STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	C 11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(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 A Recertification, Complaint, and Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Office of Licensure and Certification on 11/16/21 through 11/19/21. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Office of Licensure and Certification on 11/16/21 through 11/19/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Survey Dates: 11/16/21 through 11/19/21 Survey Census: 89 Sample Size: 18 Supplemental Residents: 0 No deficiencies were related to Intake VA00053084.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		12/27/21

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

Electronically Signed | 12/09/2021

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F 578	Continued From page 1 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on facility policy, clinical record review, and staff and family interviews, the facility failed to ensure family of one resident of five residents (Resident (R) 19) reviewed for advanced directives was adequately informed to make decisions related to the resident's code status. Code status options were not reviewed with R19's Resident Representative (RP)/Power of Attorney (POA) to determine the resident's wishes related	F 578	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility	

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F 578	Continued From page 2 to Cardio-Pulmonary Resuscitation (CPR). The findings include: The facility's "Advance Directives Policy," provided to the survey team and dated 03/24/20, read, in pertinent part, "Documents of declaration for advance directives that are approved by state law (i.e. Living Wills, Durable Powers of Attorney and/or Agents for Healthcare Decisions/Healthcare Power of Attorney, appointments for anatomic al gifts/organ donations) will be placed in the medical record as provided by the patient or legally designated representative." R19 was admitted to the facility on 08/21/21, according to the undated "Admission Record" found in the Electronic Medical Record (EMR) under the "Admissions" tab, with diagnoses including dementia and pneumonia. According to R19's "Minimum Data Set (MDS)," with an assessment reference date (ARD) of 08/25/21, R19 was severely cognitively impaired, with a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident could not complete the interview. The MDS indicated the resident had both short and long-term memory deficits, and her cognitive skills for daily decision making were severely impaired. R19's "MFA Policies Governing the Implementation of Self-Determination Rights Form," signed by the resident's POA, dated 11/17/21 (almost two months after the resident's admission to the facility), and provided to the survey team by the facility, indicated the resident had an Advance Medical Directive and the	F 578	has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 578 1. Resident R 19 Advance Directive was corrected and implemented at the time of survey. 2. Current residents will be audited by Discharge Planner to assure that all DNR information is in the clinical record per the residents wishes and appropriate orders obtained. 3. Licensed staff will be in-serviced on the DNR and Advance Directive Process and how to obtain correct orders on admission by the DON/Designee by December 21, 2021. 4. New admissions will be reviewed by the Discharge Planner on admission for Advance Directive and DNR status and report to nursing with new orders needed. 5. Any non-compliance will be reported to the QAPI committee for tracking and trending and any progressive disciplinary action as needed. 6. Completed 12/27/21	

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F 578	Continued From page 3	F 578		

directive was in the resident's medical file.

R19's "Durable, General Power of Attorney and Advance Medical Directive," dated 07/25/16 and located in the EMR under the "Miscellaneous" tab, documented the resident's wishes were "my dying shall not be artificially prolonged under the following circumstances, and do hereby declare that if at any time I should (1) have a terminal condition, (2) be comatose with little likelihood of recovery, (3) be in a persistent vegetative state, or (4) have any medical condition or disease from which recovery is unlikely and death or prolonged suffering leading to death is likely, based on then prevailing medical knowledge and treatment, and my attending physician(s) has (have) conferred with my agent and confirmed his/her/their diagnosis and such prognosis, and where the application of life-prolonging procedures would serve only to artificially prolong the dying process, then I hereby appoint, designate, authorize, direct, and empower my agent and attorney in fact (1) to do any and all things necessary to see that such procedures are withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care, or to alleviate pain, and (2) to exercise any and all powers set forth in Virginia Code 54.1-2984, A-F, H, K, and L."

R19's "Order Detail Report," dated 10/02/21 and located in the EMR under the "Orders" tab, indicated the resident's code status was Full Code.

During an interview on 11/16/21 at 4:59 PM, the Director of Nursing (DON) confirmed an

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F 578	Continued From page 4	F 578		

"Implementation of Self Determination of Rights Form" had not been completed for R19 upon admission per facility protocol, and she stated the resident's Responsible Party would be in to the facility the next morning to fill out the paperwork.

