STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495011	A. BUILDING _____ B. WING _____	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (ALEXANDRIA)	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/19/22 through 1/20/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/19/22 through 1/20/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 90 certified bed facility was 72 at the time of the survey. The survey sample consisted of 28 current resident reviews and six closed record reviews.	F 000		
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 observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure call bell placement within resident reach for one of 34 residents in the survey sample, Resident #60. During observation on 1/19/22, Resident #60's call bell was out of reach.	F 558	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center□s allegation of	2/3/22

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

Electronically Signed | 02/03/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 1 The findings include: Resident #60 was admitted to the facility on 12/28/21 with diagnoses including multiple sclerosis (1) and history of a stroke. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/1/22, Resident #60 was coded as being moderately impaired for making daily decisions. She was coded as requiring the assistance of staff for bed mobility and transfers. On 1/19/22 at 1:17 p.m. and 3:49 p.m., Resident #60 was observed lying in bed. No call bell cord was visible. When interviewed about the call bell, Resident #60 stated she did not know where it is, and had not seen it all day. A review of Resident #60's comprehensive care plan dated 12/28/21 failed to reveal information related to the resident's call bell positioning. On 1/19/22 at 3:50 p.m., LPN (licensed practical nurse) #1 was asked to locate Resident #60's call bell. She looked on both sides of the bed, and did not initially find the call bell. LPN #1 eventually moved the privacy curtain and discovered the call bell lying on the floor behind the resident's bedside table. She cleaned the call bell and placed it within the resident's easy reach. LPN #1 stated every staff member should look for the call bell every time they enter a resident's room. She admitted she had not looked for Resident #60's call bell at all during her shift since 7:00 a.m. LPN #1 stated a resident needs the call bell accessible to help provide for safety if the resident needs anything.	F 558	compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Corrective Action: Upon notification, resident #60 call bell/ light was placed within reach immediately. Identification: 100 percent audit completed to ensure that all residents call bell/ light were within reach. System Change: Staff will be re-educated on ensuring resident call bell/ light are within reach. Monitoring: Facility Administrator and/ or designee will round rooms to ensure that residents call bell/ lights are within reach 5 residents daily x5, weekly x4, and monthly x2 to ensure compliance. Date of Compliance: 2/24/2022 Per request of state agency, this POC has been resubmitted.	

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F 558	Continued From page 2 On 1/20/22 at 12:21 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated the resident's call bell should always be located next to the resident's bed, within reach. CNA #1 stated accessibility is important so the resident can contact the staff quickly. On 1/20/22 at 4:06 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, the were informed of these concerns. A review of the facility policy, "Call Light," revealed, in part: "Always position call light conveniently for use and within reach. A clip may be used to secure the light." No further information was provided prior to exit. REFERENCES (1) "Multiple sclerosis (MS) is a disease of the central nervous system. In MS the body's immune system attacks myelin, which coats nerve cells. Symptoms of MS include muscle weakness (often in the hands and legs), tingling and burning sensations, numbness, chronic pain, coordination and balance problems, fatigue, vision problems, and difficulty with bladder control. People with MS also may feel depressed and have trouble thinking clearly." This information is taken from the website https://nccih.nih.gov/health/multiple-sclerosis.	F 558		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality.	F 583		2/3/22

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F 583	Continued From page 3 The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that facility staff failed to provide curtains, shades or blinds on Resident # 21's room window to promote personal privacy for one of 34 residents in the	F 583	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State	

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F 583	Continued From page 4 survey sample. The findings include: Resident # 216 was admitted to the facility with diagnoses that included but were not limited to: heart disease, swallowing difficulties and muscle weakness. Resident # 21's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/14/2021, coded Resident # 21 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Resident # 14 was coded as requiring supervision of one staff member for ADLs [activities of daily living]. On 01/19/22 at 1:03 p.m. an observation of Resident # 21 revealed they were sitting on the side of the bed. Resident # 21 stated that they did not have any window curtains. Observation of Resident # 21's room window reveal that there were no curtains, shades or blinds on the window. Observation of the window revealed a view to the neighboring community center. On 01/19/22 at 2:27 p.m., an observation of Resident # 21's room window reveal that there were no curtains, shades or blinds on the window. Observation of the window revealed a view to the neighboring community center. On 01/19/22 at 4:12 p.m., an observation of Resident # 21's room window reveal that there were no curtains, shades or blinds on the window. Observation of the window revealed a view to the neighboring community center.	F 583	regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Corrective Action: Upon notification, facility immediately provided blinds in resident #21 room in order to promote personal privacy. Identification: 100 percent audit completed to ensure that all resident rooms contained curtain, shades, or blinds to promote personal privacy. System Change: Staff will be re-educated on promoting personal privacy to include curtains, shades, or blinds on the window. Monitoring: Maintenance Director and/ or designee will round on 5 resident rooms for blinds daily x5, weekly x4 and monthly x2 to ensure compliance. Date of Compliance: 2/24/2022	

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F 583	Continued From page 5	F 583		

On 01/20/22 at 8:17 a.m., an observation of Resident # 21's room window reveal that there were no curtains, shades or blinds on the window. Observation of the window revealed a view to the neighboring community center.

On 01/20/22 at 9:59 a.m., an interview was conducted with Resident # 21, regarding not having blinds, shades or curtains for their window. Resident # 21 stated, "It's a violation of my privacy. I would feel more private if I had curtains." Resident # 21 further stated that they have not had curtains for the past 2 years. When asked if they have privacy while changing, Resident # 21 stated, "I have to go into the bathroom to have privacy."

On 01/20/2022 at approximately 10:35 a.m., an interview and observation of Resident # 21's room window was conducted with RN [registered nurse] #1, unit manager. After observing the window RN # 1 stated that they were not aware that Resident # 21 did not have curtains, shades or blinds on Resident # 21's room window. When asked how privacy was being provided for Resident # 21, RN # 1 stated, "It can't be." When asked if Resident # 21 was entitled to privacy in her room from the outside RN # 1 stated yes.

On 01/20/2022 at approximately 10:45 a.m., an interview and observation of Resident # 21's room window was conducted with OSM [other staff member] # 1, director of maintenance. After observing the window OSM # 1 stated that the previous set of blinds that were installed on the window were broke and removed and that another set of custom measured and cut blinds had been ordered but had not been received.

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F 583	Continued From page 6 When asked how long Resident # 21's window did not have a covering to provide privacy, OSM # 1 stated, "A couple of weeks." When asked if the facility could have provided some sort of window covering to promote Resident # 21's privacy OSM # 1 stated that they were going to go out now to [Name of Store] to get a set of blinds and install them that afternoon. On 01/20/2022 at approximately 4:06 p.m., during the end of the day meeting, ASM [administrative staff member] # 1, administrator, ASM # 2, director of clinical services, ASM # 3, Quality Assurance Consultant, were made aware of the above findings. When asked if the facility could have provided some sort of window covering to promote Resident # 21's privacy until the blinds that were ordered arrived at the facility ASM # 3 stated yes. No further information was provided prior to exit.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		2/3/22

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F 584	Continued From page 7 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to maintain a clean, home like environment for two of 34 residents in the survey sample, Resident #73 and Resident #216. The facility staff failed to change the resident's bloody draw sheet on 1/19/22 and 1/20/22, and failed to ensure Resident # 21's room window had curtains or a shade to provide privacy and a home like environment.	F 584	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	

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F 584	Continued From page 8 The findings include: 1. Resident #73 was admitted to the facility on 12/21/21 with diagnoses including heart failure and diabetes. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/27/21, Resident #73 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). The resident was coded as requiring the extensive assistance of two staff members for bed mobility, and as being dependent on two staff members for transfers from bed to chair. On the following dates and times, 1/19/22 at 1:27 p.m.; 1/19/22 at 3:54 p.m.; 1/20/22 at 8:16 a.m., Resident #73 was observed lying in bed. Underneath him was a draw sheet; the sheet was observed to have a round spot of blood approximately five centimeters in diameter on the left lower edge. Resident #73 declined to be interviewed during the survey. A review of Resident #73's comprehensive care plan dated 12/22/21 revealed no information related to maintaining a clean, comfortable, home like environment. On 1/22/22 at 11:38 a.m., LPN (licensed practical nurse) #1 was interviewed regarding the last time she had checked Resident #73's bed linens. LPN #1 stated she could not remember. She stated she took care of Resident #73 on the previous day shift, and she was taking care of him on the current day shift. She stated if a draw sheet has	F 584	(a) Corrective Action: Upon notification, facility changed resident #73 draw sheet with blood stain in order to promote clean, comfortable, and homelike environment. Identification: 100 percent audit completed on all resident rooms to ensure no blood stains on draw sheet were identified. System Change: Staff will be re-educated on ensuring each resident has a safe, clean, comfortable, and homelike environment to include changing draw sheet if blood stain identified. Monitoring: Administrator and/or designee will round 5 resident rooms for blood stains on draw sheet daily x5, weekly x4 and monthly x2 to ensure compliance Date of Compliance: 2/24/2022 (b) Corrective Action: Upon notification, facility immediately provided blinds in resident #21 room in order to promote homelike environment. Identification: 100 percent audit completed on all resident rooms to ensure blinds were provided System Change: Staff will be re-educated on Safe, clean, comfortable, and homelike environment to include blinds on the window.	

