during the finalization of the sample the Resident Assessment task triggered for review. It revealed the Centers for Medicare/Medicaid Services (CMS) identified Resident #2 hadn't had a MDS assessment submitted to the MDS databank for more than 120 calendar days. Review of the clinical record revealed a nurse's dated 08/25/2021 at 12:21 p.m., which read; he resident was discharged home today around 11:45am. She was given discharge paperwork including instructions and prescriptions and she verbalized her understanding. She was reminded of her belongings to take home. On 12/1/21 at approximately 4:40 p.m., an interview was conducted with the MDS coordinator who reviewed Resident #2's MDS history. The MDS coordinator stated the clinical	F 640	12/1/2021. 2. Any Resident who has a qualifying MDS that is not encoded, transmitted and accepted in the CMS database has the potential to be affected. A review of the current and discharged resident□s MDSs will be conducted to ensure accurate encoding of the MDS. 3. The interdisciplinary team responsible for encoding MDSs will be educated regarding accurate encoding and transmitting MDSs. 4. MDS coordinator or designee(s) will conduct an audit of 10 completed MDS assessments weekly for four weeks then monthly for two months for encoding and transmitting of MDSs. Results of these audits will be analyzed and discussed for further recommendations during the facilities monthly Quality Assurance process. 5. Date of Compliance: 01/11/2022	

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F 640	Continued From page 27 record revealed Resident #2's discharge MDS Tracking Record was dated 8/25/21 and it required transmittal to the CMS databank. The MDS Coordinator stated at approximately 5:45 p.m., the discharge tracker had been submitted and accepted. CMS's Resident Assessment Instrument Version 3.0 Manual, dated October 2019, Chapter 2, page 2-36 instructions read; the Death in Facility Tracking Record must be completed when the resident dies in the facility and it must be completed within 7 days after the resident's death, which is recorded in item A2000. Discharge Date (A2000 + 7 calendar days). The Tracking Record must be submitted within 14 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 14 calendar days). On 12/1/21 at approximately 5:30 p.m., the above findings were shared with the Administrator and the Director of Nursing. They were afforded the opportunity to present additional information but; they did not.	F 640		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		1/11/22

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F 656	Continued From page 28 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and clinical record review, the facility staff failed to develop and implement a comprehensive person-centered care plan to address the preference of the resident for staff not to pull on her arms/shoulders which introduced pain during bed mobility and transfers for 1 of 45 residents	F 656	1. Resident #39□s comprehensive CP was reviewed and revised on 12/20/2021 to reflect resident□s preference for staff not to pull on her arms which introduced pain during bed mobility and transfers. 2. Any Resident who does not have a comprehensive person-centered care plan	

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F 656	Continued From page 29 (Resident #39), in the survey sample. The findings included: Resident #39 was originally admitted to the facility 4/30/21 and has not been discharged from the facility. The current diagnoses included; postpolio syndrome, chronic pain and multiple rotator cuff repairs. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/26/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #39's cognitive abilities for daily decision making was intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of two people with bed mobility, transfers, and toileting, extensive assistance of one person with personal hygiene, bathing, and dressing, limited assistance of one person with locomotion and supervision of one person with eating. On 12/1/21 at approximately 5:00 p.m., an interview was conducted with Resident #39. The resident stated during the interview that she has had two rotator repair surgeries to both shoulder joints and just a few days ago she received a cortisone injection to bilateral shoulders due to arthritic pain. The resident also stated approximately two weeks ago during a shower on the stretcher bed she almost slipped off and Certified Nursing Assistant (CNA) #2 pulled on her arm to prevent her from falling to the floor. Resident #2 further stated often during transfers from her bed to the chair and to position her in	F 656	consistent with the resident rights has the potential to be affected. A review of the current residents□ care plans will be reviewed and revised to ensure there is an appropriate care plan in place. 3. All Staff that are responsible for comprehensive person-centered care planning will be educated on comprehensive person-centered care planning. 4. The MDS Coordinator or designee(s) will conduct an audit of 10 completed care plans weekly for four weeks then monthly for two months for comprehensive care planning consistent with the resident rights. Results of these audits will be analyzed and discussed for further recommendations during the facility□s monthly Quality Assurance process. 5. Date of Compliance: 01/11/2022	

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F 656	Continued From page 30	F 656		

the bed staff pulls on her arms and it cause them to hurt more than normal. The resident stressed her preference to transfer from the bed to the wheel chair using the sliding board provided by the therapist.