A "Communication Progress Note," dated 11/17/21 and found under the "Progress Notes" tab in the EMR, read, in pertinent part, "DP/SW [Discharge Planner/Social Worker, Director of Social Services (DSS)] spoke with patient's [niece] in regards to code status. Patient has completed advance directives listing [niece] as appointed to make decisions if patient unable. DP/SW asked if patient's heart was to stop beating does she want chest compressions done and niece states no. Niece does want patient to be a DNR [Do Not Resuscitate]."

During an interview on 11/18/21 at approximately 3:00 PM, the DSS stated R19's POA was in the facility the previous evening to sign advanced directive paperwork, and indicated she wanted to have the resident be a DNR. She stated R19's POA indicated she did not know where the facility got the idea that the resident was to be full code."

During an interview on 11/18/21 at 3:51 PM, R19's POA stated she wanted R19 to be a DNR according to the resident's wishes. R19's POA stated the facility had not spoken to her about the resident's code status prior to 11/17/21. R19's POA indicated the resident's Advance Directives had been provided to the facility upon admission, and that she assumed the Advance Directives were enough to show the resident's code status was to be DNR. She stated, "I don't remember having any conversation about CPR with facility at all."

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on facility policy, clinical record review, and staff interview, the facility failed to ensure timely reporting of allegations of abuse for one of one abuse report reviewed. An allegation of verbal abuse occurred in the presence of staff, in which Resident (R) 78 verbally abused R242, and the allegation was not reported to administration.	F 609	F 609 1. Resident # R242 is no longer in the facility. 2. Resident # R 78 was interviewed by Discharge Planner and no further concerns were documented or verbalized. 3. Nursing staff was in serviced by the	12/27/21

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F 609	Continued From page 6 The findings include: The facility's "Abuse/Neglect/Misappropriation/Crime Policy," provided directly to the survey team and dated 01/23/20, read, in pertinent part, "The Administrator will ensure the timely reporting, investigating, and follow-up reporting of incidents of alleged/suspected patient abuse, neglect, mistreatment, exploitation, or crime against a patient to the State Agency and any other appropriate authorities." R78 was admitted to the facility on 03/31/21, according to the undated "Admission Record" found in the Electronic Medical Record (EMR) under the "Admissions" tab, with diagnoses including schizoaffective disorder, dementia, and anxiety. According to R78's "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 10/27/21, R78 was cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. The MDS indicated the resident was not having behaviors during the assessment reference period prior to the assessment date of 10/27/21. R78's "Behavior Care Plan," dated 03/31/21, located in the Electronic Medical Record (EMR) under the "Care Plan" tab, read, in pertinent part, "The resident exhibits adverse behavioral symptoms r/t [related to] dementia, severe anxiety, refusal of care, yelling, cursing at staff, and delusions." Interventions included administer medications as ordered and monitor for side effects and effectiveness.	F 609	DON/Designee on being a mandated reporter and reporting all allegations of abuse by 12/21/21. 4. DON/Designee will review shift report daily to assure that no allegations of abuse are documented and if they are that they were reported to appropriate staff. 5. Any non-compliance will be reported to the QAPI committee for tracking and trending and any progressive disciplinary action as needed. 6. Completed 12/27/21	

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F 609	Continued From page 7	F 609		

R78's "Behavior Progress Note," dated 07/20/21 and located in the EMR under the "Progress Notes" tab, read, in pertinent part, "Resident verbally abusive toward roommate when [R242] asked CNA [Certified Nursing Assistant] to turn on air conditioner. [R78] called [R242] "a pain pill seeking Bitch. I'm going to beat your ass." [R242] verbalized fear of [R78];" and "[R242] was moved to another room;" and "Resident no longer aggressive but pleased to have room back to herself."

R242's clinical record was reviewed and indicated no documentation of the 07/20/21 event. Review of R242's MDS revealed that R242 was discharged from the facility on 08/07/21.

The nurse who documented the incident was not available for interview.

During an interview with the Administrator on 11/18/21 at 1:41 PM, R78's 07/20/21 Progress Note was reviewed, and the administrator stated the allegation of abuse was not reported to her per facility policy. She stated her expectations was the incident should have been reported to her immediately.

During a follow-up interview with the Administrator on 11/18/21 at 2:14 PM, she stated, "If someone says something (makes an allegation of abuse), that is to be reported to the charge nurse, then the Charge Nurse reports to the Unit Manager or the DON (Director of Nursing), then they (the Unit Manager of the DON) would notify me. Or they (staff) can just call me." The Administrator stated, "(The DON) was not aware of this, either."