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F 584	Continued From page 9 blood on it, the sheet should be changed immediately. LPN #1 stated she did not know where the blood came from, and she could make sure the sheet was changed immediately. When asked if a bloody bed linen is a part of a home like environment for a resident, LPN #1 stated it is not. On 1/20/22 at 12:21 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated she was currently taking care of Resident #73. She stated she had not noticed the bloody spot on his draw sheet until a few minutes ago. CNA #1 stated if she had noticed it when she made rounds earlier in the shift, she would have changed it immediately. She stated a bloody bed linen does not provide a home like environment for a resident. On 1/20/22 at 4:06 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, the were informed of these concerns. A review of the facility policy "Focus on F Tag 584," revealed, in part: "'Environment' refers to any environment in the facility that is frequented by residents, including...the residents" rooms...The concept of creating a home setting includes...practices that can be eliminated to decrease the institutional character of the environment...furniture that does not reflect a home-like environment." No further information was provided prior to exit. 2. Resident # 216 was admitted to the facility with diagnoses that included but were not limited to:	F 584	Monitoring: Maintenance Director, Administrator, and/or designee will round 5 resident rooms for blinds on the window daily x5, weekly x4 and monthly x2 to ensure compliance. Date of Compliance: 2/24/2022	

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F 584	Continued From page 10	F 584		

heart disease, swallowing difficulties and muscle weakness.

Resident # 21's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/14/2021, coded Resident # 21 as scoring a 14 on the brief interview for mental status (BIMS) of a score of o - 15, 14 - being cognitively intact for making daily decisions. Resident # 14 was coded as requiring supervision of one staff member for ADLs [activities of daily living].

On 01/19/22 at 1:03 p.m. an observation of Resident # 21 revealed they were sitting on the side of the bed. Resident # 21 stated that they did not have any window curtains. Observation of Resident # 21's room window reveal that there were no curtains, shades or blinds on the window. Observation of the window revealed a view to the neighboring community center.

On 01/19/22 at 2:27 p.m., an observation of Resident # 21's room window reveal that there were no curtains, shades or blinds on the window. Observation of the window revealed a view to the neighboring community center.

On 01/19/22 at 4:12 p.m., an observation of Resident # 21's room window reveal that there were no curtains, shades or blinds on the window. Observation of the window revealed a view to the neighboring community center.

On 01/20/22 at 8:17 a.m., an observation of Resident # 21's room window reveal that there were no curtains, shades or blinds on the window. Observation of the window revealed a view to the neighboring community center.

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F 584	Continued From page 11	F 584		

On 01/20/22 at 9:59 a.m., an interview was conducted with Resident # 21, regarding not having blinds, shades or curtains for their window. Resident # 21 stated, "It's a violation of my privacy. I would feel more private if I had curtains." Resident # 21 further stated that they have not had curtains for the past 2 years. When asked if they have privacy while changing, Resident # 21 stated, "I have to go into the bathroom to have privacy."

On 01/20/2022 at approximately 10:35 a.m., an interview and observation of Resident # 21's room window was conducted with RN [registered nurse] #1, unit manager. After observing the window RN # 1 stated that they were not aware that Resident # 21 did not have curtains, shades or blinds on Resident # 21's room window. When asked if the lack of window covering provide a homelike environment, RN # 1 stated no.

On 01/20/2022 at approximately 10:45 a.m., an interview and observation of Resident # 21's room window was conducted with OSM [other staff member] # 1, director of maintenance. After observing the window OSM # 1 stated that the previous set of blinds that were installed on the window were broke and removed and that another set of custom measured and cut blinds had been ordered but had not been received. When asked how long Resident # 21's window did not have a covering to provide privacy OSM # 1 stated, "A couple of weeks." When asked if the facility could have provided some sort of window covering to promote Resident # 21's privacy OSM # 1 stated that they were going to go out now to [Name of Store] to get a set of blinds and install them that afternoon.

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PROMEDICA SKILLED NURSING AND REHAB (ALEXANDRIA)	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 12 On 01/20/2022 at approximately 4:06 p.m., during the end of the day meeting, ASM [administrative staff member] # 1, administrator, ASM # 2, director of clinical services, ASM # 3, Quality Assurance Consultant, were made aware of the above findings. When asked if the facility could have provided some sort of window covering for Resident # 21's room window until the blinds that were ordered arrived at the facility ASM # 3 stated yes. The facility's policy "Focus on F Tag 584" documented in part, "This concept of creating a home setting includes the elimination of institutional odors, and practices to the extent possible. Some practices that can be eliminated to decrease the institutional character of the environment include, but are not limited to, the following: Furniture that does not reflect a home-like environment or is uncomfortable; the absence of window treatments or drapes; the lack of textures or the absence of bedspreads or personal items in rooms or on walls." No further information was provided prior to exit.	F 584		
F 656 SS=D	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	F 656		2/3/22

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F 656	Continued From page 13 assessment. The comprehensive care plan must 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 staff interview, facility document review, and clinical record review, it was determined the facility staff failed to develop and/or implement the comprehensive care plan for five of 34 residents in the survey sample, Residents #69, #16, #45, #60 and #73.	F 656	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will	

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F 656	Continued From page 14 The facility staff failed to implement Resident #69's comprehensive care plan intervention to for non-pharmacological intervention for pain management prior to administering pain medication on 1/12 and 1/16/2022; failed to develop a comprehensive care plan for Resident #16's behavior of wandering as assessed and triggered for care planning on the MDS (minimum data set) with and ARD (assessment reference date) of 11/2/2021 resident assessment; failed to implement Resident # 45's comprehensive care plan intervention for checking the thrill and bruit [1], and failed to develop a care plan for Resident #60's anticoagulant use and to include Resident #73's Foley catheter (1). The findings include: 1. Resident #69 was admitted to the facility on 5/17/2018 with diagnoses that included but were not limited to: stroke (abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and resulting symptoms - sudden loss of ability to move a body part [as an arm or parts of the face], or to speak, paralysis weakness or if severe, death) (1), diabetes, and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment with an assessment reference date of 12/28/2021, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. In Section J0100, the resident was coded as receiving scheduled pain regimen. The resident was coded as stating she had no pain at	F 656	take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. (a) Corrective Action: Upon notification, interdisciplinary team reviewed and developed #69 care plan regarding implementation of non-pharmacological intervention for pain management and one on one in-service completed with employee regarding implementing a non-pharmacological intervention for pain management prior to administering pain medication. Identification: 100 percent audit completed all residents with care plans for non-pharmacological interventions. System Change: Staff will be re-educated on following and implementing a non-pharmacological intervention for pain management prior to administering pain medication. Monitoring: DON and/or designee will monitor 5 residents with care plans for non-pharmacological interventions daily x5, weekly x4 and monthly x2 to ensure staff are implementing a non-pharmacological intervention for pain management prior to administering pain medication to ensure compliance.	

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F 656	Continued From page 15 the time of the assessment. The comprehensive care plan dated, 5/17/2018, and revised on 4/16/2021, documented in part, "Focus: Pain - generalized." The "Interventions" documented in part, "Administer pain medication per physician orders. Implement non-pharmacological interventions such as music, positioning or other activities of choice to assist with pain and monitor for effectiveness." The physician order dated, 10/19/2021, documented, Ibuprofen (used to treat pain) (2) 400 mg (milligrams); Give 1 tablet orally every 12 hours as needed for mild pain. The January 2022 MAR (medication administration record) documented the above order for Ibuprofen. The Ibuprofen was documented as given on 1/12/2022 and 1/16/2022. On 1/12/2022 at 5:30 p.m. the MAR entry documented the pain level of "4." On 1/16/2022 at 6:37 a.m., the MAR entry documented the pain level of "3." Review of the nurse's notes and the eMAR (electronic medication administration record) for the above two doses of Ibuprofen, failed to evidence documentation of the location of Resident #69's pain and failed to document any non-pharmacological interventions provided prior to the administration of the medication. An interview was conducted with LPN (licensed practical nurse) #3, on 1/20/2022 at 10:35 a.m., regarding the process staff follows for resident complaints of pain. LPN #3 stated the nurse first asks the resident to rate the pain, and then check the physician orders for medication. If the	F 656	Date of Compliance: 2/24/2022 (b) Corrective Action: Upon notification, interdisciplinary team reviewed and developed #16 care plan to a patient specific comprehensive care plan regarding behavior of wandering. Identification: 100 percent audit completed of all residents assessed and triggered for wandering on MDS for care plan development. System Change: Staff who complete MDS will be re-educated on developing a patient specific care plan on behavior of wandering when behavior triggers on MDS. Monitoring: DON and/or designee will monitor 5 residents assessed and triggered for wandering on MDS daily x5, weekly x4 and monthly x2 to ensure that a comprehensive care plan has been developed regarding wandering behaviors to ensure compliance. Date of Compliance: 2/24/2022 (c) Corrective Action: Upon notification, interdisciplinary team reviewed and developed #45 care plan to ensure implementation regarding checking the thrill and bruit. Identification: 100 percent audit	