Review of the current care plan with a revision date of 10/1/21 read; (name of the resident) demonstrates the need for activities of daily living (ADL) assistance related to chronic leg pain, Post polio syndrome, bilateral rotator cuff arthropathy with chronic shoulder pain, COPD, and osteoporosis. Resident will at times refused her shower. The goal read; the resident will receive necessary level of ADL assistance through the next review, 12/25/21. The interventions related to transfers read; Provide assistance with transfers as needed.

Another care plan with a revision date of 5/10/21 read; (name of the resident) has pain or potential for pain related to chronic pain, Osteoporosis, post polio syndrome, complain of Spasms of legs. The goal read; comfort level will be achieved and managed to patient's satisfaction through the next review. The interventions included; administer pain medication as ordered. Report signs and symptoms of potential negative side effects. Assess pain level every shift and as needed and apply interventions as needed. Assist with alternate positioning and other diversional activities to relieve pain. Report breakthrough pain and/or unrelieved pain for further assessment and treatment.

Interventions to avoid lifting or pulling on the resident's arms or use of a sliding board for transfers wasn't documented on the care plan or on tools utilized by the direct care staff.

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F 656	Continued From page 31 An interview was conducted with Certified Nursing Assistant (CNA) #2 on 12/1/21 at approximately 7:15 p.m. CNA #2 stated Resident #39 can transfer with staff assistance using a sliding board but there are times when other modes of transfers are necessary such as the Hoyer lift for showers and two people for positioning in bed. An interview was also conducted with the Unit Manager for The Shenandoah Unit on 12/1/21 at approximately 7:45 p.m. The Unit Manager also stated the pulling on the resident's arms would be addressed, rehabilitation services would be asked to assess and staff educated. On 12/2/21 at approximately 5:30 p.m., the above findings were shared with the Administrator, Assistant Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 656		
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 clinical record review, staff interviews, family interview and during a complaint	F 689	1. Resident # 131 no longer resides in center. A review of the last 14 days of falls	1/11/22

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F 689	Continued From page 32 investigation, the facility staff failed to develop and implement person-centered fall safety interventions for 1 of 45, Resident #131, who was experiencing repetitive falls, in the survey sample. Resident #131 was originally admitted to the facility 8/23/21 and discharged to an acute care hospital 922/21. The diagnoses at the time of discharge included; open wound left shin, pressure injury left heel, pressure injury sacrum, diabetic wound left ankle, left 2nd toe, left lateral foot and right foot plantar surface, coronary artery disease, heart failure, a-fib, diabetes a seizure disorder and dementia. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/29/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #131's cognitive abilities for daily decision making was intact. The clinical record revealed on 8/29/21 at 10:30 p.m., Resident #133 was found on the floor beside his bed, he stated that he slid from the bed while looking for his pillow. The resident also stated that he hit his head on the side of the bed and he complained of back pain. The intervention was to ensure frequently used items were within reach. Another clinical record note dated 9/1/21 at 10:00 p.m., revealed Resident #133 was found sitting on the floor next to his bed with his wheel chair next to him, no apparent injury noted. The resident was unable to say when or how it happened. The intervention instituted read; remind the resident to call for assistance when	F 689	were reviewed to ensure that facility implemented person centered fall safety intervention 2. Any resident that has a fall in center is at risk of person-centered fall safety intervention not being implemented. 3. Director of Nursing or designee will educate licensed nursing staffing and clinical nurse leaders on implementation of person center fall safety intervention post fall. 4. The Director of Nursing or designee will audit falls for person center fall safety intervention in resident plan of care 3x week x 2, weekly x 2 than monthly x 2 Findings will be reviewed in QAPI and variances addressed. 5. Date of compliance 1/11/22	

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F 689	Continued From page 33	F 689		

getting out of bed. Activities one to one for 10 minutes. Reminders to the resident were ineffective based on staff interviews.

A clinical note dated 9/14/21 at 12:44 p.m., read; a statement from the resident that he had an intercepted fall last night around 0300 a.m., he described he had tried to repositioned self in bed and ended with his head touching floor and legs tangled up in bed sheet. No swelling or skin discoloration noted to scalp. The intervention read; therapy to continue to evaluate for proper bedside sitting and transfer modalities as indicated.