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F 610	Continued From page 8	F 610		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on facility policy, clinical record review, and staff interviews, the facility failed to ensure an allegations of abuse were investigated for one of one abuse report reviewed. An allegation of verbal abuse occurred in the presence of staff, in which Resident (R) 78 verbally abused R242, and the allegation was not investigated. The findings include: The facility's "Abuse/Neglect/Misappropriation/Crime Policy," provided directly to the survey team and dated 01/23/20, read, in pertinent part, "The Administrator will ensure the timely reporting, investigating, and follow-up reporting of incidents	F 610	F 610 1. Resident # R242 is no longer in the facility. 2. Resident # R 78 was interviewed by Discharge Planner and no further concerns were documented or verbalized. 3. Nursing staff was in serviced by the DON/Designee on being a mandated reporter and reporting all allegations of abuse by 12/21/21. 4. DON/Designee will review shift report daily to assure that no allegations of abuse are documented and if they are that they were reported to appropriate staff. 5. Any non-compliance will be reported	12/27/21

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F 610	Continued From page 9 of alleged/suspected patient abuse, neglect, mistreatment, exploitation, or crime against a patient to the State Agency and any other appropriate authorities." R78 was admitted to the facility on 03/31/21, according to the undated "Admission Record" found in the Electronic Medical Record (EMR) under the Admissions Tab, with diagnoses including schizoaffective disorder, dementia, and anxiety. According to R78's "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 10/27/21, R78 was cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. The MDS indicated the resident was not having behaviors during the assessment reference period prior to the assessment date of 10/27/21. R78's "Behavior Care Plan," dated 03/31/21, located in the Electronic Medical Record (EMR) under the "Care Plan" tab, read, in pertinent part, "The resident exhibits adverse behavioral symptoms r/t [related to] dementia, severe anxiety, refusal of care, yelling, cursing at staff, and delusions." Interventions included administer medications as ordered and monitor for side effects and effectiveness. R78's "Behavior Progress Note," dated 07/20/21 and located in the EMR under the "Progress Notes" tab, read, in pertinent part, "Resident verbally abusive toward roommate when [R242] asked CNA [Certified Nursing Assistant] to turn on air conditioner. [R78] called [R242] "a pain pill seeking Bitch. I'm going to beat your ass." [R242] verbalized fear of [R78];" and "[R242] was moved	F 610	to the QAPI committee for tracking and trending and any progressive disciplinary action as needed. 6. Completed 12/27/21	

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F 610	Continued From page 10 to another room;" and "Resident no longer aggressive but pleased to have room back to herself." R242's clinical record was reviewed and indicated no documentation of the 07/20/21 event. R242 discharged from the facility on 08/07/21. The nurse who documented the progress note was not available for interview. During an interview with the Administrator, who was also the facility's abuse coordinator, on 11/18/21 at 1:41 PM, R78's 07/20/21 Progress Note was reviewed, and the administrator stated, "I'm not going to lie to you. I was not aware of that incident and so there is not likely going to be an investigation." The Administrator stated her expectation was allegations of abuse be reported to her immediately so an investigation could be started. During a follow-up interview with the Administrator on 11/18/21 at 2:14 PM, she stated she was unable to locate an investigation related to incident of 07/20/21. She stated facility policy was all allegations of abuse were to be investigated immediately. The Administrator stated that allegations were to be reported to her and then she was responsible for conducting the investigation.	F 610		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and	F 655		12/27/21

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F 655	Continued From page 11	F 655		

implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

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F 655	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and policy review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours of admission to the facility for one resident (Resident (R)1) of six residents reviewed for baseline care plans in a total sample of 18 residents. This deficient practice increased the risk for R1 not to receive the appropriate care. Findings include: Review of facility policy titled, "Care Planning," dated 11/01/19, revealed, "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient. The computerized baseline Care Plan is initiated and activated within 48 hours. The Center will provide the patient and representative(s) with a summary of the baseline care plan that includes but is not limited to: . . . any services and treatments to be administered by the Center and personnel acting on behalf of the Center." Review of R1's "Face Sheet" found in the electronic medical record (EMR) under the "Diagnoses" tab, revealed that R1 was admitted on 11/04/21 for skilled services to address nontraumatic subdural hematoma (SDH-bruising under the membranous covering of the brain) due to a fall prior to admission. R1 had been a resident of the facility for multiple episodes of	F 655	F 655 1. Resident #1 care plan was updated at the time of survey and falls, and catheter added. 2. Current residents care plans were audited to assure that residents with suprapubic catheters had care plans in place and current residents had care plans for falls or potential for falls. 3. Licensed staff were in serviced on starting the initial care plan with each admission and what needed to be started by the DON/Designee by 12/21/21 4. New admission will be audited within 24 hours of the admission to assure that the initial care plan was started by the Unit Manager/ Designee and reported to the DON in clinical meeting each day. 5. Any non-compliance will be reported to the QAPI committee for tracking and trending and progressive disciplinary as needed. 6. Completed 12/27/21	

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care (EOC) in 2018, 2019, and 2021 and diagnoses on the "Face Sheet" included hydrocephalus (fluid on the brain), presence of cerebrospinal fluid draining device (drain implanted in the brain to remove excess cerebrospinal fluid), muscle weakness, abnormalities of gait and mobility, cognitive communication deficit, benign prostatic hyperplasia (BPH) with lower urinary tract symptoms, seizures, presence of urogenital implant, repeated falls, and unsteadiness of feet.

Review of R1's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 11/08/21 indicated "in progress." The MDS did not record a "Brief Interview for Mental Status (BIMS)" score for R1, or information regarding R1's fall history and risk, or information regarding use of a urinary catheter.

Review of R1's active orders in the EMR under the "Orders" tab reflected no orders for indwelling suprapubic (urinary catheter inserted into the bladder through an incision in the abdomen) catheter care until 11/17/21. Orders, dated 11/17/21, included for staff to "change suprapubic every 30 days, change suprapubic cath [catheter] PRN [as needed] for clinical indications (s/s infection, etc.) suprapubic cath care q [every] shift, foley suprapubic cath care q shift, suprapubic cath 20 F/10 cc, flush suprapubic w/60 ml sterile water every 3 days and PRN." Further review of R1's physician's orders revealed no orders for fall precautions.

Review of R1's "Baseline Care Plan," found in the EMR under the "Care Plan" tab and dated 11/05/21, revealed the care plan did not address falls or indwelling catheter status until 11/18/21

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F 655	Continued From page 14 and 11/17/21, respectively, which was not within 48 hours of admission. During an interview on 11/18/21 at 9:25 AM, the Unit Manager (UM) stated said that she was still in training for development of baseline care plans and that the UM who usually completed the baseline care plans was not working on 11/18/21. During an interview on 11/18/21 at 9:53 AM the Director of Nursing (DON) said it was her expectation that initial care plans address all issues and that the UM is responsible for making sure the care plan is complete. The DON also stated that the UM is responsible for completing audits regarding physician orders. The DON had no explanation as to why R1 did not have a baseline care plan/physician's order for falls and urinary catheter usage. During interviews on 11/18/21 at 12:30 PM and 1:20 PM, the MDS Coordinator (MDS) confirmed that a resident-centered "Baseline Care Plan" was not completed for R1. The MDS Coordinator stated that a "Baseline Care Plan" was initiated on 11/04/21 and verified that the falls and catheter care plans were not in the care plan until 11/18/21 and 11/17/21, respectively. The MDS Coordinator stated that the Unit Manager was responsible for reviewing baseline care plans and orders to make sure they were correct within 48 hours of admission.	F 655		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		12/27/21

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F 689	Continued From page 15 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to assess fall risk, develop a fall care plan, and provide supervision to prevent accidents for one (Resident (R) 1) of one resident reviewed for accidents in a total sample of 18 residents. Findings include: Review of the facility "Falls Management Program," dated 11/01/19, reflected that "The Center considers all patients to be at risk for falls ... A fall is defined as an unintentional change in position coming to rest on the ground or onto the next lower surface ..." The Procedure notes that "A Fall Risk Assessment will be completed upon admission, readmission ... Incorporate identified interventions into the Comprehensive Care Plan as applicable." The Falls Management Pathway reflected "Selected interventions are to be included in the plan of care with supporting documentation/orders ... and Risk Areas were noted to include medications, mobility, unsafe behavior, and other." Review of R1's "Face Sheet," found in the Electronic Medical Record (EMR) under the "Diagnoses" tab, revealed that R1 was admitted on 11/04/21 for skilled services to address a nontraumatic subdural hematoma (bruising under the membranous covering of the brain) due to a fall before admission. Review of the "Face Sheet"	F 689	F 689 1. Resident R 1 had falls risk assessment completed and care plan updated at the time of survey. 2. Current residents will be audited to assure falls risk assessment is complete and in medical record and care plans are in place and updated for fall interventions as needed. 3. DON/ Designee will in service staff on the falls risk assessment and the implementation of interventions on the care plan by 12/21/21. 4. Residents that fall will be reviewed by the Unit Manager as they occur to assure that falls risk assessment is in place, care plan is revised for updates with falls and interventions are in place. Unit Manager will report this in daily clinical meeting. 5. Any non-compliance will be reported to the QAPI committee for tracking and trending and progressive disciplinary action as needed. 6. Completed 12/27/21	

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revealed that R1 had been a resident of the facility for multiple episodes of care (EOC) in 2018, 2019, and 2021. Diagnoses on the "Face Sheet" included hydrocephalus (fluid on the brain), presence of cerebrospinal fluid draining device (drain implanted in the brain to remove excess cerebrospinal fluid), cognitive communication deficit, other seizures, generalized muscle weakness, abnormalities of gait and mobility, and repeated falls.

Review of R1's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 11/08/21 indicated "in progress." The "MDS" did not record a "Brief Interview for Mental Status" (BIMS)" score for R1. Review of this "MDS" reflected that R1 had a fall in the month before admission as well as a fall during the two to six months before admission. Review of the Care Area Assessment (CAA) reflected that falls were triggered as an area of concern but the care planning decision was not marked. Cross Reference: F655-Baseline Care Plan.

Review of the EMR revealed staff had not completed a fall risk assessment upon R1's admission to the facility despite a history of falls during previous admissions as well as falls prior to admission to the facility on 11/04/21.

Review of the most current "Falls Risk Assessment," dated 07/29/21 and provided by the facility, revealed that R1 had suffered a fall on 07/28/21 at 11:30 PM. Further review of this "Fall Risk Assessment" revealed "pt [patient] observed in floor beside bed [sic] . . . History [hx, sic] of falls; unsteady gait . . . scratch on upper left arm . . .Recommendations: close monitoring . . . "

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Review of "Nursing Progress Notes," found in the EMR under the "Progress Notes" tab, revealed a "Late Entry" effective 11/04/21 at 8:00 PM stating, "Behavior Note Type of Behavior: Pt was found lying on floor out in hallway. Pt stated 'I didn't fall. I was coming out here to some of ya' [sic] Pt stated he slid down the wall and onto the floor but did not hit his head." Further review of the "Progress Note," in the EMR and dated 11/16/21, revealed "Behavior Note Type of Behavior: Pt sat himself in the floor, DON [Director of Nursing] in with pt during fall, pt slid down leg [sic]."

Review of a "Physical Therapy (PT) PT Evaluation & Plan of Treatment," dated 11/05/21 and provided by the therapy department, reflected that R1 was referred to PT for "Current Illness: Admission from hospital (sic) after fall suffering SDH [subdural hematoma]" with noted medical history including recurrent falls: "Precautions: fall risk." The PT "Fall Risk Assessment," dated 11/05/21 reflected a history of falls with injury and that R1 "worries" about falling. PT records reflected that R1 received PT on 11/05/21, 11/07/21, 11/10/21, 11/11/21, 11/15/21, and 11/17/21 and all treatments noted fall risk precautions. Review of the therapy notes revealed no specific fall risk precautions implemented for R1.

Review of an "Occupational Therapy (OT) OT Evaluation & Plan of Treatment," dated 11/05/21 and provided by the therapy department, reflected that R1 was referred to OT for "Current Illness: mechanical fall ... found to have acute on chronic SDH" with noted medical history including multiple falls. "Precautions: fall risk, cognition, shunt, suprapubic catheter." The OT "Fall Risk Assessment" section dated 11/05/21 reflected a

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history of falls with injury, impaired safety awareness, and that the resident "worries" about falling. OT records reflected that R1 received OT on 11/05/21, 11/09/21, 11/10/21, 11/11/21, 11/12/21, 11/15/21, 11/17/21, and 11/18/21 and all treatments noted fall risk precautions. Review of these OT notes revealed no specific fall risk precautions implemented for R1.