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F 656	Continued From page 16 resident does not have an order for pain medication, then you contact the doctor to see if they want to order something. When asked if the nurse should ask the resident where the pain is located, LPN #3 stated, yes, that's part of the assessment for pain. When asked if the nurse try's anything prior to giving the medication, LPN #3 stated, Yes, I check on them, if any pain, I then give medication When asked if the staff offers non-pharmacological interventions, LPN #3 stated if a resident is in pain, we can change position. When asked where the location and the offering of non-pharmacological interventions is documented, LPN #3 stated, if we offered those things, it would be documented in the MARS or nurses notes. An interview was conducted with RN (registered nurse) #1, on 1/20/2022 at 10:45 a.m., regarding the process the staff follows for resident complaints of pain. RN #1 stated, the nurse should assess the pain, its location, and intensity, what can be done to relieve the pain. If the pain is not relieved, we go to the physician orders and see if they have an order for pain. If they don't have any medication ordered we contact the doctor. When asked where the assessment, with location of the pain and the non-pharmacological interventions offered was documented, RN #1 stated it should be documented in the pain assessment or in the nurse's notes. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/20/2022 at 11:00 a.m., regarding the process staff follows for resident complaints of pain. ASM #2 stated, the nurse will assess the resident for the location of pain, the intensity of the pain, rate the pain on a pain scale of 0 -10.	F 656	completed all residents care plans with interventions of monitoring bruit and thrill checks for bruit and thrill check interventions. System Change: Staff will be re-educated on implementation of care plan regarding monitoring thrill and bruit. Monitoring: DON and/or designee will monitor residents with care plans with interventions of monitoring bruit and thrill checks daily x5, weekly x4 and monthly x2 to ensure compliance Date of Compliance: 2/24/2022 (d) Corrective Action: Upon notification, interdisciplinary team reviewed and developed #60 care plan and developed an anticoagulant use care plan. Identification: 100 percent audit completed of all residents on anticoagulant medications to ensure that a comprehensive care plan has been developed. System Change: Staff will be re-educated on developing an anticoagulant use care plan. Monitoring: DON and/or designee will monitor 5 residents with anticoagulant medications daily x5, weekly x4 and monthly x2 to ensure that a comprehensive care plan has been developed regarding anticoagulant use to	

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F 656	Continued From page 17 We try diversional activities, talk to the patient, or reposition the patient. You follow up with the resident after the diversional activity, if the pain is not relieved; the nurse checks the physician orders to see if they have an order for a pain medication. If no order, the nurse should contact the physician for an order. When asked where the assessment with the pain intensity, location and non-pharmacological (diversional) interventions were documented, ASM #2 stated it should be documented in the pain assessment or the nurse's notes. The above concern of no documentation of the location of Resident #69's pain and no documentation evidencing non-pharmacological interventions were offered/ provided prior to the administration of the pain medication was shared with ASM #2. On 01/20/2022 at approximately 4:30 p.m. an interview was conducted with RN (registered nurse) # 1 regarding comprehensive care plans. When asked to describe the purpose of a resident's care plan RN # 1 stated, it's based on the patient's care and it tells the staff what to follow. When asked about if the care plan was implemented if there was no documented evidence the care planned intervention for non-pharmacological interventions was attempted or provided, RN # 1 stated no. The facility policy, "Interdisciplinary Care Planning" documented in part, Assessment: Assessment allows members of the interdisciplinary team to gather essential information about the patient....Planning: Planning the patient's care includes identifying problems and/or risk (potential or actual), strengths, and needs; evaluating whether the problem is acute or chronic; setting measurable goals with time	F 656	ensure compliance. Date of Compliance: 2/24/2022 (e) Corrective Action: Upon notification, interdisciplinary team reviewed and developed resident #73 care plan and implemented care plan regarding use of Foley catheter. Identification: 100 percent audit completed on all residents with Foley catheter to ensure that a comprehensive care plan has been developed regarding Foley catheter. System Change: Staff will be re-educated on developing and implementing a care plan regarding use of Foley catheter Monitoring: DON and/ or designee will monitor 5 residents with Foley catheter daily x5, weekly x4 and monthly x2 to ensure that a comprehensive care plan has been developed regarding Foley catheter to ensure compliance. Date of Compliance: 2/24/2022	

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frames; and determining the interventions that will enable the patient to meet their goals. Key factors to focus on are: evaluating how current interventions are going to address the risk factors and help the patient reach their goals, identifying risk versus benefits of the current interventions, clarifying how the interventions regarding treatments and other services will be evaluated for effectiveness and monitored for negative consequences, identifying members of the interdisciplinary team (in the center or outside, such as hospice) responsible for implementing interventions. Implementation: Once the care plan is developed. The staff must implement the interventions identified in the care plan. These may include, but not limited to: administering treatments and medications, performing therapies, and participating in activities with the patient."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (3)

On 1/20/2022 at 4:07 p.m., ASM #1, the administrator, ASM #2, and ASM #3, the quality assurance consultant, were made aware of the above concern.

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No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114.
(2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682159.html
(3) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.
2. Resident #16 was admitted to the facility with diagnoses that included but were not limited to Alzheimer's disease (1), dementia (2) and major depressive disorder (3).

Resident #16's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/2/2021, coded Resident #16 as scoring a 7 (seven) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 7- being severely impaired for making daily decisions. Section E coded Resident #16 as displaying wandering behaviors daily. Section V triggered behavioral symptoms as an area to be care planned.

On 1/19/2022 at approximately 12:30 p.m., an observation was made of Resident #16 in their room. Resident #16 was observed sitting on the side of the bed eating lunch.

Additional observations of Resident #16 on 1/19/2022 at approximately 3:15 p.m. and 1/20/2022 at approximately 10:45 a.m. revealed Resident #16 walking in the hallways of the unit they resided on.

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The comprehensive care plan for Resident #16 failed to evidence a care plan for the assessed and triggered wandering behaviors.

On 1/20/2022 at 1:20 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that residents were monitored for behaviors every shift. LPN #2 stated that the care plan was a protocol for the staff to follow to care for the resident and behaviors specific to the resident were documented on the care plan. LPN #2 stated that residents who wandered should have care plans developed for the behavior.

On 1/20/2022 at approximately 3:00 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that the care plan was a guideline for the care of the resident. When asked about behaviors for Resident #16, RN #1 stated that she wandered and did not sleep. RN #1 stated that Resident #16 should have a care plan addressing specific behaviors and documentation of behavior monitoring.

On 1/20/2022 at 3:35 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked about behaviors for Resident #16, ASM #2 stated that Resident #16's baseline was wandering, pacing back and forth and not sleeping. ASM #2 stated that Resident #16 should have a care plan regarding their medications, side effects of medications and some monitoring.

On 1/20/2022 at approximately 4:00 p.m., a request was made to ASM #1, the administrator for the facility policy on developing the care plan.

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On 1/20/2022 at 6:54 p.m., ASM #1 provided via email, "Interdisciplinary Care Planning" dated 11/2016 which documented in part, "...Assessment allows members of the interdisciplinary team to gather essential information about the patient. Assessment includes completion of the Minimum Data Set (MDS), Care Area Assessments (CAAs), and facility-specific assessments. Planning the patient's care includes identifying problems and/or risks (potential or actual), strengths, and needs; evaluating whether the problem is acute or chronic; setting measurable goals with time frames; and determining the interventions that will enable the patient to meet their goals..."

On 1/20/2022 at approximately 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant were notified of the findings. No further information was provided prior to exit.

References:

1. Alzheimer's disease: "Alzheimer's disease is an irreversible, progressive brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks. It is the most common cause of dementia in older adults." This information is taken from the website https://www.nia.nih.gov/health/alzheimers/basics.

2. Dementia: A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

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3. Major depressive disorder: is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm.

3. Resident # 45 was admitted to the facility with diagnoses included but were not limited to: end stage renal disease [2]. Resident # 45's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/11/2021, coded Resident # 45 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being severely impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 45 for "Dialysis" while a resident.

The physician's order sheet documented in part, "Check AV [arterial/venous] fistula (R-[right] Upper Arm) thrill/bruit every day shift. Order Date: 10/13/2021. Start Date 10/19/2021"

The comprehensive care plan for Resident # 45 dated 11/18/2021 documented in part, "Focus: Renal insufficiencies related to: chronic renal failure. Date Initiated: 06/24/2021." Under "Interventions" it documented in part, "Check access site for lack of thrill/bruit, evidence of infection, swelling, or excessive bleeding per facility guidelines. Report abnormalities to physician. Date Initiated: 06/24/2021."

The eTAR [electronic treatment record] for Resident # 45 dated December 2021

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PROMEDICA SKILLED NURSING AND REHAB (ALEXANDRIA)	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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documented in part, "Check AV [arterial/venous] fistula (R-[right] Upper Arm) thrill/bruit every day shift." Further review of the eTAR revealed blanks on the 7:00 a.m. to 3:00 p.m. shift on 12/12/2021, 12/27/2021 and on 12/30/2021.

The eTAR [electronic treatment record] for Resident # 45 dated January 2022 documented in part, "Check AV [arterial/venous] fistula (R-[right] Upper Arm) thrill/bruit every day shift." Further review of the eTAR revealed blanks on the 7:00 a.m. to 3:00 p.m. shift on 01/07/2022.

On 01/20/2022 at approximately 10:24 a.m., an interview was conducted with RN [registered nurse] # 1, unit manager. After reviewing the eTARs dated December 2021 and January 2022 for the dates listed above, RN # 1 was asked to interpret the blanks. RN # 1 stated, "If it's not signed off then it's not done." When asked to describe the purpose of a resident's care plan RN # 1 stated, "It's based on the patient's care and it tells the staff what to follow." When asked if an intervention on the resident's care plan is not implemented can they say that the care plan is being implemented RN # 1 stated no. After reviewing the eTAR for Resident # 45 dated December 2021 and January 2022 and Resident # 45's comprehensive care plan, RN # 1 was asked if Resident # 45's care plan was being implemented. RN # 1 stated no.