Another clinical note dated 9/15/21 at 11:21 p.m., read; the Nurse was alerted by Certified Nursing Assistant (CNA) that the resident had an unwitnessed fall. He was found by the CNA sitting on the floor in front of his wheel chair at the foot of his bed. The resident stated he was attempting to pick up his glasses off the floor, but glasses were on his face. The CNA stated she attempted to put the resident to bed three times prior to fall but he refused stating he wanted to finish watching the football game. The intervention instituted was frequent rounding on the resident. During an interview with he Assistant Director of Nursing (ADON) on 12/2/21 at approximately 12:30 p.m., the ADON was unable to clarify specifics regarding frequent rounding.

A clinical note dated 9/17/21 at 8:12 a.m., read; this writer was called to the resident's room by the wound nurse. When this writer got to the room the resident was observed in a crawling position holding unto his wheelchair and when asked what happened he told this writer "I was trying to get into my chair and go to the bathroom". This writer

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F 689	Continued From page 34	F 689		

offered him a urinal but he refused. No injuries noted at this time. The resident's private sitter told this writer the resident stated earlier he was going to put himself on the floor. The resident was up several times during the night. The intervention read; Resident is non-compliant. Labs ordered as indicated. During an interview with the Assistant Director of Nursing (ADON) on 12/2/21 at approximately 12:30 p.m., the ADON was unable to clarify specifics regarding the resident was non-compliant.

An interview was conducted with Registered Nurse (RN) #1 on 12/2/21 at approximately 10:15 a.m. RN #1 stated Resident #131 was often very confused and angered easily. RN #1 stated the resident often stated people were attempting to poison him and in return he would throw his food on the floor or attempt to hit the staff. RN #1 stated the resident could use the call light and sometimes self-propelled his wheel chair. She could recall no fall events on the day shift.

An interview was also conducted with Licensed Practical Nurse (LPN) #8 on 12/2/21 at approximately 10:22 a.m. LPN #8 stated the resident had many short stays at the facility and he had continued to exhibit episodes of confusion and lacked the ability to follow directions consistently. LPN #8 stated the resident thought he could self-transfer but he wasn't capable without assistance yet once he was in the wheel chair he could self-propel it. LPN #8 stated Resident #131 had a high risk for falls because of his cognitive status.

Review of Resident #131's person-centered care

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F 689	Continued From page 35 plan dated 8/24/21 read; (name of resident) had an Actual fall and remain at risk for further fall related to a history of falls,heart failure, A-fib, Gait and balance problem, had wound on left foot, has lower extremities, edema, has tendency to sit at the edge of the bed, increased confusion at night, lack of awareness of safety hazard. The goal read; the resident will not sustain an avoidable fall or injury through the next review and 11/22/21. The interventions included; one to one private sitter times twelve hours beginning 9/20/21, fall mat at bedside when patient in bed (9/14/21), Pharmacy and MD to do med review (9/16/21), When patient is in bed, ensure bedside is free of clutter or safety hazards (9/18/21). On 12/2/21 at approximately 5:30 p.m., the above findings were shared with the Administrator, Assistant Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 689		
	COMPLAINT DEFICIENCY			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility staff failed to ensure the one resident (Resident #93's) Dialysis communication book	F 698	1. It is noted that facility staff failed to provide care and services for a complete	1/11/22

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F 698	Continued From page 36 was updated timely during Dialysis treatments in a survey sample of 43 residents. The findings included: Resident #93 was admitted to the facility on 05/28/15 and re-admitted to the facility on 11/20/21 with diagnoses which included displaced fracture of first cervical vertebra, osteoporosis without current pathological fracture, diabetes, hypothyroidism, stage 5 chronic kidney disease, dementia without behavioral disturbance, type III traumatic spondylolisthesis of seventh cervical vertebra and dependence of renal dialysis. Resident #93 was involved in an accident while being transported to her dialysis appointment on 11/19/21. Resident #93's dialysis communication book had not been updated since 11/19/21. An Annual Minimum Data Set (MDS) dated 11/07/21 assessed this resident in the area of Speech, Vision and Hearing as being able to understand others. In the area of Cognitive Patterns this resident was assessed in the area of Brief Interview for Mental Status (BIMS) as a (04). In the area of Activities of Daily Living (ADL's) this resident was assessed as a (4/3) for bed mobility - total dependence- two person physical assist. In the area of Transfers - this resident was assessed as a 4/3 - two person physical assist. In the area of Ambulation- this resident was assessed as unable to ambulate. Not able to balance self without physical assistance.	F 698	dialysis program for resident #93 Dialysis books updated to include center information. 2. Any resident who received Dialysis could be affected if the facility fails to provide a complete dialysis program and ensure there is effective communication between facilities. 100% audit of all residents who receive dialysis will be audited to ensure the center has implemented a dialysis program for these patients. 3. The Director of Nursing or designee will educate licensed nurses and clinical nurse leaders on dialysis policy including communication. 4. Director of Nursing or designee will audit dialysis patients to ensure dialysis program and dialysis communication books are current and up to date 3x week x 2, weekly x 2 then monthly x 2 Findings will be reviewed in QAPI and variances addressed. 5. Compliance date 1/11/22	