Review of R1's physician's orders, dated 11/04/21 and located in the EMR under the "Orders" tab, revealed no orders related to falls.

Review of R1's "Care Plan" found in the EMR under the "Care Plan" tab revealed a baseline care plan initiated on 11/05/21, however falls were not addressed despite R1's history of falls during previous admissions, on 11/04/21, and on 11/16/21.

During an observation on 11/17/21 at 4:52 PM, R1 told the surveyor that he had just suffered a fall today and that the doctor had "checked him out." R1 said he did not know why he fell. A discolored and swollen "goose-egg" area approximately 2.5 centimeters (ovoid) was noted on the right side of R1's forehead.

During an interview on 11/17/21 at 4:55 PM, Licensed Practical Nurse (LPN) 3 stated that she was completing a risk assessment form for R1's unwitnessed fall on 11/17/21.

Review of the facility provided "Privileged and Confidential-Not part of the Medical Record-Do not Copy report" of the Un-witnessed fall completed by LPN3 revealed the fall occurred on 11/17/21 at 4:02 PM. Further review of the fall report revealed " . . . Patient observed in [sic]

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floor in front of wheelchair beside room door. Patient Description: 'I just got up and fell over.' Immediate Action Taken Description: Pt assessed from head to toe. Nero [sic] assessment provided. Pt assessed for injury. Pt states no pain at this time other then [sic] to head. Pt Pupils Equal and Reactive to Light and Accommodation (PERLA) Range of motion (ROM) and reflexes baseline to all extremities. Physician (MD) in house and notified about Pt fall. MD in to assess Pt post fall. No new orders at this time . . . Behavior(s); Predisposing Physiological Factors Gait Imbalance, Impaired Memory, Recent Illness, and Weakness/Fainted; Predisposing Situation Factors Admitted within Last 72 hours, Ambulating without Assist, During Transfer, Recent Room Change, and Wanderer . . . Problems with Mobility of Unsteady gait/poor balance and Use of assistive device, Unsafe Behaviors of Wandering without regard for fatigue and Attempts to rise/ambulate/transfer unsafely . . . Other: History of falls, Memory loss, and New Environment."

Further review of this fall report revealed the following new interventions initiated in response to the fall: "Provide ambulation assistance and Restorative ROM [range of motion] . . . Unsafe Behavior Re-direct/provide diversional activity . . . Education regarding call for assistance . . . Pt with Stop and call sign placed to closet door . . . Unsafe Behavior Observed or history of (check all that apply): Tries to stand, transfer, or walk alone unsafely, Tries to climb, get out of bed alone unsafely, Walks or paces alone when too tired to be safe, Propels or walks alone in unsafe places . . . Medical Note dated 11/18/21 of the provider notes and a reference Into [sic] see for fall. Had fall last night . . . Assessment/Plan: fall with

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hematoma to forehead, Monitor neuro status, Discussed falls risks and the importance to call for help, call button with the patient. Patient agreeable to plan to call, Nursing to place stop and call sign in room, CNA offering bathroom every (q) two hours, Instructed if does not have call bell to yell out, Door open for easier review of patient . . . "

Review of the "Care Plan," located in the EMR under the "Care Plan" tab, revealed a falls care plan initiated on 11/18/21 after three falls during the current admission (11/04/21, 11/16/21, and 11/17/21) with the fall on 11/17/21 resulting in a hematoma to R1's forehead.

Review of this falls care plan with an initiation date of 11/18/21 revealed the following: "Focus: resident is at risk for falls r/t [related to] Confusion, Gait/balance problems, Poor communication/comprehension, Unaware of safety needs" with "Interventions: Anticipate and meet the resident's needs, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c . . . Focus: The resident had an actual fall with minor injury Poor Balance, Unsteady gait on 11/17/21 . . . Interventions: Activities consult for increased stimulation, Education regarding call for assistance, Keep environment well-lit during day, Monitor changes in behavior, PT consult for strength and mobility, Re-direct/provide diversional activity, Re-locate to high visibility area, and Vital signs as needed."

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F 689	Continued From page 21 During an interview on 11/18/21 at 9:32 AM, Certified Nursing Assistant (CNA) 2 stated that she had worked with R1 during his previous and current admissions. CNA2 stated that she knew that he was a fall risk, so they tried to remind him to request assistance. CNA2 stated that the CNAs use the information on the "Treatment Administration Record (TAR)" for resident specific care needs. Review of the TAR, located in the EMR under the "Orders" tab and dated November 2021, revealed no fall precautions listed for staff to implement prior to 11/18/21. During an interview on 11/18/21 at 9:42 AM, LPN3 stated that she did not know R1 very well and said that fall interventions were in place for R1. The surveyor asked her for specific interventions, and LPN3 said she would look at R1's care plan. LPN3 pulled up R1's care plan on the computer and stated that there was no care planning for falls on the care plan prior to the day of this interview. LPN3 was unable to indicate what fall interventions the nursing staff was implementing prior to 11/18/21. During an interview on 11/18/21 at 10:10 AM the Administrator said she was familiar with R1. The Administrator said that there were interventions in place but R1 refused to follow guidance, they were doing the best they could, and she knew falls were a recurrent issue. The Administrator was unable to specify what fall interventions were in place for R1 and what interventions had been attempted since R1 refused to "follow guidance" leading up to the fall on 11/17/21, which resulted in a hematoma on the right side of the forehead.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693		12/27/21

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F 693	Continued From page 22 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on facility policy, clinical record review, and staff interview, the facility failed to ensure appropriate care of a gastrostomy (g, a tube inserted through the wall of the abdomen directly into the stomach)-tube during medication administration for one resident of three residents (Resident (R) 146) who were reviewed during medication administration. Findings include: The facility's "Feeding Tubes Policy," provided by the facility and dated 11/01/19, read, in pertinent part, "The patient will receive the necessary skills	F 693	F 693 1. Nurse who administered resident R 146 medication did receive education on the proper procedure for administering medication via a G-Tube. 2. Audit was done of all residents with G-Tube were assessed for orders to administer medications all at one time or one at a time and MD notified for orders as needed. Charts were audited to assure HOB orders were in place to keep head of beds elevated and also to verify tube placement. 3. DON/Designee will in service staff on	

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F 693	Continued From page 23 and services necessary to maintain skin integrity related to the stoma site, maintain patency of the feeding tube to the degree possible, assess for placement and residual amounts, ensure proper functioning of the tube feeding equipment, ensure tube feeding formulas are maintained according to the manufacturer's recommendations, and administered by physician's orders;" and "Procedure: Medication Administration: 2. Elevate head of bed to 30 to 45 degrees, 4. Verify tube placement and residual amounts, 7. Pour one medication at a time into the syringe and instill into feeding tube; follow with 15 cc (cubic centimeters) water flush, or as prescribed by physician; and 8. Repeat other medications one at a time." R146 was admitted to the facility on 11/13/21, according to the undated "Admission Record" found in the electronic medical record (EMR) under the "Admissions" tab, with diagnoses including history of stroke and dysphagia. According to R146's "Minimum Data Set (MDS)," Assessment Reference Date (ARD) of 09/14/21, R146 was severely cognitively impaired, with a Brief Interview for Mental Status (BIMS) score of 99. The MDS indicated the resident had both short and long-term memory deficits. The assessment indicated the resident received 51 percent or more of his daily caloric intake via his g-tube. R146's "Order Summary Report," dated 11/18/21 and located in the EMR under the "Orders" tab, indicated the resident was to be NPO (Nothing Per Mouth) and orders were in place for the resident to receive Chewable Aspirin 81 milligrams (MG) via g-tube one time daily,	F 693	procedure for administering medication thru a G-Tube by using policy #1401 by 12/21/21 4. DON/ Unit Manager will monitor nurses daily for two weeks on administering medications thru a G tube and then weekly for 4 weeks. Corrective action will be done at the time of observation. 5. Any non- compliance will be reported to the QAPI committee for tracking and trending and progressive disciplinary actions as needed. 6. Completed 12/27/21.	

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	495294	A. BUILDING _____ B. WING _____	C 11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 693	Continued From page 24	F 693		

Clindamycin 600 MG via g-tube three times daily, prednisone 20 MG via g-tube one time daily, and sertraline 75 MG via G-Tube one time daily. A crush order was in place for the resident, to facilitate administration of the medication through the resident's g-tube. No order could be found on the "Order Summary Report" to indicate medications were to be crushed together and given via the resident's g-tube at the same time.

Licensed Practical Nurse (LPN) 2 was observed administering R146's medications on 11/17/21 at 9:42 AM. R146's aspirin, prednisone, and sertraline were placed into a medication cup and crushed all together. R146's clindamycin capsule was opened, and the medication was added to the other crushed medication and then all four of the medications were mixed with approximately 20 milliliters (MLs) of water. The placement of R146's g-tube was not checked prior to administration of the g-tube medications. R146 was in bed at the time of his medication administration, and the head of his bed was elevated approximately 10 degrees. LPN2 did not raise the head of R146's bed to the required 30 to 45 degrees prior to administering the medication. LPN2 was observed to flush the resident's g-tube with approximately 15 MLs of water and then the medications were administered via the resident's g-tube all at the same time. After administering the resident's medications, LPN2 flushed the resident's g-tube with another 15 MLs of water.

During an interview on 11/17/21 at 10:09 AM, LPN2 verified R146 did not have an order to mix all of his medications together for administration and stated, "I normally check placement (of the g-tube prior to administration of medications), but I didn't today." LPN2 acknowledged the head of

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F 693	Continued From page 25 the resident's bed should be up at least 30 degrees when administering medication through his g-tube. During an interview on 11/17/21 at 10:35 AM, the Director of Nursing (DON) stated her expectation for administration of g-tube medications was that the resident's head of bed should be up at least 30 degrees and nurses should be following facility policies related to administration of g-tube medications.	F 693		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		12/27/21

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F 880	Continued From page 26	F 880		

procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

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F 880	Continued From page 27 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and policy review, the facility failed to follow hand hygiene protocol for one resident (R146) of three residents observed during medication administration. This deficient practice increased the risk for spread of infection for these residents. The facility's "Administration Procedures for All Medications Policy," dated 09/2018 and provided by the facility, read, in pertinent part, "Medications will be administered in a safe and effective manner;" and "Administration: 3. Cleanse hands using antimicrobial soap and water or facility approved hand sanitizer before beginning a med pass, before handling medication, and before contact with a resident." R146 was admitted to the facility on 11/13/21, according to the undated "Admission Record" found in the electronic medical record (EMR) under the "Admissions" tab, with diagnoses including history of stroke and dysphagia. According to R146's "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) 09/14/21, R146 was severely cognitively impaired, with a Brief Interview for Mental Status (BIMS) score of 99. The MDS indicated the resident had both short and long-term memory deficits. The assessment indicated R146 received 51 percent or more of his daily caloric intake via his gastrostomy (g, a tube inserted through the wall of the abdomen directly into the stomach)-tube. R146's "Order Summary Report," dated 11/18/21	F 880	F 880 1. Nurse who administered resident 146 medications did receive education on proper hand washing and not touching medications with medication pass. 2. Licensed nurses were educated on hand washing and not touching medications with medication pass by DON/Designee by 12/21/21 3. Unit Manager/ DON/ Designee will monitor hand washing and proper medication pass procedure for current nurses and then they will monitor medication pass two times per week for two weeks they monthly for the next quarter. 4. Any noncompliance will be reported to the QAPI committee for tracking and trending and progressive disciplinary action. 5. Completed 12/27/21	

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and located in the EMR under the "Orders" tab, indicated the resident was to receive Clindamycin 600 milligrams (MG) (a capsule) via g-tube three times daily.

Licensed Practical Nurse (LPN) 2 was observed administering R146's medications on 11/17/21 at 9:42 AM. LPN2 dispensed the resident's clindamycin capsule into a medication cup with three other medications (all in tablet form). After dispensing all the resident's g-tube medications into the medication cup, LPN2 removed the clindamycin capsule from the medication cup, touching the outside of the clindamycin capsule as well as the other medication tablets, without first sanitizing her hands or putting on gloves. The capsule was opened with the nurse's bare fingers and the contents of the capsule was placed back into the medication cup with the resident's other g-tube medications prior to administration.

During an interview on 11/17/21 at 10:09 AM, LPN2 stated, "When I pulled the capsule out [of the medication cup] I didn't touch the medicine, so I didn't put on gloves."

During an interview on 11/17/21 at 10:35 AM, the Director of Nursing (DON) stated, "She [LPN2] should not have been touching anything with her bare hands when passing meds [medications]."