On 01/20/2022 at approximately 4:06 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of clinical services, ASM # 3, Quality Assurance Consultant, were made aware of the above findings.

No further information was provided prior to exit.

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References:
[1] When you slide your fingertips over the site you should feel a gentle vibration, which is called a "thrill." Another sign is when listening with a stethoscope a loud swishing noise will be heard called a "bruit." If both of these signs are present and normal, the graft is still in good condition. This information was obtained from the website: https://www.vascularhealthclinics.org/institutes-divisions/vascular-surgery-and-medicine/dialysis-access/#:~:text=When%20you%20slide%20your%20fingertips,is%20still%20in%20good%20condition.

[2] The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.
4. Resident #60 was admitted to the facility on 12/28/21 with diagnoses including multiple sclerosis (1) and history of a stroke. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/1/22, the resident was coded as being moderately impaired for making daily decisions. She was coded as receiving an anticoagulant during the look back period.

A review of Resident #60's physician's orders revealed the following order: "12/28/21 Rivaroxaban (2) Tablet 20 MG (milligrams). Give 1 tablet by mouth one time a day for A FIB (atrial fibrillation) (3). Give after Dinner."

A review of Resident #60's comprehensive care plan dated 12/28/21 failed to reveal any information related to the resident's use of

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Rivaroxaban.

On 1/20/22 at 11:09 a.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated the interdisciplinary team is responsible for developing the comprehensive care plan. She stated residents are reviewed in the daily morning meetings. Nursing and the MDS coordinator focus on the clinical items like medications. ASM #2 stated an anticoagulant should be included in a resident's care plan because the care plan is a snapshot of the resident, and instructs the staff on how best to care for the resident.

On 1/22/22 at 11:38 a.m., LPN (licensed practical nurse) #1 was interviewed. She stated an anticoagulant should be included in the care plan in order for all of the caregivers to know what the resident needs.

On 1/20/22 at 4:06 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, the were informed of these concerns.

No further information was provided prior to exit.

REFERENCES
(1) "Multiple sclerosis (MS) is a disease of the central nervous system. In MS the body's immune system attacks myelin, which coats nerve cells. Symptoms of MS include muscle weakness (often in the hands and legs), tingling and burning sensations, numbness, chronic pain, coordination and balance problems, fatigue, vision problems, and difficulty with bladder control. People with MS also may feel depressed

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and have trouble thinking clearly." This information is taken from the website https://nccih.nih.gov/health/multiple-sclerosis.

(2) "Rivaroxaban (Xarelto) is used to treat deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung). Rivaroxaban is also used to prevent DVT and PE from happening again after initial treatment is completed. It is also used to help prevent strokes or serious blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body, and possibly causing strokes) that is not caused by heart valve disease." This information is taken from the website https://medlineplus.gov/druginfo/meds/a611049.html.

(3) "Atrial fibrillation is one of the most common types of arrhythmias, which are irregular heart rhythms. Atrial fibrillation causes your heart to beat much faster than normal. Also, your heart's upper and lower chambers do not work together as they should. When this happens, the lower chambers do not fill completely or pump enough blood to your lungs and body. This can make you feel tired or dizzy, or you may notice heart palpitations or chest pain. Blood also pools in your heart, which increases your risk of forming clots and can leads to strokes or other complications. Atrial fibrillation can also occur without any signs or symptoms. Untreated fibrillation can lead to serious and even life-threatening complications." This information is taken from the website https://www.nhlbi.nih.gov/health-topics/atrial-fibrillation.

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5. Resident #73 was admitted to the facility on 12/21/21 with diagnoses including heart failure and diabetes. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/27/21, Resident #73 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as having an indwelling catheter in his bladder during the look back period.

On the following dates and times, 1/19/22 at 1:27 p.m. and 1/19/22 at 3:54 p.m., Resident #73 was observed lying in bed, and the Foley catheter collection bag was lying in direct contact with the floor.

Resident #73 declined to be interviewed during the survey.

A review of Resident #73's physician's orders revealed, in part: "12/21/21 Maintain Foley catheter 16 FR (French - designates catheter size) with 10cc (cubic centimeter) balloon for Neurogenic Bladder. Change PRN (as needed) for obstruction."

A review of Resident #73's comprehensive care plan dated 12/22/21 revealed no information related to an indwelling catheter.

On 1/20/22 at 11:09 a.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated the interdisciplinary team is responsible for developing the comprehensive care plan. She stated residents are reviewed in

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F 656	Continued From page 28 the daily morning meetings. Nursing and the MDS coordinator focus on the clinical items like Foley catheters. She stated a Foley catheter should be included in a resident's care plan because the care plan is a snapshot of the resident, and instructs the staff on how best to care for the resident. On 1/22/22 at 11:38 a.m., LPN (licensed practical nurse) #1 was interviewed. She stated a Foley catheter should be included in the care plan in order for all of the caregivers to know they need to monitor the catheter. On 1/20/22 at 4:06 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, the were informed of these concerns. No further information was provided prior to exit. References (1) "A urinary catheter (brand name Foley) is a tube placed in the body to drain and collect urine from the bladder." This information is taken from the website https://medlineplus.gov/ency/article/003981.htm.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		2/3/22

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F 657	Continued From page 29 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, clinical record review, facility document review and staff interview, it was determined facility staff failed to review and/or revise the comprehensive care plan for one of 34 residents in the survey sample, Resident #65 and Resident #5. The facility staff failed to revise the comprehensive care plan of Resident #65 to include the use of bed rails. The findings include: 1. Resident #65 was admitted to the facility with diagnoses that included but were not limited to atrial fibrillation (1) and muscular dystrophy (2). Resident #65's most recent MDS (minimum data	F 657	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Corrective Action: Upon notification, #65 care plan was revised for use of side rails. Identification: 100 percent audit	

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F 657	Continued From page 30 set), a quarterly assessment with an ARD (assessment reference date) of 12/26/2021, coded Resident #65 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section G coded Resident #65 as requiring extensive assistance from one staff member for bed mobility, eating, toilet use and personal hygiene. On 1/19/2022 at approximately 1:15 p.m., an observation was made of Resident #65 in their room. Resident #65 was observed in their bed with one quarter bed rail in the up position on the upper right side of the bed. At that time an interview was conducted with Resident #65. Resident #65 stated that they used the bed rail to grab onto for positioning and during care. Resident #65 stated that they were not sure if they had signed a consent for the bed rail but they used it. Additional observations of Resident #65 on 1/19/2022 at 2:45 p.m. and 4:15 p.m. and 1/20/2022 at 9:15 a.m. revealed Resident #65 in bed with the quarter bed rail up on the upper right side of the bed. The physician orders for Resident #65 failed to evidence an order for bed rails. The comprehensive care plan for Resident #65 dated 10/01/2018 documented in part, "At risk for complications due to musculoskeletal problems r/t (related to) muscular dystrophy, loss may be unavoidable. Date Initiated: 10/01/2018, Revision on: 10/01/2018." The care plan failed to evidence documentation for the use of bed rails.	F 657	completed on residents with side rails for care plan revision. System Change: Staff will be re-educated on care plan revisions with use of side rails. Monitoring: Administrator and/or designee will monitor residents with siderails daily x5, weekly x4 and monthly x2 to ensure that residents with side rails have a care plan revision to ensure compliance. Date of Compliance: 2/24/2022	

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On 1/20/2022 at 12:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the RN's (registered nurses) were responsible for updating the care plans. LPN #2 stated that the care plan was updated when there was a change in status or anything new. LPN #2 stated that the purpose of the care plan was to provide a protocol for them to follow in caring for the resident.

On 1/20/2022 at 3:00 p.m., an interview was conducted with RN #1, unit manager. RN #1 stated that the purpose of the care plan was to provide guidelines for the care of the resident. RN #1 stated that updates to the care plan were conducted by the unit manager and the MDS coordinator. RN #1 stated that residents who required bed rails were assessed for them to ensure they were appropriate. RN #1 stated that when a resident was assessed as needing bed rails they obtained a physician's order and documented them on the care plan. RN #1 stated that they were not sure what was in place for Resident #65 because she was a long term care resident who had been in the facility for years and may have been assessed a few years ago. RN #1 stated that there should be a current assessment to determine if the bed rails were still appropriate for Resident #65.

On 1/20/2022 at approximately 4:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy for reviewing and revising the care plan and bed rails.