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	495179	A. BUILDING _____ B. WING _____	C 12/02/2021

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F 698	Continued From page 37	F 698		

This resident was assessed as using a wheelchair for mobility with assistance.

A Care Plan dated 08/07/21 indicated: Focus- Resident #93 has pain or potential for pain related to impaired mobility, osteoarthritis and cervical vertebra fracture. Goal- comfort level will be maintained; Interventions- administer pain medication as ordered, note effectiveness, assist with positioning to enhance comfort level.

Focus- Resident is on Antiplatelet therapy/blood thinner placing patient at risk for bleeding/brushing. Goal- Resident will not have an avoidable negative outcome from antiplatelet/blood thinner therapy. Interventions- Use extra precautions when providing ADL care and treatment to prevent bleeding or brushing problems.

Focus- Resident has renal Disease requiring dialysis - Goal- Resident #93 will receive dialysis services as ordered with no avoidable negative effects. interventions- Coordinate with Dialysis center for dialysis treatment as ordered. Communicate with dialysis provider regularly via pre/post treatment notes.

A Physician's order dated 11/21/21 indicated: " Dialysis treatment MWF."

A Dialysis Communication Sheet dated 11/19/21 indicated: Weight -pre- 39.0 Weight Post - blank - Labs - No, Change in Condition- None, Changes in medication- none, Diet to Center- blank, Nutrition % Taken - , Signature (NS). Observation of the communication sheet on 12/02/21 did not indicate any communication of Resident #93's accident was recorded. There was no indication

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F 698	Continued From page 38 that Resident #93 did not receive Dialysis treatment on 11/19/21 and was transported to the hospital via 911 on this date. There was no additional communication in the Dialysis Communication Book after the entry of 11/19/21. During an interview on 12/02/21 at 11:05 a.m. with the Second Floor Unit Manager, she stated, that was all the documentation. Resident #93 continued to receive dialysis treatments on MWF.	F 698		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility document review, the facility staff failed to ensure 1 of 45 residents (Resident #74) in the survey sample were free of significant medication error. The findings included: The facility staff failed to ensure the following significant medication (Pregabalin) was administered to Resident #74 on 11/27/21 (3-11 shift) and 11/28/21 (7-3 and 3-11 shift). Resident #74 was admitted to the nursing facility on 10/18/21. Diagnosis for Resident #74 included but not limited to Fibromyalgia and fracture of right fibula. Resident #74's Minimum Data Set (MDS - an assessment protocol) an annual assessment with an Assessment Reference Date of 10/23/21	F 760	1. Resident #74 physician notified that medication was not administer per MD order. RN #1 was re-educated on the rights of medication administration. Resident #74 medical record updated with physician notification no untoward effects to resident noted. 2. Any resident with orders for controlled substance is at risk of medication not being administer per MD order. Any resident that receive controlled medication may be impacted if staff fail to clarify the orders, access control box stat box, cubex or obtain hard script from Physician. A 100% audit of all patients in past 7 days was performed to identify any other patients who may be impacted. 3. DON or designee will educate Licensed nurses and clinical nurse leaders will be educated on the Center□s	1/11/22

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F 760	Continued From page 39 coded Resident #74's Brief Interview for Mental Status (BIMS) scored a 13 out of a possible score of 15 indicating no cognitive skills for daily decision-making. Resident #74's person-centered care plan with a revision date 10/25/21 documented resident has pain or potential for pain due to recent fall with fracture and skin breakdown. The goal set for the resident by the staff is to maintain comfort level will be achieved and managed to patient's satisfaction through next review (01/17/22). One intervention/approaches to manage goal included to administer pain medication as ordered and to report sign/symptoms of potential negative side effects. During the review of Resident #74's Controlled Drug Receipt/Record/Disposition Form with License Practical Nurse (LPN) #1 revealed Resident #74's routine Pregabalin capsule 50 mg was not signed off as being administered on the following days: 11/27/21 (3-11 shift) and 11/28/21 (7-3 and 3-11 shift). When asked if Resident #74 received her scheduled Pregabalin capsule 50 mg on the days mentioned, she replied, "It does not appear that she did because the narcotic count is correct." Review of the November 2021 Order Summary Report revealed the following order: Pregabalin 50 mg - give 1 capsule by mouth two times a day for Neuropathy pain. During the review Control Drug Record Disposition Form revealed the medication Pregabalin 50 mg was not administered on the following scheduled days: 11/27/21 at 9:00 p.m., 11/28/21 at 9:00 a.m., and 11/28/21 at 9:00 p.m.	F 760	process for medication administration. 4. The Director of Nursing or Designee will audit 20% of resident that receive controlled medication to ensure proper medication administration and physician order followed 3x week x 2, weekly x 2 than monthly x 2 Findings will be reviewed in QAPI and variances addressed. 5. Date of compliance 1/11/22	

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F 760	Continued From page 40	F 760		

An interview was conducted with Resident #74 on 11/30/21 at approximately 2:30 p.m., who denies pain or discomfort. When asked if she receives her scheduled pain medication (Pregabalin) as ordered by the physician, she replied, "Yes, I believe so."

On 12/02/21 at approximately 12:15 p.m., an interview was conducted with Registered Nurse (RN) #1 and the Assistant Director of Nursing (ADON). RN #1 was assigned to administer Resident #74 with her scheduled Pregabalin on 11/28/21 (7-3 shift). The RN and ADON reviewed and compared the November 2021 MAR to the November 2021 Control Drug Record Disposition Form for the administration of Pregabalin 50 mg capsule for Resident #74. After they reviewed the two documents, the ADON stated, "Resident #74's Pregabalin was not administered on 11/27/21 (3-11 shift) and 11/28/21 (7-3 or 3-11) shift. The ADON said the Control Drug Record Disposition Form went from 11/27/21 (7-3 shift) to 11/29/21 indicating Resident #74 did not receive her scheduled Pregabalin on the days mentioned because the Control Drug Record count is correct.

On 12/01/21 at approximately 1:25 p.m., the above findings were discussed with Administrator, Clinical Service Specialist, Regional RAI Consultant and Clinical Service Specialist. The Administrator stated, "The expectation is for the nurses to administer medication as ordered by the physician and/or Nurse Practitioner."

Definitions
1. Fibromyalgia is a condition characterized by pain in your muscles and fibrous tissues (such as

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F 760	Continued From page 41 the tendons and ligaments), accompanied by fatigue, low mood, and sleep problems (https://www.drugs.com/condition/fibromyalgia.html). 2. Pregabalin is used to treat pain caused by nerve damage due to diabetes, shingles (herpes zoster) infection, or spinal cord injury (www.webmd.com).	F 760		
F 761 SS=E	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 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	F 761		1/11/22