On 1/20/2022 at 6:54 p.m., ASM (administrative staff member) #1 provided via email "Interdisciplinary Care Planning" dated 11/2016

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F 657	Continued From page 32 which documented in part, "The patient's care plan is a communication tool that guides members of the interdisciplinary team in how to meet each individual patient's needs. It also identifies the types and methods of care that the patient should receive..." The facility policy "Bed Rail Guidelines" dated 4/20214 documented in part, "...The individualized comprehensive care plan addresses the medication symptom, the goal for the use of the bed rail, individualized interventions and the plan for reduction or elimination of the bed rail..." On 01/20/2022 at 4:00 p.m., ASM #1, the administrator, ASM # 2, the director of nursing and ASM #3, the quality assurance consultant were made aware of the findings. No further information was provided prior to exit. References: 1. Atrial fibrillation: A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html>. 2. Muscular dystrophy: Muscular dystrophy (MD) is a group of more than 30 inherited diseases. They all cause muscle weakness and muscle loss. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=muscular+dystrophy	F 657		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		2/3/22

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F 690	Continued From page 33 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it	F 690	The statements made on this plan of correction are not an admission to and do	

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F 690	Continued From page 34 was determined that the facility staff failed to provide care and services for a Foley catheter for one of 34 residents in the survey sample, Resident #73. The facility staff failed to evidence regular care of Resident #73's Foley catheter, and failed to position the catheter in a manner to prevent infection. On 1/19/22 and 1/20/22 observation revealed Resident #73's Foley catheter collection bag was lying in direct contact with the floor. The findings include: Resident #73 was admitted to the facility on 12/21/21 with diagnoses including heart failure and diabetes. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/27/21, Resident #73 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). Resident #73 was coded as having an indwelling catheter in his bladder during the look back period. On the following dates and times, 1/19/22 at 1:27 p.m. and 1/19/22 at 3:54 p.m., Resident #73 was observed lying in bed, and the Foley catheter collection bag was lying in direct contact with the floor. Resident #73 declined to be interviewed during the survey. A review of Resident #73's physician's orders revealed, in part: "12/21/21 Maintain Foley catheter 16 FR (French - designates catheter size) with 10cc (cubic centimeter) balloon for Neurogenic Bladder. Change PRN (as needed)	F 690	not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Corrective Action: Upon notification, resident #73 immediately received regular care for Foley catheter and proper positioning, off the floor, was ensured to prevent infection. Identification: 100 percent audit completed on all residents with Foley Catheter for evidence of regular care and for positioning in a manner to prevent infection such as, not in contact with the floor. System Change: Staff will be re-educated on Foley catheter regular care and Foley catheter positioning in a manner to prevent infection, such as, not in contact with the floor. Monitoring: DON and/ or designee will monitor 5 residents with Foley catheter daily x5, weekly x4, monthly x2, to ensure evidence of regular care and positioning in a manner to prevent infection, such as, not in contact with the floor. Date of Compliance: 2/24/2022	

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PROMEDICA SKILLED NURSING AND REHAB (ALEXANDRIA)	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

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F 690	Continued From page 35	F 690		

for obstruction."

A review of Resident #73's MARs (medication administration records), TARs (treatment administration records), and point of care records for the dates of his admission to the facility revealed no evidence that Resident #73 had received any care for his Foley catheter.

A review of Resident #73's comprehensive care plan dated 12/22/21 revealed no information related to an indwelling catheter.

On 1/22/22 at 11:38 a.m., LPN (licensed practical nurse) #1 was interviewed regarding the care that should be provided for a resident with a Foley catheter. LPN #1 stated, "It should be cleaned every shift, at least." She stated the cleaning included the insertion site as well as the catheter tubing. LPN #1 stated the CNAs (certified nursing assistants) provide the catheter care, and document it in the computer record. When asked if she could verify the catheter care is being done if there is no documentation, she stated she could not. LPN #1 stated, "If it is not documented, it is not done. Period." When asked how a catheter collection bag should be positioned in relation to the floor, LPN #1 stated the bag should never be in contact with the floor. She stated the floor could contain items that could contaminate the catheter bag, resulting in an infection.

On 1/20/22 at 12:21 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated she was currently taking care of Resident #73. She stated if a resident has a Foley catheter, the tubing should be cleaned at least every shift, and more often if it is soiled. CNA #1 stated the bag is emptied every shift, and that she documents all

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F 690	Continued From page 36 her care on the computer. She stated if she sees a collection bag on the floor, she picks it up. CNA #1 stated the floor has a risk of contamination. She states she charts on the computer when she has completed Foley catheter care for a resident. On 1/20/22 at 4:06 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, the were informed of these concerns. The management staff members were asked to provide information to evidence that Resident #73 had received Foley catheter care since his admission to the facility. A review of the facility policy, "Catheter Care: Indwelling Catheter," failed to reveal any information regarding routine catheter care or correct positioning of the urine collection bag. No further information was provided prior to exit. References (1) "A urinary catheter (brand name Foley) is a tube placed in the body to drain and collect urine from the bladder." This information is taken from the website https://medlineplus.gov/ency/article/003981.htm.	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 697		2/3/22

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F 697	Continued From page 37 by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain a complete pain management program for one of 34 residents in the survey sample, Resident #69. The facility staff failed to document the location of Resident #69's pain and failed to attempt/offer non-pharmacological interventions prior to administering pain medication to Resident #69. The findings include: Resident #69 was admitted to the facility on 5/17/2018 with diagnoses that included but were not limited to: stroke (abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and resulting symptoms - sudden loss of ability to move a body part [as an arm or parts of the face], or to speak, paralysis weakness or if severe, death) (1), diabetes, and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment with an assessment reference date of 12/28/2021, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. In Section J0100, the resident was coded as receiving scheduled pain regimen. The resident was coded as stating she had no pain at the time of the assessment. The physician order dated, 10/19/2021, documented, Ibuprofen (used to treat pain) (2) 400 mg (milligrams); Give 1 tablet orally every 12 hours as needed for mild pain.	F 697	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Corrective Action: Upon notification, resident #69 was assessed for pain and denied pain at the time. #69 care plan was reviewed and revised to ensure staff document the location of resident's pain and attempt/ offer a non-pharmacological intervention for pain management prior to administering pain medication. Identification: 100 percent audit completed of all residents on PRN pain medication for documentation of location of pain and for attempting/ offering non-pharmacological interventions. System Change: Staff will be re-educated on following pain management guidelines to include documentation of location of pain and attempting/ offering non-pharmacological interventions. Monitoring: DON and/or designee will monitor 5 residents receiving PRN pain medications for documentation of location of resident's pain and attempting/ offering	

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F 697	Continued From page 38 The January 2022 MAR (medication administration record) for Resident #69 documented the above physician order for Ibuprofen. The Ibuprofen was documented as given on 1/12/2022, 1/16/2022 and 1/17/2022. On 1/12/2022 at 5:30 p.m. the MAR entry documented the pain level of "4." On 1/16/2022 at 6:37 a.m., the MAR entry documented the pain level of "3." On 1/17/2022 at 5:27 p.m., the MAR entry documented the pain level of "0." Review of the nurse's notes and the eMAR (electronic medication administration record) for the above dated and three doses of Ibuprofen, failed to evidence documentation of the location of Resident #69's pain and failed to document non-pharmacological interventions were attempted/provided prior to the administration of the medication. The comprehensive care plan dated, 5/17/2018, and revised on 4/16/2021, documented in part, "Focus: Pain - generalized." The "Interventions" documented in part, "Administer pain medication per physician orders. Implement non-pharmacological interventions such as music, positioning or other activities of choice to assist with pain and monitor for effectiveness." An interview was conducted with LPN (licensed practical nurse) #3, on 1/20/2022 at 10:35 a.m., regarding the process staff follows for resident complaints of pain. LPN #3 stated the nurse first asks the resident to rate the pain, and then check the physician orders for medication. If the resident does not have an order for pain medication, then you contact the doctor to see if they want to order something. When asked if the	F 697	non-pharmacological interventions daily x5, weekly x4 and monthly x2 to ensure compliance. Date of Compliance: 2/24/2022	

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nurse should ask the resident where the location of the pain is, LPN #3 stated, yes, that's part of the assessment for pain. When asked if the nurse try's anything prior to giving the medication, LPN #3 stated, Yes, I check on them, if any pain, I then give medication. When asked if the staff offers/attempts non-pharmacological interventions, LPN #3 if a resident is in pain, we can change position. When asked where the location and the offering of non-pharmacological interventions is documented, LPN #3 stated, if we offered those things, it would be documented in the MAR or nurses notes.

An interview was conducted with RN (registered nurse) #1, on 1/20/2022 at 10:45 a.m., regarding the process staff follows for resident complaints of pain. RN #1 stated, the nurse should assess the pain, its location, and intensity, what can be done to relieve the pain. If the pain is not relieved, we go to the physician orders and see if they have an order for pain. If they don't have any medication ordered we contact the doctor. When asked where the assessment, with location of the pain and attempted /offered non-pharmacological interventions is documented, RN #1 stated it should be documented in the pain assessment or in the nurse's notes.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/20/2022 at 11:00 a.m., regarding the process staff follows for resident complaints of pain. ASM #2 stated, the nurse will assess the resident for the location of pain, the intensity of the pain, rate the pain on a pain scale of 0 -10. We try diversional activities, talk to the patient, or reposition the patient. You follow up with the resident after the diversional activity, if the pain is

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not relieved; the nurse checks the physician orders to see if they have an order for a pain medication. If no order, the nurse should contact the physician for an order. When asked where the assessment with the pain intensity, location and attempted/offered non-pharmacological (diversional) interventions were documented, ASM #2 stated it should be documented in the pain assessment or the nurse's notes. The above concern of no documentation of the location of Resident #69's pain and no documentation evidencing attempted/offered non-pharmacological interventions prior to the administration of the pain medication was shared with ASM #2.

The facility policy, "Pain Management Guidelines" documented in part, "Pain is evaluated and documented....before and after the administration of PRN (as needed) pain medication.....Non-pharmacological interventions should be attempted first. These include: patient education, exercise or therapy intervention, relaxation techniques, positioning, counseling, aromatherapy, bio-feedback, massage, hypnosis, music/art therapy, transcutaneous electrical nerve stimulation (TENS), ultrasound, imagery, nerve blocks, cryotherapy, thermal therapy, meditation, yoga, tai chi."