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F 761	Continued From page 42 by: Based on observation and staff interviews the facility staff failed to ensure medications were labeled and stored in accordance with currently accepted professional principles in 1 out of 4 facility medication carts and 1 out of 2 medication refrigerators. The facility staff failed to ensure one Lantus insulin pen and antibiotic eye drop (Neo/poly ointment) were dated once opened. The facility staff failed to ensure a multi-dose vial of PPD vaccine was dated once opened. The findings included: A. On 12/30/21 at approximately 2:20 p.m., the medication cart on Alleghery Unit (cart 1) was inspected with License Practical Nurse (LPN) #4. Stored inside the medication cart was an open Lantus (insulin) pen and antibiotic eye drop (Neo/poly ointment) without an open date. The LPN was asked, "When was the insulin pen and antibiotic eye drops open" she replied, "I have no way of knowing since they (insulin and eye drop) does not have a date indicating when they were open. The LPN said, since the insulin and eye drops do not have an open date, they need to be thrown away and a new insulin pen and eye drop need to be ordered. On 12/01/21 at approximately 1:25 p.m., the above findings were discussed with Administrator, Clinical Service Specialist, Regional RAI Consultant and Clinical Service Specialist. The Clinical Service Specialist stated, "All insulin and eye drops are to be dated once open." B. On 11/30/21 at approximately @ 10:30 a.m., the medication refrigerator was inspected on the	F 761	1. It is noted that facility failed to label and store medication correctly in medication carts and refrigerators: Lantus, antibiotic eyedrops (neo-poly eyedrops) and PPD vaccine discarded on 12/2/21 2. Any resident who resides at the facility could be affected if the facility fails to provide proper labeling and storage of drugs. 3. The Director of Nursing or Designee will educate licensed nursing staff and clinical leaders on proper storage and labeling of drugs. 4. Director of Nursing or designee will audit drug storage and labeling 3x week x 2, weekly x 2 than monthly x 2 Findings will be reviewed in QAPI, and variances addressed 5. Compliance date is 1/11/22	

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F 761	Continued From page 43	F 761		

Tidewater Unit (cart 2) with License Practical Nurse (LPN) #1. Stored inside the medication refrigerator was an open multidose vial of Aplisol (PPD) vaccine without a date when opened. The LPN stated the vial of PPD should have been dated once it was opened. The LPN said since the vial is not dated, there is no way of knowing how long the vial has been in the refrigerator. When asked, how long is PPD solution is good for once opened, she replied, "30 days." The LPN stated, "The PPD solution need to be dated once open, so the nurse's will know when the vial was first open and when the PPD solution need to be thrown away."

On 12/01/21 at approximately 1:25 p.m., the above findings were discussed with Administrator, Clinical Service Specialist, Regional RAI Consultant and Clinical Service Specialist. The Clinical Service Specialist stated, "PPD solution is to be dated once open."

Definitions
1. Lantus (insulin glargine) is a man-made form of a hormone that is produced in the body. Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood. Insulin glargine is long-acting insulin that starts to work several hours after injection and keeps working evenly for 24 hours. Storing opened (in use) Lantus: Store the injection pen at room temperature (do not refrigerate) and use within 28 days (www.drugs.com/lantus.html).

2. Neo/poly ointmentmedication is used to treat or prevent bacterial eye infections (https://www.webmd.com/drugs/2/drug-3896/neo-poly-bac-hc-ophthalmic-eye/details).

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F 761	Continued From page 44 3. Aplisol (tuberculin PPD, diluted) is a sterile aqueous solution of a purified protein fraction for intradermal administration as an aid in the diagnosis of tuberculosis. 4. Manufacture Guidelines: Aplisol (PPD) vials should be inspected visually for both particulate matter and discoloration prior to administration and discarded if either is seen. Vials is use for more than 30 days should be discarded due to possible oxidation and degradation which may affect potency.	F 761		
F 812 SS=D	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 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of the facility's policy, the facility staff failed	F 812	1. The facility failed to store food in accordance with professional standards	1/11/22

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F 812	Continued From page 45 to store food under sanitary conditions. The finding included; On 12/01/21 at approximately 11:00 AM., during a follow up visit to the kitchen with OSM/CDM (Other Staff Member/Certified Dietary Manager) #5. An inspection of the dairy cooler was made. Located inside of the dairy cooler were multiple cartons of milk and spilled milk with a strong odor. The CDM stated, "A staff member normally keep the cooler clean but due to the Thanksgiving holiday it was not cleaned. He usually cleans it once a week." On 12/02/21 at approximately 3:20 p.m., the above findings were shared with the Administrator, The Corporate Consultant, The Social Services Coordinator and The Corporate Clinical Services Specialist. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 812	for food service safety. Cooler was cleaned and milk cartons were discarded upon notification. 2. Any resident residents at the facility is at risk of being affected by improper storage of food. A 100% audit of food storage areas was completed to identify potential areas of risk. 3. The Dietary manager or designee will provide education on routine cleaning and maintenance of sanitary work environment to ensure proper storage of food. 4. The Dietary Manager or designee will audit/monitor cleaning schedule daily x3 weeks; weekly x 3 weeks; monthly x3 months. Findings will be reviewed in QAPI and variances addressed. 5. Compliance date 1/11/22	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842		1/11/22

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F 842	Continued From page 46	F 842		

professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

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

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F 842	Continued From page 47 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record for 1 of 45 residents (Resident #74) in the survey sample. The findings included: The facility staff failed to ensure Resident #74's Medication Administration Record (MAR) was accurate for the administration of a scheduled pain medication Pregabalin. Resident #74 was admitted to the nursing facility on 10/18/21. Diagnosis for Resident #74 included but not limited to Fibromyalgia and fracture of right fibula. Resident #74's Minimum Data Set (MDS - an assessment protocol) an annual assessment with an Assessment Reference Date of 10/23/21 coded Resident #74's Brief Interview for Mental Status (BIMS) scored a 13 out of a possible score of 15 indicating no cognitive skills for daily decision-making.	F 842	1. Resident #74 medical record corrected to reflect correct medication administration. RN #1 was re-educated on complete and accurate documentation in EMAR. 2. Any resident with orders for controlled substance medication order are risk of inaccurate documentation on EMAR. A 100% audit of all patients in past 7 days was performed to identify any other patients who may be impacted. 3. The DON or designee will educate licensed nursing staff on complete and accurate documentation on the EMAR. 4. The Director of Nursing or Designee will audit 20% of resident that receive controlled medication to ensure the resident EMAR documentation is complete and accurate. 3x week x 2, weekly x 2 than monthly x 2 Findings will be reviewed in QAPI, and variances addressed 5. Date of compliance 1/11/22	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POTOMAC FALLS HEALTH & REHAB CENTER	46531 HARRY BYRD HIGHWAY STERLING, VA 20164

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Resident #74's person-centered care plan with a revision date 10/25/21 documented resident has pain or potential for pain due to recent fall with fracture and skin breakdown. The goal set for the resident by the staff is to maintain comfort level will be achieved and managed to patient's satisfaction through next review (01/17/22). One intervention/approaches to manage goal included to administer pain medication as ordered and to report sign/symptoms of potential negative side effects.

During the review of Resident #74's Controlled Drug Receipt/Record/Disposition Form with License Practical Nurse #1 revealed Resident #74's routine Pregabalin capsule 50 mg was not signed off as being administered on the following days: 11/27/21 (3-11 shift) and 11/28/21 (7-3 and 3-11 shift). When asked if Resident #74 received her scheduled Pregabalin capsule 50 mg on the days mentioned, she replied, "It does not appear that she did because the narcotic count is correct."

During the review Control Drug Record Disposition Form revealed the medication Pregabalin 50 mg was not administered on the following days: 11/27/21 at 9:00 p.m., 11/28/21 at 9:00 a.m., and 11/28/21 at 9:00 p.m.

During the review of Resident #74's (MAR) for November 20201 revealed the following order: Pregabalin 50 mg - give 1 capsule two times a day at 9:00 a.m., and 9:00 p.m., for neuropathy pain. Further review of the MAR revealed the nurse's had signed off that Pregabalin 50 mg was administered on the following days: 11/27/21 at 9:00 p.m., 11/28/21 at 9:00 a.m., and 11/28/21 at 9:00 p.m.

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On 12/02/21 at approximately 12:15 p.m., an interview was conducted with Registered Nurse (RN) #1 and the Assistant Director of Nursing (ADON). RN #1 was assigned to administer Resident #74 with her scheduled Pregabalin on 11/28/21 (7-3 shift). The RN and ADON reviewed and compared the November 2021 MAR to the November 2021 Control Drug Record Disposition Form for the administration of Pregabalin 50 mg capsule for Resident #74. After they review the two documents, the ADON stated, "Resident #74's Pregabalin was not administered on 11/27/21 (3-11 shift) and 11/28/21 (7-3 or 3-11) shift. The ADON said the control sheet goes from 11/27/21 (7-3 shift) to 11/29/21 indicating Resident #74 did not receive her scheduled Pregabalin on the days mentioned because the Control Drug Record count is correct. When asked if the MAR was accurate, the ADON replied, "No."

On 12/01/21 at approximately 1:25 p.m., the above findings were discussed with Administrator, Clinical Service Specialist, Regional RAI Consultant and Clinical Service Specialist. The facility did not have any further questions or present any further information about the findings

Definitions
1. Fibromyalgia is a condition characterized by pain in your muscles and fibrous tissues (such as the tendons and ligaments), accompanied by fatigue, low mood, and sleep problems (https://www.drugs.com/condition/fibromyalgia.html).