According to Fundamentals of Nursing, Fifth Edition, 2007, Lippincott Williams & Wilkins, page 1176 to 1207. "Pain, one of the most complex human experiences, is an invisible phenomenon influenced by the interaction of affective (emotional), behavioral, cognitive, and physiologic-sensory factors. Because pain is a highly individual experience, the basis for pain management is simply the client's description of

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pain. Pain exists whenever the person says it does....Typically people describe pain by its location, intensity, quality, and temporal pattern. Sensory components of the pain experience are subjective but can be measured using standardized tools....Assessment: An accurate assessment focusing on pain's cause is essential for determining proper therapy. Ongoing assessment also is important for implementing an effective pain management plan....Document pain assessment information in an accessible location. Even the best pain assessment conducted by the one nurse is of limited value unless he or she shares the information with other healthcare professionals responsible for the client's care. Subjective Data: In an attempt to assess the client's pain, obtain answers to the following questions: Where is the pain located? What is the magnitude or intensity (level) of the pain? What level of pain would the client like to have? What level of pain would the client be willing to tolerate? How does the pain feel to the client; how is it described (its quality)? How does the pain change with rest, activity, or time (its temporal pattern)?...Inadequate or poor pain assessment is a leading factor in poor pain control...Objective data....Physiologic responses to pain are the result of the activation of the autonomic nervous system. With acute pain, the general responses observed include tachycardia, elevated blood pressure, increased respiratory rate, diaphoresis, and gastric distress. With persistent chronic pain, these responses may be modified or absent....Related symptoms may give additional clues about pain. Nausea and vomiting, fatigue, anorexia, and withdrawal are common with pain....Observe the client's facial expressions and body movements. Wincing, frowning, and grimacing can indicate pain...Body

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F 697	Continued From page 42 movements may represent protective actions to decrease the pain. Body movements such as rubbing, splinting, guarding, immobilizing, elevating the painful extremity, or changing positions frequently may increase with pain..." On 1/20/2022 at 4:07 p.m., ASM #1, the administrator, ASM #2, and ASM #3, the quality assurance consultant, were made aware of the above concern. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682159.html.	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and service for a complete dialysis [1] program for one of 34 residents in the survey sample, Residents # 45.	F 698	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will	2/3/22

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F 698	Continued From page 43 The facility staff failed to have ongoing communication with Resident #45's dialysis treatment center and failed to ensure ongoing monitoring for potential complications as evidenced by the staff failure to assess Resident #45's AV [arterial/venous] dialysis fistula in the resident right upper arm for a thrill/bruit per the physician orders on 1/12/21, 12/27/21, 12/30/21 and 1/07/22. The findings include: Resident # 45 was admitted to the facility with diagnoses included but were not limited to: end stage renal disease [2]. Resident # 45's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/11/2021, coded Resident # 45 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being severely impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 45 for "Dialysis" while a resident. The physician's order sheet documented in part, "Check AV [arterial/venous] fistula (R-[right] Upper Arm) thrill/bruit every day shift. Order Date: 10/13/2021. Start Date 10/19/2021" and "Dialysis Days one time a day every MON, Wed, Fri [Monday, Wednesday, Friday] for Dialysis 10AM [10:00 a.m.] Order Date: 10/13/2021. Start Date 10/19/2021." "Hemodialysis [Name of Dialysis Center] Monday, Wednesday, Friday every day shift every Mon, Wed, Fri for dialysis. Order Date: 11/02/2021. Start Date: 11/03/2021. End Date: 12/08/2021."	F 698	take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Corrective Action: Upon notification, #45 dialysis care plan reviewed and revised to ensure implementation of ongoing communication with resident dialysis treatment centers with a Hemodialysis Communication Form and ongoing monitoring for potential complications such as bruit and thrill assessment. Identification: 100 percent audit completed of all residents receiving dialysis services to ensure ongoing communication with residents dialysis treatment centers with Hemodialysis Communication form and ongoing monitoring for potential complications such as bruit and thrill assessment. System Change: Staff will be re-educated on communication with residents dialysis treatment centers with Hemodialysis Communication form and ongoing monitoring for potential complications such as bruit and thrill assessment Monitoring: DON and/or designee will monitor residents receiving dialysis services to ensure ongoing communication with residents dialysis treatment centers with Hemodialysis Communication Form and ongoing monitoring for potential complications	

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F 698	Continued From page 44 The comprehensive care plan for Resident # 45 dated 11/18/2021 documented in part, "Focus: Renal insufficiencies related to: chronic renal failure. Date Initiated: 06/24/2021." Under "Interventions" it documented in part, "Dialysis: Days of the week: 3 x [three times] a week M/W/F [Monday/Wednesday/Friday]. Date initiated: 06/24/2021; Check access site for lack of thrill/bruit, evidence of infection, swelling, or excessive bleeding per facility guidelines. Report abnormalities to physician. Date Initiated: 06/24/2021." On 01/20/2022 at approximately 9:30 a.m. a review of Resident # 45's dialysis communication book was conducted. The "Hemodialysis Communication Forms" in Resident # 45's dialysis communication book documented in part, "Section 1: Completed by [Name of Healthcare Company] staff (send with patient to dialysis center). Significant change/decline since last dialysis treatment: __No __Yes (explain):___. Fall risk: __No __Yes (explain):___. Vital signs: Time Obtained: Temperature:___ __Axillary __Tympanic __Temporal. B/P [blood pressure]: Pulse: Resp [respiration]: Weight:__lbs [pounds]. Dialysis Access Site: Redness, if present, describe: Drainage, if present, describe: Pain/Burning, if present, describe: Thrill/Bruit, if absent, describe: Dressing dry/intact: Patient Status: __Orientated x3 [times three]. __Confused. __Agitated. __Sedated/lethargic. __Weakness. __SOB [short ness of breath]. __Chest Pain. __Lung Congestion. __Edema. __Neck Vein Distension. __N/V [nausea/vomiting]. __Prolonged Bleeding (explain):__. Lab [laboratory] Tests (attach copy if needed): Result/Date Received: Diet Order / Fluid Restrictions (include patient compliance and	F 698	such as bruit and thrill assessment daily x5 weekly x4 and monthly x2 to ensure compliance. Date of Compliance: 2/24/2022	

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I&O [input and output] monitoring): Current Medications (attach copy if needed): Changes in medication regime since last dialysis treatment: Nurse Signature: Date: ..."

Further review of the Resident # 45's "Hemodialysis Communication Form" revealed the following:
- The form dated 01/05/2022 failed to evidence documentation in all of section 1 [one].

- The form dated 01/07/2022 failed to evidence documentation under "Significant change/decline since last dialysis treatment; Dialysis Access Site; Lab Tests (attach copy if needed); Result/Date Received; Diet Order / Fluid Restrictions (include patient compliance and I&O [input and output] monitoring); Current Medications (attach copy if needed); Changes in medication regime since last dialysis treatment; Nurse Signature; and Date."

- Resident #45's form dated 01/10/2022 failed to evidence documentation under "Significant change/decline since last dialysis treatment; Dialysis Access Site; Lab Tests (attach copy if needed); Result/Date Received; Diet Order / Fluid Restrictions (include patient compliance and I&O [input and output] monitoring); Current Medications (attach copy if needed); and Changes in medication regime since last dialysis treatment."

- The form date 01/12/2022 failed to evidence documentation under "Significant change/decline since last dialysis treatment; Dialysis Access Site; Lab Tests (attach copy if needed); Result/Date Received; Diet Order / Fluid Restrictions (include patient compliance and I&O [input and output]

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (ALEXANDRIA)	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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monitoring); Current Medications (attach copy if needed); Changes in medication regime since last dialysis treatment; Nurse Signature; and Date."

- The form dated 01/14/2022 failed to evidence documentation under "Significant change/decline since last dialysis treatment; Dialysis Access Site; Lab Tests (attach copy if needed); Result/Date Received; Diet Order / Fluid Restrictions (include patient compliance and I&O [input and output] monitoring); Current Medications (attach copy if needed); Changes in medication regime since last dialysis treatment; Nurse Signature; and Date."

- The forms dated 01/16/2022 failed to evidence documentation under "Significant change/decline since last dialysis treatment; Dialysis Access Site; Lab Tests (attach copy if needed); Result/Date Received; Diet Order / Fluid Restrictions (include patient compliance and I&O [input and output] monitoring); Current Medications (attach copy if needed); Changes in medication regime since last dialysis treatment; Nurse Signature; and Date."

- The form 01/19/2022 failed to evidence documentation under "Significant change/decline since last dialysis treatment; Dialysis Access Site; Lab Tests (attach copy if needed); Result/Date Received; Diet Order / Fluid Restrictions (include patient compliance and I&O [input and output] monitoring); Current Medications (attach copy if needed); Changes in medication regime since last dialysis treatment; Nurse Signature; and Date."

The eTAR [electronic treatment record] for

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Resident # 45 dated December 2021 documented in part, "Check AV [arterial/venous] fistula (R-[right] Upper Arm) thrill/bruit every day shift." Further review of the eTAR revealed blanks on the 7:00 a.m. to 3:00 p.m. shift on 12/12/2021, 12/27/2021 and on 12/30/2021.

The eTAR [electronic treatment record] for Resident # 45 dated January 2022 documented in part, "Check AV [arterial/venous] fistula (R-[right] Upper Arm) thrill/bruit every day shift." Further review of the eTAR revealed blanks on the 7:00 a.m. to 3:00 p.m. shift on 01/07/2022.