2. Pregabalin is used to treat pain caused by nerve damage due to diabetes, shingles (herpes

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F 842	Continued From page 50 zoster) infection, or spinal cord injury (www.webmd.com).	F 842		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and review of facility documents, the facility's staff failed to have the call bell accessible and functional for resident's use. For 1 of 45 residents (Resident #47), in the survey sample. The Findings included; Resident #47 was originally admitted to the facility 11/26/19 and readmitted 09/23/21 after an acute care hospital stay. The current diagnoses included; Fracture of Upper and Lower End of the Right Fibula and Hypertensive Heart Disease with Heart Valve. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/06/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #47cognitive abilities for daily decision making were intact.	F 919	1. Resident #47 call bell repaired 12/1/21 2. Any resident is at risk of call bell malfunction. 100% audit of all resident call bells was completed on 12/17/21. 3. The Director of Nursing or designee will educate center staff on call bell function and repair, reporting malfunction immediately and providing an alternate method of calling pending repair. 4. Director of Nursing or designee will audit 5 residents per unit call bell function 5x a week for 4 weeks and monthly x2 and report findings to QAPI committee with any variances addressed. 5. Date of compliance is 1-11-22	1/11/22

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In section "G"(Physical functioning) the resident was coded as requiring extensive assistance one person assistance with bed mobility, dressing eating, toilet use, personal hygiene and bathing. Extensive assistance of two persons with transfers.

On 12/01/21 at approximately 10:21 AM an interview was conducted with Resident #47 concerning her care. She stated, "I am hurting can you please get my nurse," She was asked by the said surveyor to push her call bell to notify nursing staff of her pain. Resident #47 then stated, "I can't use my right hand well do to having a stroke." The call bell was observed clamped to the sheet near Resident's left shoulder. The said surveyor pushed the call bell but noticed the light on the wall didn't light up. The surveyor informed resident that she will let the nurse know that she needs her.

On 12/01/21 at approximately 10:25 AM., Licensed Practical Nurse (LPN) #3 was notified that resident needed assistance and immediately entered the room. She repositioned the resident and reminded her that she had given her pain medication almost an hour ago. She pushed the call bell and notice that it was only working if pushed from the wall.

LPN #2 entered room shortly there after (10:26 AM) stating that she will let maintenance know that the call bell isn't working. The call light would only work if pushed at the wall. Resident is not close to the wall.

Call Bell Timeline below reads:

12/01/21 12:07 PM Surveyor entered room. Call

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bell not working. Call bell not within reach. No substitute given.

12/01/21 1:02 PM entered Resident's room (Surveyor). Call bell still not working. No alternative call system given to resident to alert staff was seen.

12/01/21 at approximately 1:05 PM, LPN #2 states that she put the order in and had called maintenance. No substitute call bell was observed.

12/01/21 1:35 PM Followed up on nurse LPN #3 concerning call bell. Asked her if she would follow up with surveyor once maintenance repairs the call bell. She stated that she will call downstairs to try to get maintenance. She also stated that the resident's nurse is on another unit but will return later.

12/01/21 1:50 PM Nurse informed me that maintenance is in the residents' room fixing her call bell. Spoke to maintenance (OSM/Other Staff Member) #3 he stated, "The call bell unit had to be replaced from the wall with new cord.

On 12/01/21 at approximately, 1:55 PM an interview was conducted with LPN #2 and LPN #3. They were asked moving forward what should have been done concerning Resident #47 and her call bell. LPN #3 stated, that she would have continued to call maintenance. They were also asked if they could have offered resident an alternative to the call bell. LPN #2 stated. "I checked on the resident often." LPN #3 stated, "We could have used a bell."

A review of the call bell work order reads: Created

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on 12/01/21 at 10:22 AM. Time Log: 30 minutes by OSM #3. OSM #3: The light was broken inside and then I replaced the plate and the cord for the call light.

The facility's policy: Call Lights: Accessibility and Timely Response. Dated: 06/01/21. Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. 5. With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed. 6. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. (Examples include: replace "call light", provide a bell or whistle, increase frequency of rounding, etc.)

On 12/02/21 at approximately 3:20 p.m., the above findings were shared with the Administrator, The Corporate Consultant, The Social Services Coordinator and The Corporate Clinical Services Specialist. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.