On 01/20/2022 at approximately 10:24 a.m., an interview was conducted with RN [registered nurse] # 1, unit manager. When asked to describe the purpose of a resident's dialysis communication book RN # 1 stated, "Use to communicate between us [facility] and the dialysis center." RN #1 was asked who was responsible for completing Section 1 of the facility's "Hemodialysis Communication Form." RN # 1 stated, "The nurse who is working at the time." When asked why it was important to complete Section 1 of the "Hemodialysis Communication Form", RN # 1 stated, "So the dialysis center would know the condition of the resident." After reviewing Resident # 45's hemodialysis communication forms for the dates listed above, RN # 1 was asked if the forms were complete. RN # 1 stated, "No, all areas [in section 1] should be filled in." After reviewing the eTARs dated December 2021 and January 2022 for the dates listed above, RN # 1 was asked to interpret the blanks. RN # 1 stated, "If it's not signed off then it's not done."

On 01/20/2022 at approximately 11:05 a.m., an

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interview was conducted with LPN # 3. When asked to describe the purpose of a resident's dialysis communication book, LPN # 3 stated, "Use to communicate with the dialysis center." When asked who was responsible for completing Section 1 of the facility's "Hemodialysis Communication Form" LPN # 3 stated, "The nurse who is working at the time." When asked why it was important to complete Section 1 of the "Hemodialysis Communication Form" LPN # 3 stated, "So there is a baseline of the resident when they go to dialysis." After reviewing Resident # 45's hemodialysis communication forms for the dates listed above, LPN # 3 was asked if the forms were complete. LPN # 3 stated, "No, they're not completed."

On 01/20/2022 at approximately 4:06 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of clinical services, ASM # 3, Quality Assurance Consultant, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Dialysis treats end-stage kidney failure. It removes waste from your blood when your kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000707.htm.

[2] The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website:

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F 698	Continued From page 49 https://medlineplus.gov/ency/article/000500.htm.	F 698		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review it was determined that the facility staff failed to assess and obtain consent for the use of bed rails for one of 34 residents in the survey sample, Resident #65. The facility staff failed to evidence an assessment or consent for the use of a bed rail for Resident #65.	F 700	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged	2/3/22

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F 700	Continued From page 50 The findings include: Resident #65 was admitted to the facility with diagnoses that included but were not limited to atrial fibrillation (1) and muscular dystrophy (2). Resident #65's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/26/2021, coded Resident #65 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section G coded Resident #65 as requiring extensive assistance from one staff member for bed mobility, eating, toilet use and personal hygiene. On 1/19/2022 at approximately 1:15 p.m., an observation was made of Resident #65 in their room. Resident #65 was observed in their bed with one quarter bed rail in the up position on the upper right side of the bed. At that time an interview was conducted with Resident #65. Resident #65 stated that they used the bed rail to grab onto for positioning and during care. Resident #65 stated that they were not sure if they had signed a consent for the bed rail but they used it. Additional observations of Resident #65 on 1/19/2022 at 2:45 p.m. and 4:15 p.m. and 1/20/2022 at 9:15 a.m. revealed Resident #65 in bed with the quarter bed rail up on the upper right side of the bed. The physician orders for Resident #65 failed to evidence an order for bed rails. The comprehensive care plan for Resident #65	F 700	deficiencies cited have been or will be corrected by the date indicated. Corrective Action: Upon notification, resident #65 was assessed for bed rail and consent obtained. Identification: 100 percent audit completed of residents with bed rails. System Change: Staff will be re-educated on bed rail guidelines. Monitoring: Administrator and/or designee will monitor 5 residents with bed rails daily x5, weekly x4 and monthly x2 to ensure compliance. Date of Compliance: 2/24/2022	

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F 700	Continued From page 51	F 700		

dated 10/01/2018 documented in part, "At risk for complications due to musculoskeletal problems r/t (related to) muscular dystrophy, loss may be unavoidable. Date Initiated: 10/01/2018, Revision on: 10/01/2018." The care plan failed to evidence documentation of the use of bed rails.

On 1/19/2022 at approximately 4:30 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of a bed rail assessment and consent for the use of bed rails for Resident #65.

On 1/20/2022 at 3:00 p.m., an interview was conducted with RN (registered nurse) #1, unit manager. RN #1 stated that residents who required bed rails were assessed for them to ensure they were appropriate. RN #1 stated that when a resident was assessed as needing bed rails they obtained a physician's order and documented them on the care plan. RN #1 stated that they were not sure what was in place for Resident #65 because she was a long term care resident who had been in the facility for years and may have been assessed a few years ago. RN #1 stated that there should be a current assessment to determine if the bed rails were still appropriate for Resident #65.

On 1/20/2022 at approximately 4:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy for bed rails. At this time, ASM #3, the quality assurance consultant stated that they were still looking for the bed rail assessment and consent for Resident #65.

On 1/20/2022 at 6:54 p.m., ASM #1 provided via email "Bed Rail Guidelines" dated 4/20214

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F 700	Continued From page 52	F 700		

documented in part, "...Prior to the utilization of a bed rail, the interdisciplinary team completes an evaluation of the patient including review of hospital discharge records, transfer sheets or other historical documents; an interview of the patient and family or resident representative about the patient's history and risk factors; identification of previous interventions utilized; medical evaluation of the presenting medical symptom necessitating the use of the bed rail; resident assessment for risk of entrapment and appropriateness of bed dimensions for patient. Whenever bed rail use is determined as the only available interventions, the interdisciplinary team explains to the patient, family and resident representative how the use of the bed rail would treat the patient's medical symptom and assists the patient in attaining or maintaining the highest practicable level of physical or psychological well-being. In addition, the potential negative consequences of bed rail use are explained and informed consent is obtained. A physician's order for a bed rail includes the number of bed rails; the medical symptom for which the bed rail(s) is being used; circumstances in which the bed rail is applied..."

On 01/20/2022 at 4:00 p.m., ASM #1, the administrator, ASM # 2, the director of nursing and ASM #3, the quality assurance consultant were made aware of the findings.

No further information was provided prior to exit.

References:

1. Atrial fibrillation: A problem with the speed or rhythm of the heartbeat. This information was obtained from the website:

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F 700	Continued From page 53 <https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html>. 2. Muscular dystrophy: Muscular dystrophy (MD) is a group of more than 30 inherited diseases. They all cause muscle weakness and muscle loss. Some forms of MD appear in infancy or childhood. Others may not appear until middle age or later. The different types can vary in whom they affect, which muscles they affect, and what the symptoms are. All forms of MD grow worse as the person's muscles get weaker. Most people with MD eventually lose the ability to walk. There is no cure for muscular dystrophy. Treatments can help with the symptoms and prevent complications. They include physical and speech therapy, orthopedic devices, surgery, and medications. Some people with MD have mild cases that worsen slowly. Others cases are disabling and severe. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=muscular+dystrophy	F 700		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		2/3/22

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F 757	Continued From page 54 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure the drug regime for one of 34 residents in the survey sample was free of unnecessary pain medication, Resident #69. Resident #69's physician ordered pain medication as needed every twelve hours for mild pain. On 1/17/22 the facility staff administered the as needed pain medication to Resident #69's when the residents documented pain level rating was zero indicating no pain. The findings include: Resident #69 was admitted to the facility on 5/17/2018 with diagnoses that included but were not limited to: stroke (abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and resulting symptoms - sudden loss of ability to move a body part [as an arm or parts of the face], or to speak, paralysis weakness or if severe, death) (1), diabetes, and high blood pressure. The most recent MDS (minimum data set)	F 757	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Corrective Action: Upon notification, resident #69 was assessed for pain and reported a 0 pain score at the time. One to one in-service conducted with employee regarding not administering PRN pain medication when resident pain score is 0. Identification: 100 percent audit of residents with PRN pain medications for unnecessary medications-receiving PRN pain medication when pain level zero indicating no pain	

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F 757	Continued From page 55 assessment, a quarterly assessment with an assessment reference date of 12/28/2021, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. In Section J0100, the resident was coded as receiving scheduled pain regimen. The resident was coded as stating she had no pain at the time of the assessment. The physician order dated, 10/19/2021, documented, Ibuprofen (used to treat pain) (2) 400 mg (milligrams); Give 1 tablet orally every 12 hours as needed for mild pain. The January 2022 MAR (medication administration record) documented the above physician order. On 1/17/2022 at 5:27 p.m., the documented pain level for Resident #69 was zero. The MAR entry documented the staff nurse administered the Ibuprofen 400 mg to Resident #69 with a pain level of zero. Review of Resident #69's nurse's notes and MAR notes failed to document the location of Resident #69's pain, the pain level or if non-pharmacological interventions were offered/attempted. The comprehensive care plan dated, 5/17/2018, and revised on 4/16/2021, documented in part, "Focus: Pain - generalized." The "Interventions" documented in part, "Administer pain medication per physician orders. Implement non-pharmacological interventions such as music, positioning or other activities of choice to assist with pain and monitor for effectiveness." An interview was conducted with LPN (licensed	F 757	System Change: Staff will be re-educated on following pain management program to include not administering PRN pain medication when resident pain score is 0. Monitoring: DON and/or designee will monitor 5 residents with PRN pain medications for unnecessary medications-receiving PRN pain medications when pain level zero indicating no pain daily x5, weekly x4, and monthly x2 to ensure compliance. Date of Compliance: 2/24/2022	

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F 757	Continued From page 56 practical nurse) #3 on 1/20/2022 at 10:35 a.m. When asked if pain medication ordered for mild pain should administered if the pain scale rating is documented at zero, LPN #3 stated, no, it should not be given if the resident has no pain. An interview was conducted with RN (registered nurse) #1 on 1/20/2022 at 10:45 a.m. When asked if a pain medication ordered for mild pain should be given for a documented pain level of zero, RN #1 stated, no, it should not have been given. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/20/2022 at 11:00 a.m. When asked if an as needed pain medication ordered by the physician for mild pain should be administered for a pain level rating of zero, ASM #2 stated, no, if the resident has no pain, then you don't give the pain medication. On 1/20/2022 at 4:07 p.m., ASM #1, the administrator, ASM #2, and ASM #3, the quality assurance consultant, were made aware of the above concern. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682159.html.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use	F 758		2/3/22

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F 758	Continued From page 57 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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F 758	Continued From page 58 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review it was determined that the facility staff failed to ensure one of 34 residents in the survey sample was free from unnecessary psychotropic medications, Resident #16. The facility staff failed to ensure specified targeted behaviors for qualitative quantitative monitoring for the administration and use of the antipsychotic medication Seroquel for Resident #16. The findings include: Resident #16 was admitted to the facility with diagnoses that included but were not limited to Alzheimer's disease (1), dementia (2) and major depressive disorder (3). Resident #16's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/2/2021, coded Resident #16 as scoring a 7 (seven) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 7- being severely impaired for making daily decisions. Section E documented Resident #16 displaying wandering behaviors daily. Section N documented Resident #16 receiving	F 758	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Corrective Action: Upon notification, #16 care plan reviewed and developed a comprehensive care plan regarding monitoring resident specific/ targeted behavior for the administration and use of anti-psychotic medication Seroquel. Identification: 100 percent audit of residents with psychotropic medications-Seroquel for unnecessary medications-specified targeted behaviors for qualitative and quantitative monitoring for the administration of Seroquel.	

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F 758	Continued From page 59 antipsychotic and antidepressant medications. On 1/19/2022 at approximately 12:30 p.m., an observation was made of Resident #16 in their room. Resident #16 was observed sitting on the side of the bed eating lunch. Additional observations of Resident #16 on 1/19/2022 at approximately 3:15 p.m. and 1/20/2022 at approximately 10:45 a.m. revealed Resident #16 walking in the hallways of the unit they resided on. The comprehensive care plan for Resident #16 dated 9/8/2021 documented, "At risk for adverse effects related to: use of antianxiety medication, use of antidepressant/antipsychotic medication, history of dementia. Date Initiated: 09/08/2021, Revision on: 12/22/2021." Under "Goal" it documented "Show improvement in mood/behavior. Date Initiated: 09/08/2021, Revision on 11/23/2021." Under "Interventions" it documented in part, "Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs. Date Initiated: 09/08/2021..." The care plan failed to evidence resident specific targeted behavioral symptoms for the use of the antipsychotic medication Seroquel. . The physician order's for Resident #16 documented in part the following: - "Monitor for side effects related to use of psychotropic medications. My initials indicate absence of signs and symptoms of side effects. every shift for Monitor for side effects of psychotropic medications. Order Date: 10/11/2021." - "Seroquel Tablet (Quetiapine Fumarate) Give 75	F 758	System Change: Staff will be educated on behavior practice guide to include documentation for unnecessary medications-specified targeted behaviors for qualitative and quantitative monitoring for the administration of Seroquel Monitoring: DON and/or designee will monitor 5 residents with psychotropic medications of Seroquel for unnecessary medications-specified targeted behaviors for qualitative and quantitative monitoring for the Administration of Seroquel daily x5, weekly x4 and monthly x2 to ensure compliance. Date of Compliance: 2/24/2022	

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mg (milligram) by mouth at bedtime for dementia with BPSD (behavioral and psychological symptoms). Order Date: 12/18/2021."
- "Trazodone HCL 50 mg tablet Give 1 (one) tablet orally at bedtime for Insomnia. Order Date: 07/29/2021."

The "Psychotropic Medication Use" dated 7/29/2021 for Resident #16 documented the resident receiving antipsychotic, antianxiety, antidepressant and sedative/hypnotic medications. It documented in part, "Patient response to medication: Behavioral symptoms unchanged..." The form failed to identify/document the identified target behavioral symptoms for the use of the antipsychotic medication Seroquel.

The "Social Services Assessment and History" for Resident #16 dated 11/2/2021 failed to evidence documentation of any behaviors.

The eMARs (electronic medication administration records) for Resident #16 dated 10/1/2021-10/31/2021, 11/1/2021-11/30/2021, 12/1/2021-12/31/2021 and 1/1/2022-1/31/2022 documented side effect monitoring for the use of psychotropic medications. The eMARs failed to evidence monitoring of behaviors.

The progress notes for Resident #16 failed to evidence monitoring of behaviors.

On 1/20/2022 at approximately 11:30 a.m., a request was made to ASM (administrative staff member) #1, the administrator for documentation of behavior monitoring for Resident #16.

On 1/20/2022 at approximately 3:00 p.m., ASM

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#1 provided eMARs for Resident #16 dated 10/1/2021-10/31/2021, 11/1/2021-11/30/2021, 12/1/2021-12/31/2021 and 1/1/2022-1/31/2022 which documented side effect monitoring for the use of psychotropic medications every shift. The eMARs failed to evidence monitoring of behaviors. ASM #1 also provided "Geriatric Psychiatry Progress Notes" for Resident #16 dated 4/13/2021, 4/29/2021, 9/14/2021 and 12/18/2021 along with monthly pharmacy reviews with recommendations related to gradual dose reduction.

The "Geriatric Psychiatry Progress Notes" for Resident #16 documented in part the following:
- "4/13/2021...agitated at night. nights are bad. restless, poor sleep...Behaviors persist. leave or lower dose..."
- "4/29/2021...Met with staff to discuss: Strategies to manage agitation & delusion..."
- "9/14/2021...poor sleep. Pt (patient) has sleep wake cycle (change). Noted to get restless & pace at times. Reviewed sleep hygiene."
- "12/18/2021...Pt fair, she has been very restless, pacer, sleepy...up entire night per staff..."

The medication regimen review progress note dated 8/26/2021 for Resident #16 documented in part, "...still (with) behaviors..."

On 1/20/2022 at 1:20 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that residents taking psychotropic medications were monitored for behaviors every shift. LPN #2 stated that behavior monitoring was documented on the eMAR in the computer.

On 1/20/2022 at approximately 3:00 p.m., an

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interview was conducted with RN (registered nurse) #1. RN #1 stated that residents taking psychotropic medications were monitored for behaviors every shift and they were documented on the eMAR in the computer. RN #1 stated that Resident #16 wandered the hallways and did not sleep.

On 1/20/2022 at 3:35 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked about behaviors for Resident #16, ASM #2 stated that Resident #16's baseline was wandering, pacing back and forth and not sleeping. When asked about the eMAR documentation provided for Resident #16, ASM #2 stated that they had a monitoring system in place every shift to watch for side effects of the medications. ASM #2 stated that Resident #16 had not displayed any behaviors so there was not documentation of behavior monitoring although staff were doing it. ASM #2 stated that staff were to do a behavior assessment for any new behaviors and write a progress note. ASM #2 stated that residents with new behaviors were triggered in the morning meeting for review and Resident #16 was at their baseline and had not triggered for review in the morning meetings. ASM #2 stated that the psychiatrist relied on the staff to report any behaviors to them when they come to assess Resident #16. ASM #2 stated that the psychiatrist spoke to them, the nurse assigned and the unit manager for updates on the resident. When asked if wandering, pacing back and forth and not sleeping were indications for the administration of Seroquel, ASM #2 stated, "No." ASM #2 stated that Seroquel was prescribed for psychiatric behaviors and disorders, like schizophrenia or psychosis. When

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asked how new staff would know what Resident #16's specific behaviors were, ASM #2 stated that they would receive that information in their shift report each day. When asked what evidenced the need for the anti-psychotic medication without documentation of behaviors, ASM #2 stated that Resident #16 was at their baseline so there was not documentation of behaviors because they were not displaying any that triggered a review in the morning meetings.

On 1/20/2022 at approximately 4:00 p.m., a request was made to ASM #1, the administrator for the facility policy on behavior monitoring and unnecessary psychiatric medications.

On 1/20/2022 at 6:54 p.m., ASM #1 provided via email, "Behavioral Symptom Evaluation and Documentation Process" dated 2017. The algorithm documented in part, "Patient demonstrates a new onset behavior- Staff documents observed behavior in Custom Alert in POC (plan of care) or Mood/Behavior Progress note- Nursing and, or Social Services document evaluation of behavior in Mood/Behavior PN (progress note) & 24 hr (hour) report- Is behavioral symptom new or escalating- No- Review care plan or Kardex for non-pharm (non-pharmacological) interventions to implement- Monitor for changes, patterns in behavior..." The facility document, "Focus on F Tag 758" documented in part, "...Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that: ...Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs..." It further documented, "...Medications are monitored

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including responses, laboratory results when appropriate, potential adverse effects/consequences, effectiveness of non-pharmacological interventions particularly for high risk medications, such as warfarin, insulin and opiods..."

On 1/20/2022 at approximately 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant were notified of the findings. No further information was provided prior to exit.

References:

1. Alzheimer's disease: "Alzheimer's disease is an irreversible, progressive brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks. It is the most common cause of dementia in older adults." This information is taken from the website https://www.nia.nih.gov/health/alzheimers/basics.

2. Dementia: A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

3. Major depressive disorder: Major depression is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm.