STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495405	A. BUILDING _____ B. WING _____	03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT SQUARE	501 OAK AVENUE WAYNESBORO, VA 22980

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/8/22 through 3/10/22. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/8/22 through 3/10/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code report will follow. The census in this eighteen certified bed facility was seventeen at the time of the survey. The survey sample consisted of nine current record reviews and two closed record reviews.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this	F 582		4/1/22

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

Electronically Signed | 03/23/2022

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F 582	Continued From page 1 section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to provide advance	F 582	Step I Resident #5 was provided notice of	

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F 582	Continued From page 2 notice of Medicare non-coverage for one of three residents reviewed regarding beneficiary notification protection. Resident #5 was not provided notice of Medicare non-coverage. The findings include: The facility's notifications of Medicare non-coverage were reviewed on 3/9/22. The facility documented on the review sheet that Resident #5's skilled Medicare part A services began on 8/12/21 and the last day of part A services was 9/13/21. This form indicated that no notification about the non-coverage was provided to the resident or the resident's representative. The explanation documented about the lack of notification was "unable to locate." On 3/9/22 at 4:06 p.m., the facility's social services director (other staff #1) was interviewed about the lack of notification of Medicare non-coverage for Resident #5. The social services director stated she started working at the facility in October 2021 and this occurred prior to her hire date. The social services director stated she looked for the notice and did not locate it. No other evidence of notification was presented prior to the end of the survey. This finding was reviewed with the administrator and director of nursing during a meeting on 3/9/22 at 4:30 p.m.	F 582	Medicare non-coverage as the resident transitioned from skilled nursing to staying in the healthcare unit. The ABM form was placed in the resident's electronic Medical record on 3/21/22. Step II A review of current healthcare residents was completed to identify if notices of Medicare/Medicaid services, charges, changes in coverage under 483.10(g)(18) were completed. Any deficient practice was corrected. Step III The Summit Square Social Worker was educated by an experienced Social Worker from a sister facility regarding these requirements on 3/17/22. Step IV The Administrator or Executive Director will ask the Social Worker each week for the next 5 weeks to submit a short report of the residents who received notices. The Administrator or Executive Director will monitor Monday through Friday AM meeting and weekly Resident Review meetings (in which the Social Worker attends) that notices are given. The Administrator or Executive Director will be responsible for re-educating if any required notices are missed. Clinical Consultants will be asked to audit 2 random charts in April and May and will submit findings for QAPI. Any issues will be discussed at monthly performance improvement and brought to quarterly quality assurance meetings as needed.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		4/1/22

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F 658	Continued From page 3 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review the facility staff failed to follow professional standards of care for 2 of eleven residents in the survey sample, Resident 14 and #10. Resident #14 was not accurately monitored for bowel elimination. During a medication pass observation, a nurse removed a lidocaine patch from the original packaging and left it in Resident #10's room after the resident requested to have the patch at a later time. Approximately 1.5 hours later, the patch was found in the unit's shower room and had not been applied to the resident. The findings include: 1. Resident #14 was admitted to the facility on 11/16/2021 with diagnoses that included overactive bladder, mxed irritable bowel syndrome, depression, anemia, muscle weakness, and hypertension. The most recent minimum data set (MDS) dated 2/15/2022 was a quarterly assessment and assessed Resident #14 as moderately impaired for daily decision making with a score of 10 out of 15. Under Section H - Bowels and Bladder, the MDS assessed Resident #14 as frequently incontinent for urinary function	F 658	Step I Resident #14 is continent of bowel and often goes independently to the bathroom. Nurse aides are asking Resident #14 of her bowel and bladder habits for the shift in order to document findings in the resident's bowel and bladder record in point of care electronic medical record documentation. The day nurse is checking Resident #14 bowel record daily and providing further assessment if resident patterns have changed. Resident #10 is receiving the Lidocaine patch. It is applied by the nurse and the patch is kept protected in the package up until the application. Step II The bowel records of current residents were evaluated to determine if any resident were having constipation (no bowel movement for 3 days. Other current residents with a medication topical patch will be evaluated for proper administration and care of the patch. Step III The Director of Nursing, Unit Manager/MDS Nurse and RN #1 were educated by the Administrator on the responsibility licensed staff have on practicing within our standards of practice and also the responsibility of monitoring	

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F 658	Continued From page 4 and always continent for bowel function. The MDS assessed Resident #14 as requiring limited assistance with one person physical assistance for toileting. On 03/09/2022 at 11:02 a.m., Resident #14 was interviewed regarding the quality of care and quality of life since her admission to the facility. Resident #14 shared she previously resided on the assisted living unit, but she was now on the healthcare side because she required more assistance. Resident #14 was asked if staff assisted her with her activities of daily living (ADLs). Resident #14 stated the staff helped her with sometimes, but she liked to do most things on her own. Resident #14 stated she had some difficulty urinating and had constipation sometimes. Resident #14 stated she liked to receive her Miralax in her coffee. Resident #14's electronic health record (EHR) was reviewed on 03/09/2022. Observed on the care plans was the following focus area: "(Resident #14) has an ADL (activity of daily living) self-care performance deficit r/t (related to) Edema of BLE (bilateral lower extremity), HTN (hypertension), CKD 3a (chronic kidney disease 3), Decreased functional mobility, Chronic pain, IBS (irritable bowel syndrome) - mixed, GERD (gastro esophageal reflux disease), mild asthma. Dated Initiated: 12/03/2021. Revision: 02/15/2022. Goal: The Resident will maintain current level of function in through the review date. Date Initiated: 12/03/2021. Revision: 03/01/2022. Target Date: 05/15/2022. Interventions:.... Toilet (Resident #14) approx (approximately) every 2 hours to decrease risk of falls. TOILET USE: (Resident #14) requires staff assist for toileting...."	F 658	other nurses. Nurses and Nurse Aides are being educated on the importance of recording bowel as well as bladder function. A revised Bowel Protocol policy will provide procedures and protocols on the importance of monitoring residents bowel habits, documentation in point of care and the day nurse assessing each day for issues of constipation and need for further medical and or dietary intervention. Staff will be educated on this. Step IV The DON will audit 5 residents' bowel records once each week for 5 weeks and re-educate staff as needed. The Unit Manager will be responsible that this process continues and will report to the DON any variances found. Clinical Consultants will be asked to audit 2 random charts in April and May and will submit findings to DON and Administrator/Executive Director for review. Variances or deficient practices with the protocol will be brought to Monthly Performance Improvement meetings which are called Clinical Operations Report Review and brought to Quarterly Quality Assurance meeting.	

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Resident #14's bowel and bladder elimination record was reviewed for the period of November 2021 through March 2022. A review of the bowel elimination record documented Resident #14 did not have a bowel movement for the following days: 11/23/21 - 11/26/21; 11/28/21 - 11/30/21; 12/11/21 - 12/13/21; 12/19/21 - 12/22/21; 12/25/21 - 12/31/21; 01/10/22 - 01/12/22; 01/19/22 - 02/11/22; 02/19/22 - 02/23/22; and 03/01/22 - 03/09/22.

On 03/10/2022 the above findings were reviewed with the Administrator, director of nursing (DON), and corporate consultant at 4:30 p.m.

On 03/10/2022 at 8:30 a.m., the bowel and bladder elimination report were reviewed with the DON. The DON was asked who was responsible for documenting bowel and bladder continence/incontinence. The DON stated the CNAs (certified nursing assistants) documented the information. The DON was advised of the concern that Resident #14's (EHR) documented several consistent days of "No bowel movement." The DON stated she believed this was a reporting issue. The DON was asked if there was a report to show residents who did not have a bowel movement within a certain time period. The DON stated the night nurse ran the report. The DON was asked for the facility's bowel and bladder management protocol. The DON stated, "I don't think we have a specific protocol, but I will look and get back with you." The DON was asked if the facility had specific standing orders for bowel and bladder management. The DON stated, "No, but I will look and let you know."

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On 03/10/2022 at 9:22 a.m., registered nurse (RN) #1 who routinely provided care for Resident #14 was interviewed regarding Resident #14's bowel elimination. "RN #1 stated, "She is a obsessed with going to the bathroom. She eats her meals and then will come back and go the bathroom. Sometimes she will sit in there until she strains or finally goes to the bathroom." RN #1 was asked if she had any conversations with either the CNAs or Resident #14 not having any bowel movements. RN #1 stated, "No." RN #1 was asked who was responsible for documenting the bladder and bowel information. RN #1 stated, "Normally the CNAs do, but I think there is a problem with the (software). I know she (Resident #14) goes to the bathroom several times a day." RN #1 was asked if Resident #14 had a daily bowel movement. RN #1 stated, "No, I don't think so but she does have them many times a week. RN #1 was asked if staff assisted Resident #14 with toileting. RN #1 stated, "No, she is able to transfer her self on/off the toilet and she is able to clean herself as she requests to have multiple rolls of toilet paper and/or wipes in her bathroom."

On 03/10/2022 at 9:44 a.m., Resident #14 was interviewed regarding her bowel continence. Resident #14 was asked how often did she have a bowel movement. Resident #14 stated, "Not every day, but at least 2-3 days per week." Resident #14 was asked if staff helped her with toileting. Resident #14 stated, "No." Resident #14 was asked if she any concerns of constipation or bloating. Resident #14 stated, "No, I get constipated sometimes and I like my Miralax in my coffee."

On 03/10/2022 at 10:02 a.m., the DON stated,

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"(Resident #14) is independent for toileting. We don't always know when she goes to the bathroom. We would like for her to let us know when she needs assistance. The CNAs need a little more education about asking the residents when they have used the bathroom; they don't know they need to ask the residents if and when they use the bathroom. They've been trained so well that they don't ask if they don't see. We need to do some reeducation for the CNAs and nurses for each shift. I did discuss with the night shift nurse the report concern and she had a conversation during report between shifts about the documentation and it kind of ended there. They need to verify with the resident if they actually have a bowel movement." The DON was asked if nursing had reported to her about their concerns about the bowel elimination report. The DON stated, "No." The DON was asked for clarity regarding the CNAs documentation of "no bowel movement." The DON stated, "Basically because they don't assist (Resident #14) with toileting, they don't know that she has had a bowel movement. So they simply document as if she hasn't had one instead of asking and verifying with her."

On 03/10/2022 at 11:04 a.m., the DON advised that there were no standing orders for bowel and bladder management. The DON stated, "What I've found for the policy really doesn't work. It should be individualized based on the resident. For (Resident #14) we could place her on a toileting schedule." The DON was asked how was it communicated to the staff that as a standard of nursing practice they should contact the physician if there was a concern if a resident had not had a bowel movement. The DON stated "They should use nursing judgement." The DON

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was asked what resources did they follow to help guide their nursing policies and procedures. The DON stated, "A standard needs to be established and we will need to get creative with the unit manager to come up with a standard."

No additional information was provided to the survey team prior to exit on 03/10/2022 at 12:45 p.m.

2. A medication pass was conducted on 3/9/22 at 7:31 a.m. with registered nurse (RN) #1 administering medications to Resident #10. The medications prepared for Resident #10 include a lidocaine 5% patch. RN #1 administered oral medications and an eye drop to Resident #10 at the bedside. Resident #10 stated at this time that she wanted to wait until after her shower to apply the lidocaine patch. Upon completion of the medication administration, RN #1 left the lidocaine patch on the resident's dresser beside the television. The patch was not in the original packaging or sealed in any type of envelope or container. RN #1 returned to the medication cart and proceeded with medication administration to other residents on the unit.

Resident #10's clinical record documented a physician's order for Lidoderm (lidocaine) 5% patch to be applied to the lower back once per day for pain management.

On 3/9/22 at 8:50 a.m., the lidocaine 5% patch was no longer on the dresser beside the resident's television. RN #1 was interviewed at this time about where the patch was located and if the patch had been applied. RN #1 stated she thought the CNA (certified nurses' aide) took the patch with the resident to the shower room.

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On 3/9/22 at 8:56 a.m., accompanied by RN #1, the shower room was entered. RN #1 located the lidocaine 5% patch on a shelf in the shower room. The patch was uncovered and not enclosed in type of packaging. RN #1 stated at this time that the aides were going to let her know when the shower was finished so she could apply the lidocaine patch.

On 3/9/22 at 10:37 a.m., the unit manager (RN #2) was interviewed about RN #1 leaving the lidocaine patch in Resident #10's room and aides taking the patch to the shower room. RN #2 stated no medications were supposed to be left at the bedside or in resident rooms and nurses were required to administer medications.

The facility's policy titled Medication Administration in the Skilled Nursing Center (revised 9/18/19) documented, "...Only persons licensed or permitted by the State of Virginia may prepare, administer or record the administration of medications (e.g., RNs & LPNs)...The individual administering the medication must ensure that the right resident, right medication, right dosage, right time and right method of administration are verified before the medication is administered...Should a drug be withheld or refused, the individual administering the medication will chart as not given..."

The National Institutes of Health describes Lidoderm (lidocaine) 5% patch as a topical anesthetic used for post-herpetic pain relief. Instructions for handling of the lidocaine patch include, "...Keep this medication in the container it came in, tightly closed...Store it at room temperature and away from excess heat and moisture (not in the bathroom). Do not store

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F 658	Continued From page 10 patches and topical systems outside the sealed envelope..." (1) This finding was reviewed with the administrator and director of nursing during a meeting on 3/9/22 at 4:30 p.m. (1) Lidocaine Transdermal patch. Medline Plus. National Institutes of Health. 3/14/22. https://medlineplus.gov/druginfo/meds/a603026.html	F 658		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to assess and implement interventions for prevention/care of pressure ulcers for one of eleven residents in the survey sample, Resident #8. For over two months, physician ordered treatments of Resident #8's pressure ulcers were not implemented and facility	F 686	Step I Resident #8 has a current weekly skin check and orders written for wound care in her electronic medical record. Her care plan has been updated with interventions to prevent and heal pressure sores. Step II Current resident's electronic medical	4/1/22

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F 686	Continued From page 11 staff failed to thoroughly assess and provide routine monitoring of the wounds. Resident #8 acquired new pressure ulcers after weeks without routine skin assessments/body audits. The findings include: Resident #8 was admitted to the facility on 10/11/21 with diagnoses that included hypothyroidism, COPD (chronic obstructive pulmonary disease), gastroesophageal reflux disease, severe protein-calorie malnutrition, polyneuropathy, major depressive disorder, sacral pressure ulcer and chronic pain. The minimum data set (MDS) dated 1/11/22 assessed Resident #8 as cognitively intact and a requiring the extensive assistance of one person for bed mobility and toileting. Resident #8's clinical record included an admission nursing assessment dated 10/11/21 documenting the resident's skin as warm, dry and with normal color with no pressure ulcers or skin impairments. A nurse practitioner (NP) note dated 10/14/21 documented, "...She does have wounds on her coccyx. They are being treated with calmoseptine and Allevyn dressings. They appear to be stage II. They are in the coccyx region... Continue calmeseptine and cover with allyven dressing..." (sic) The clinical record documented no physician orders for the Calmoseptine cream or Allyven dressings referenced by the NP. The resident's treatment administration record (TAR) for October 2021 documented no treatments or dressing changes to the pressure ulcers as reference by	F 686	records were checked for weekly skin checks, and if the resident had a pressure sore, for treatment orders and care plan interventions. Consistency of documentation of wounds was also reviewed. Step III A full skin check on current residents was completed 3/20/22 and results reported to Unit Manager. Medical intervention was obtained for any resident with skin injury. Staff education on weekly skin checks, prevention of pressure sores, treatment orders and wound measurement documentation was completed. Nursing Managers were educated by Administrator regarding the need for a communicated Pressure Sore Prevention system and need for routine monitoring for adherence to the system tasks. National Pressure Injury Advisory Panel clinical guidelines have been ordered for nursing managers and nurses to use as professional standards. System changes include but are not limited to: • A consistent person held accountable for weekly wound measurements, documentation and checking treatment orders. • Tracking weekly skin checks • Investigation of any new pressure sore • Evaluation at admission for measures to prevent pressure sores. Step IV The DON will audit 5 residents for weekly skin check records once each week for 5 weeks and re-educate staff as needed.	

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F 686	Continued From page 12 the NP. The NP documented the following additional pressure ulcer assessments during October 2021 referencing ongoing treatment with Calmoseptine with Allevyn dressings: 10/19/21 - "...Pressure ulcer on coccygeal region, stage 2 Continue calmeseptine and cover with allevyn dressing..." 10/21/21 - "...Pressure ulcer of coccygeal region, stage 2 Continue calmeseptine and cover with allevyn dressing..." 10/26/21 - "...Pressure ulcer of coccygeal region, stage 2 Continue calmeseptine and cover with allevyn dressing. We will try to get her to get up more often and change her positions..." 10/29/21 - "...Pressure ulcer of coccygeal region, stage 2 Continue calmeseptine and cover with allevyn dressing. We will try to get her to get up more often and change her positions..." (sic) There was no nursing assessment of Resident #8's pressure ulcers referenced by the NP on 10/14/21 until ten days later on 10/24/21. A nursing note dated 10/24/21 documented, "Resident has an excoriated sacral area. We have been doing dressing changes with Optifoam AG and frequent turns. The buttocks' are less reddened and excoriated. The skin is damp and pink. There are two areas that are stage 2 sores. 1) is 1.5 x 1 cm open it is located on the left side, oval shaped. Draining scant purulent drainage. 2) is 2 x 1 cm open rectangular shaped. It appears to also be draining purulent drainage. Both areas were cleansed with dermal wound care and dried. Skin prep was applied to the surrounding areas. Then the Optifoam AG was applied. We discussed with the resident the	F 686	The Unit Manager will be responsible that this process continues and will report to the DON any variances found. Clinical Consultants will be asked to audit 2 random charts in April and May and will submit findings to DON and Administrator/Executive Director for review. Variances or deficient practices found will be brought to Monthly Performance Improvement meetings which are called Clinical Operations Report Review and brought to Quarterly Quality Assurance meeting.	

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importance of turning side to side frequently, and increasing protein intake." (sic)

The next assessment of Resident #8's pressure ulcer was on 10/29/21 and documented only one wound. This assessment listed the resident had a stage 2 pressure ulcer on the sacrum measuring 2 cm x 1 cm x .1 cm (length x width x depth in centimeters), with slough on the wound bed, thin/watery drainage, no odor, no tunneling and macerated skin around the wound. There was no mention of the status of the second pressure ulcer referenced in the 10/24/21 note.

Nursing notes and NP notes for October 2021 documented conflicting treatments for Resident #8's pressure ulcers.
A physician's order was documented on 10/27/21 for an air mattress. Nursing notes documented use of wound cleanser, skin prep and Optifoam AG when the NP notes only listed treatment with Calmoseptine and Allyven. The record documented no orders for any of these treatments, and the treatment administration record (TAR) for October 2021 documented no pressure ulcer treatments of any type other than the air mattress on 10/27/21. There were no entries on the resident's October 2021 TAR indicating if or when the treatments mentioned in the notes were routinely implemented.

A NP progress note dated 11/1/21 documented, "...Still has a sacral wound that has not been healing. She was recently given an air mattress...Continue calmeseptine and cover with allevyn dressing...Will consult with wound care clinic..." (sic)

A nursing note dated 11/4/21 documented,

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"Update to chronic sacral decubitus...Dressing changed today. Old Mepilex was soiled...entire sacral area was washed with dermal wound cleanser...surrounding area is looking better, with pink tissue around it...still have 2 small separate areas at the midline area 1 cm long x .5 cm wide rectangle shaped. just down from it to the right is an oval shaped area 1 cm x .3 cm. Both are stage 2. minimal purulent dressing. Calcium Alginate applied to area. covered with a Mepilex dressing..." (sic)

The record documented no physician's order for the calcium alginate or Mepilex referenced in the 11/4/21 nursing note.

Resident #8 went to a wound clinic for evaluation and treatment on 11/11/21. The wound clinic note dated 11/11/21 documented the assessment of one sacral pressure ulcer. The report included no staging of the wound or any description, size, location or appearance of the ulcer other than "Wound #1 Sacral." Recommended treatment orders included dermal wound cleanser, Calmoseptine mixed with Vaseline to wound with dressing changes every time she used the bathroom and use of a bedside commode. The note documented, "She (Resident #8) isn't likely to request going to the BR (bathroom). We want her not to rely on voiding in briefs. Her wound won't heal as it is mostly due to the toxicity of the urine on her skin."

The clinical record documented no physician's order for the wound cleanser, Calmoseptine mixed with Vaseline, dressing changes with each bathroom visit or a bedside commode, as recommended by the wound clinic. The record documented a physician's order dated 11/10/21

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for wound cleanser, calcium alginate and Mepilex for "one time only." It was unclear from the November 2021 notes if the resident had one open area as reported by the wound clinic or two open areas as listed in the nursing note of 11/4/21.

The resident's November 2021 TAR documented one dressing change to the pressure ulcer with wound cleanser, calcium alginate and Mepilex on 11/10/21 and no administration of the wound clinic recommended Calmoseptine/Vaseline mix.

A nursing note on 11/12/21 documented treatment with Calmoseptine and Vaseline even though there were no orders in the record or on the TAR for this treatment. The 11/12/21 note documented, "Resident's bottom is red with open areas in the cleft, calmoseptine and vaseline applied per order, covered with a large sacral foam patch for support..."

A physician's order was documented on 12/7/21 for Calmoseptine and Vaseline mixed in equal parts with instructions to apply to buttocks/peri-area twice per day. The resident's TAR for December 2021 documented this treatment was administered twice per day as ordered.

A nursing note dated 12/9/21 documented, "Observed (Resident #8's) buttocks. Area remains red, no open areas. Staff continues to use Calmoseptine and Vaseline as per orders..."

A NP note dated 12/14/21 documented the coccyx pressure ulcer as "Resolved."

The clinical record documented no routine skin

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assessments or body audits from 10/12/21 through December 2021. A TAR entry for a skin check was signed off as completed on 12/20/21 and 12/27/21but there were no documented assessments describing the condition and/or appearance of the resident's skin or sacral area on these dates.

A NP note dated 12/23/21 documented a pressure area on the resident's coccyx had "reopened" due to decreased movement and listed, "...does have a quarter wound on left buttocks." There was no other documented assessment of the left buttock ulcer referenced by the NP on 12/23/21. There were no measurements, staging or any documentation of the condition or characteristics of the wound including color, odor, drainage or depth. There were no treatment orders entered for the left buttock until 12/27/21. A physician's order was documented on 12/27/21 for dressing changes to buttocks with calcium alginate patch every 3 days and as needed. Resident #8's TAR documented these daily dressing changes as ordered until discontinued on 12/30/21.

A nursing note dated 12/29/21 documented new pressure ulcers on the resident's sacrum. The nursing note dated 12/29/21 documented, "bilateral sacral sores were cleansed with DWC (dermal wound cleanser), Calcium Alginate with and Optifoam dressing applied. Left measures 4.2 CM x 4 CM yellow exudate to base. Small amt (amount) yellow drainage. Right side measures 4 CM x 3.9. It is clean with pink tissue. Older areas clean and healed with pink tissue."

A nursing note dated 12/30/21 documented, "Informed...NP that (Resident #8's) buttock

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wounds appear to be getting worse and feel that the calcium alginate patch is holding in the moisture. Have suggested that we go back to using Calmoseptine and Vaseline mixed in equal parts and apply to buttocks BID (twice per day) and PRN (as needed) incontinence. She agreed to treatment plan." It was unclear from the clinical record if the wounds described in the 12/29/21 nursing note were the same as that assessed by the NP on 12/23/21.

A physician's order was entered on 12/30/21 for Calmoseptine and Vaseline mixed in equal parts to be applied to buttocks twice per day and as needed with incontinence. Treatment records documented this treatment twice per day as ordered.

Additional NP visits documented the following regarding the resident's pressure ulcers:

1/6/22 - "Seen today for concerns from staff regarding loose stools...worsening of her sacral wound...Nursing staff reports it is not any worse than it was at last assessment..."
1/11/22 - "...Her sacral wound has continued to get worse...Deferred exam of her coccyx wound..."
1/13/22 - "...Coccyx wound visualized there are 5 smalls (small) eraser sized open area. No drainage or signs and symptoms of infection..."

There were no nursing assessments of Resident #8's pressure ulcers from 12/30/21 until 1/21/22 despite a deteriorated condition described by the NP. A note dated 1/21/22 documented, "sacral area was photographed and measured...Area was cleansed and Calmaseptine and Vaseline was applied. the area is clean and appears to be

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healing. 2 small open areas..." (sic) There was no further mention of the five openings assessed by the NP on 1/13/22.

There were no further nursing notes or assessments documenting the status of the resident's sacral pressure ulcers. Interdisciplinary team meeting notes on 2/9/22, 2/16/22 and 3/2/22 documented discussion of changes in the wounds but listed no description, appearance, size or status of the wounds.

A NP note on 2/10/22 documented, "...Her sacral wound has started to heal..."

A physician's order discontinued application of the Calmoseptine/Vaseline mix on 2/16/22. An order was entered on 2/16/22 for Greer's Goo to be applied twice per day for skin care with the TAR documenting application of Greer's Goo as ordered.

On 3/9/22 at 8:22 a.m., the registered nurse (RN #1) caring for Resident #8 was interviewed about the skin assessment protocol. RN #1 stated that certified nurses' aides looked at skin during showers and if they saw any problems, they would get the nurse for assessment. RN #1 stated Resident #8 had open areas on her buttocks since her admission and the original areas had healed. RN #1 stated the resident liked to stay in bed and "once in a while" got pinprick sized open areas on her buttock.

On 3/9/22 at 10:43 a.m., the unit manager (RN #2) was interviewed about skin/wound assessments. RN #2 stated the nurses were responsible for weekly skin assessments that included a full body audit. RN #2 stated the

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audits were supposed to be in the health record with skin and wound assessments documented in notes or under the assessment tab. RN #2 stated that pressure ulcer staging was used as part of the assessment and any treatments and orders were supposed to be entered in the record and reflected on the TAR. RN #2 stated Resident 8's buttocks was not open as of last week and the resident currently had no order for a dressing.

On 3/9/22 at 1:30 p.m., with the resident's permission and accompanied by RN #1, Resident #8's buttocks was observed. Both buttock cheeks were bright red. There were two pencil-point sized open areas on the top of the left buttock adjacent to the midline. There was no odor or drainage noted. No other open areas were observed on the resident's buttocks.

On 3/9/22 at 1:52 p.m., the director of nursing (DON) was interviewed about Resident #8's conflicting wound assessments, treatments, lack of skin assessments and treatment orders not entered and/or implemented. The DON stated skin assessments were supposed to be performed weekly by the floor nurses and all pressure ulcers required assessment at least weekly. The DON stated the NP provided staging of pressure ulcers and the nurses were expected to measure and document assessment of the wounds including location and appearance. After reviewing Resident #8's clinical record, the DON stated she thought staff performed the treatments and observations of the sacral ulcers but the documentation in the record did not reflect evidence of the assessments and/or treatments. The DON stated problems with skin assessments and pressure ulcer monitoring had been identified as an area needing improvement.

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On 3/9/22 at 2:00 p.m., the unit manager (RN #2) was interviewed again about Resident #8's pressure ulcers and the lack of ongoing monitoring, treatments and conflicting assessments. RN #2 stated she thought the dressings were changed as ordered but the record did not indicate the care/treatments provided. RN #2 stated they converted to a new electronic health record in October 2021. RN #2 stated staff were not familiar with the new system and had challenges entering orders and treatments. RN #2 stated nurses did not understand that the assessments had to be entered in a particular place in the record.

On 3/9/22 at 3:04 p.m., the DON was interviewed again about Resident #8's pressure ulcer assessments, treatment orders and lack of skin assessments. The DON stated in October 2021 nursing notes referenced treatments but there was no order in the record and nothing on the TAR indicating the treatments were provided. The DON stated since there was nothing on the TAR, she could not verify treatments and dressing changes were performed as ordered other than those documented in the nursing notes. The DON stated the first treatment order she saw in the record was on 11/8/21 and that was entered incorrectly as a one-time treatment. The DON stated the 11/8/21 order for calcium alginate and Optifoam should have been done each Monday, Wednesday and Friday and was done only once. The DON stated the transition to the new electronic health record software "was difficult." The DON stated treatments with the Calmoseptine/Vaseline mix as recommended by the wound clinic were not entered on the TAR or MAR in November 2021. The DON stated from

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October (2021) through December (2021) there were no other wound assessments other than those documented by the NP and in nursing notes. The DON stated weekly skin assessments were supposed to be documented under the assessment tab in the electronic health record. The DON stated that weekly pictures of the pressure ulcers were started on 12/15/21 as a way to monitor the status of the wounds. The DON stated the pictures included a calculated wound size but no other characteristics of the wound. The DON stated the pictures were used in wound meetings when discussing pressure ulcer treatments.

Resident #8's plan of care (revised 2/15/22) documented the resident had two pressure ulcers on the right buttock and one ulcer in the gluteal cleft with potential for additional pressure injury due to immobility and poor nutrition. The plan documented on 1/19/22, "Wound has evolved into 1 (one) red area with several opened areas within it." Interventions to promote healing and prevent further ulcers included, "...Administer treatments as ordered and monitor effectiveness...Assess/record/monitor wound healing (weekly) Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD (physician)...Follow facility protocols for the prevention/treatment of skin breakdown...needs (monitoring/reminding/assistance) to turn/reposition at least every 2 hours...Monitor/document report PRN any changes in skin status: appearance, color, wound healing, s/sx (sign/symptoms) of infection, wound size (length x width x depth),

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stage...Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate..."

The facility's policy titled Pressure Ulcers - Care of Skilled Nursing (revised 10/31/19) documented the facility, "...will act to protect resident skin integrity and strive to minimize the risk of pressure ulcers...The charge nurse will conduct and document a thorough skin assessment on the resident's admission...Admission orders will include a pressure relief mattress...and a weekly full body skin assessment to be conducted by the charge nurse...C.N.A. (certified nurses' aide) will observe for and report early signs of skin breakdown to the Charge Nurse...If a pressure ulcer is discovered, the nurse will notify the physician...and the Director of Health Services..."

These findings were reviewed with the administrator and director of nursing during a meeting on 3/9/22 at 4:30 p.m.

The National Pressure Injury Advisory Panel (NPIAP) defines a pressure injury as, "...localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear..." The NPIAP defines a stage 2 pressure injury as, "Partial-thickness loss of skin with exposed dermis. The wound bed in viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister..." (1)

The NPIAP Pressure Injury Prevention Points

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F 686	Continued From page 23 documents concerning care to prevent pressure ulcers, "...Inspect all of the skin upon admission as soon as possible (but within 8 hours)...Inspect the skin at least daily for signs of pressure injury, especially nonblanchable erythema...Assess pressure points, such as the sacrum, coccyx, buttocks, heels, ischium, trochanters, elbows and beneath medical devices..." (2) This finding was reviewed with the administrator and director of nursing on 1/13/22 at 1:50 p.m. (1) NPIAP Pressure Injury Stages. National Pressure Ulcer Advisory Panel. 3/12/22. www.npiap.com (2) Pressure Injury Prevention Points. 2020 National Pressure Injury Advisory Panel. 3/12/22. www.nipiap.com	F 686		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic 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	F 758		4/1/22

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F 758	Continued From page 24 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to ensure four of eleven residents were free from unnecessary medications, Resident #3, #16, #6 nd #15. Resident #3 had physician orders for an antianxiety medication beyond the 14-day limit and without a specified duration. Residents #16	F 758	Step I Resident #16 expired per her advanced directives. Resident #3 prn Lorazepam order was able to be discontinued. Resident #15 prn Lorazepam order was able to be discontinued.	

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F 758	Continued From page 25 and #6 had no attempted gradual dose reduction of psychotropic medications and no rationale to decline reduced doses. Facility staff failed to respond to a pharmacy recommendation to discontinue a prn (as needed) order of lorazepam in a timely manner for Resident #15. The findings include: 1. Resident #3 was admitted to the facility on 9/10/21 with diagnoses that included dementia with behaviors, delusional disorder, anxiety, myocardial infarction, heart failure, hypothyroidism, diabetes, chronic pain and osteoarthritis. The minimum data set (MDS) dated 12/14/21 assessed Resident #3 with severely impaired cognitive skills. Resident #3's clinical record documented a physician's order dated 9/30/21 for lorazepam concentrate 2 mg/ml (milligrams per milliliter) with instructions to "give 0.25 ml orally every 4 hours as needed for anxiety...may titrate up to 0.50 ml Q (every) 4 hours prn" for moderate to severe anxiety. The order had been in place since 9/30/21 with no 14-day limit and with no specified duration of treatment. Resident #3's plan of care (revised 12/4/21) documented the resident used psychotropic medication including antianxiety medication due to behaviors. Care plan goals regarding psychotropic medication use included, "...resident will be/remain free of psychotropic drug related complications including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavior impairment..." Interventions to meet psychotropic care plan goals included, "Administer	F 758	Resident #6 Trazodone was evaluated by the medical provider and rationale given for continued use with no dose reduction. Step II Current resident electronic medical records were audited for unnecessary medications checking for: • Prn psychotropic medications orders • psychotropic gradual dose reductions • pharmacy recommendations being responded to timely with rationale for approval or not approving. • Documentation of non-pharm interventions • Documentation of behaviors Step III Nursing Managers were educated by Administrator and Managers educated staff nurses on the requirements. Medical Providers who routinely visit residents were educated on the requirements of preventing unnecessary medication use, gradual dose reductions and timely detailed responses to pharmacist review/suggestions. Step IV The DON will audit 5 residents records psychotropic medication orders, MAR, pharmacy review and documentation for 5 weeks and re-educate staff as needed. The Unit Manager will be responsible that this process continues and will report to the DON any variances found. Clinical Consultants will be asked to audit 2 random charts in April and May and will submit findings to DON and Administrator/Executive Director for review. Variances or deficient practices found will	

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F 758	Continued From page 26 psychotropic medications as ordered by physician. Monitor for side effects and effectiveness Q-shift...Drowsiness, lack of energy, clumsiness, slow reflexes, Sslurred (slurred) speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision..." On 3/9/22 at 3:00 p.m., the registered nurse unit manager (RN #2) was interviewed about Resident #3's lorazepam order with no 14-day limit or specified duration. RN #2 stated Resident #3 was admitted from the hospital on hospice and the lorazepam order had been in place since September 2021. RN #2 stated she was not sure if the 14-day limit applied to hospice medications. The Nursing 2022 Drug Handbook on page 909 describes lorazepam as an anxiolytic used for the treatment of anxiety, insomnia from anxiety and status epilepticus. This reference lists under warnings about use on page 910, "Use cautiously in elderly, acutely ill, or debilitated patients..." This finding was reviewed with the administrator and director of nursing during a meeting on 3/9/22 at 4:30 p.m. (1) Woods, Anne Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022 2. Resident #16 was admitted to the facility on 6/3/21 with diagnoses that included major depressive disorder, cognitive communication deficit, chronic kidney disease, spinal stenosis, hypertension, neuropathy, gastroesophageal reflux disease, insomnia, chronic pain, congestive	F 758	be brought to Monthly Performance Improvement meetings which are called Clinical Operations Report Review and brought to Quarterly Quality Assurance meeting.	

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heart failure, atrial fibrillation and anemia. The minimum data set (MDS) dated 2/8/22 assessed Resident #16 with moderately impaired cognitive skills.

On 3/8/22 at 2:45 p.m., Resident #16 was interviewed about quality of life/care in the facility. When asked about any problems regarding mood/depression, Resident #16 stated took medication for depression but had recently felt good with no concerns about poor mood or worsening depression.

Resident #16's clinical record documented a physician's order dated 9/16/21 for duloxetine (Cymbalta) 20 mg (milligrams) each day for major depressive disorder listed as "recurrent, mild." Resident #16's medication administration record documented the duloxetine was administered each day as ordered.

Resident #16's clinical record documented a consultant pharmacist's medication review dated 12/15/21 with the following recommendation: "Resident is taking Duloxetine DR 20 mg Capsules, 1 QAM (each morning) to manage behavior, stabilize mood, or treat a psychiatric disorder. Recommend review Resident's current condition and consider tapering medication to evaluate if Resident is on the lowest possible dose, or continues to need the medication. Tapering may be indicated when the residents' clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmacological intervention, including behavioral interventions, have been effective in reducing the symptoms. If resident is stable on current regimen, recommend a trial discontinuation and monitoring for

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depression symptoms."

There was no response to the 12/15/21 recommendation for until 1/20/22. A nurse practitioner (NP) documented a response on 1/20/22 with no indication of agreement and/or disagreement with the recommendation. The NP wrote on the form, "She still needs medications." There was no documented rationale to decline the dose reduction.

The clinical record documented no changes or concerns with the resident's mood and/or behaviors. The NP documented the following psychiatric/mood assessments before and after the pharmacy recommendation to reduce the duloxetine dose:

12/7/21 - "...Denies change in mood/anxiety, suicidal thoughts/ideation, hallucinations...No overt signs of anxiety or depression. No evidence of psychosis. No confusion or irritability..."
12/14/21 - Denies change in mood/anxiety, suicidal thoughts/ideation, hallucinations...No overt signs of anxiety or depression. No evidence of psychosis. No confusion or irritability..."
12/23/21 - "...Denies any other complaints or issues at this time...No overt signs of anxiety or depression. No evidence of psychosis. No confusion or irritability..."
1/27/22 - "...Denies change in mood/anxiety, suicidal thoughts/ideation, hallucinations..."
2/1/22 - "...Denies change in mood/anxiety, suicidal thoughts/ideation, hallucinations..."
2/3/22 - "...No complaints of anxiety or depression...No overt signs of anxiety or depression. No evidence of psychosis. No

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confusion or irritability..."
1/16/22 - "...No complaints of anxiety or depression..."
3/3/22 - "...No complaints of anxiety or depression..."

None of the NP assessments specifically referenced the use of duloxetine and documented no rationale for continue use of the medication without an attempted dose reduction.

Resident #16's plan of care (revised 12/1/21) documented the resident had potential for mood problems including depression and behaviors that required use of psychoactive medications. Interventions to prevent complications from depression and medications included, "Administer antidepressant medications as ordered by physician...Monitor/document side effects...Educate (Resident #16)/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of (anti-depressant drugs being given)...Monitor/document/report...adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal, decline in ADL (activities of daily living) ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance prbs (problems), movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt (weight) loss..."

On 3/9/22 at 2:53 p.m., the registered nurse unit manager (RN #2) was interviewed about no attempted dose reduction for Resident #16's duloxetine. RN #2 stated the NP responded to the pharmacy recommendation indicating the

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resident still needed the antidepressant and there was no order to decrease or discontinue the medication. RN #2 stated Resident #16 had recently had no issues with mood or depression. RN #2 stated that in September 2021 the resident had been upset when one of her friends on the unit passed away. RN #2 stated the resident effectively processed grief for her friend and was now stable.

On 3/10/22 at 8:34 a.m., the director of nursing (DON) was interviewed about no attempted dose reduction for Resident #16's duloxetine. The DON stated they had a new nurse practitioner that was still learning about the requirements regarding psychotropic medications. The DON stated the QA committee had recognized an issue with unnecessary medications and had started a plan to address the issues within the last month.

The Nursing 2022 Drug Handbook on page 479 describes duloxetine as an antidepressant used for treatment of major depressive disorder, generalize anxiety and neuropathic pain. This reference on pages 481 and 482 documents, "...Black Box Warning...Monitor all patients for worsening of depression or emergence of suicidal thoughts or behavior, especially when therapy starts or dosage changes...Older patients may be more sensitive to drug effects than younger adults..." (1)

This finding was reviewed with the administrator and director of nursing 3/10/22 at 8:45 a.m.

(1) Woods, Anne Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022

3. Resident #15 was admitted to the facility on 11/12/2021 with diagnoses that included

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gastro-esophageal reflux disease (GERD), hypothyroidism, hyperlipidemia, hypertension, gait abnormalities, muscle weakness and depression. The most recent minimum data set (MDS) dated 2/8/2022 was a quarterly assessment and assessed Resident #15 as moderately impaired for daily decision making with a score of 12 out of 15.

Resident #15's electronic health record (EHR) was reviewed on 03/08/2022. Observed on the order summary report was the following: "LORazepam Concentrate 2 MG/ML (milligrams/milliliters) Give 0.25 ml by mouth every 4 hours as needed for anxiety try non-pharm interventions first and document. Order Date: 11/12/2021. Start Date 11/12/2021."

Observed within the progress notes was the following: "2/18/2022. 09:26. Health Status Note. Note Text: Resident C/O (complained of) feeling SOB (shortness of breath) this AM (morning). She said you better go get the oxygen tank for me. Upon assessment she denied any pain just feels like she is not getting oxygen. BS (breath sounds) were diminished but clear, sats were 96% on RA (room air). RR (respiratory rate) 22. B/P (blood pressure) 121/71 heart rate 72. I offered her Ativan for her nerves and explained it may help feel less anxious. She agreed 0.25 MG of Ativan given. (Nurse Practitioner) was in to see her also this am (morning). No new orders placed..."

Observed within the EHR was a Medication Regimen Review dated 11/16/2021 that documented the following recommendation: "....This resident has a current PRN (as needed) order for Lorazepam 2 mg/ml oral concentrate as

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needed for anxiety with no stop date indicated in the MAR (medication administraton record). PRN orders for psychotropic drugs, excluding anti-psychotic drugs, are limited to 14 days but may extended if appropriate. To be complaint with CMS 483.45 (e)(4) please ensure the following documentation are made in the resident's medical record. Any PRN psychotropic order extended beyond 14 days must include documentation by the physician of their rational and indicate the duration of the PRN order. Note: Order duration not available on MAR." The Physician/Prescriber Response was checked as "Other...Discontinued Pt (patient) not using @ (at) this time." The Physician/Prescriber signed and dated the form as of 2/16/22.

A review of the medication administration record (MAR) for the period of November 2021 through March 2022, documented Resident #15 received one dose of the PRN Lorazepam on 2/18/2022 which was after the provider had signed the order to discontinue the medication on 02/16/2022.

The above findings were reviewed with the Administrator, director of nursing (DON),corporate consultant, and unit manager during a meeting on 03/09/2022 at 5:00 p.m. The DON was asked about the process and/or time period for completing pharmacy review recommendations. The DON stated, "It is a lengthy process. We receive the recommendations from the pharmacist and they are placed in a file for the provider to review. Once the provider reviews and signs off on them, nursing then makes any orders changes."

On 03/10/2022 at 8:57 a.m., the DON was interviewed regarding why it may have taken 3

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months to complete the recommendation from (November 16, 2021 to February 16, 2022) and then once the provider discontinued the medication why it was not discontinued thus allowing the nurse to administer a dose on 2/18/202. The DON stated, "I'm not sure why it took that long other than it was over looked." The DON stated, "Within the last month, we have found a concern regarding psychotropic medications. We have a new provider who needs resources and understanding regarding the regulations. It is a work in progress and we are all learning together."

No additional information was received by the survey team prior to exit on 03/10/2022 at 12:45 p.m.

4. Resident #6 was originally admitted to the facility on 05/05/202 and readmitted on 07/09/2021 with diagnoses that included type 2 diabetes, vascular dementia without behavioral disturbances, asthma, depression, anxiety disorder, bipolar disorder, sleep deprivation, and insomnia. The most recent minimum data set (MDS) dated 12/28/2021 was a quarterly assessment and assessed Resident #6 as cognitively intact with daily decision making with a score of 14 out 15.

Under Section N - Medications, the MDS documented Resident #6 had received antipsychotic and antidepressant medications for 7 days during the look back period of the MDS. Section N0450 - A. Antipsychotic Medication Review documented "Yes, Antipsychotics were received on a routine basis only. B. Has a gradual dose reduction (GDR) been attempted. No. D. Physician documented GDR as clinically

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contraindicated. No."

Resident #6's electronic health record (EHR) was reviewed. Observed on the order summary report were the following orders:
"TRAzodONE 50 MG TB* Give 0.5 tablet orally at bedtime related to INSOMNIA, UNSPECIFIED. Order Date 9/16/2021. Start Date: 10/5/2021."

"TRINTELLIX 10 MG TABLET. Give 1 tablet orally one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE. Order Date: 09/16/2021. Start Date: 10/05/2021."

"TRINTELLIX 5 MG tablet. Give 1 tablet orally one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE. Order Date: 09/16/2021. Start Date: 10/05/2021.

Observed on Resident #6's care plan was the following focus areas: "(Resident #6) carries a dx (diagnosis) of Depression. she has the potential for alteration in mood and behavior. Date Initiated: 10/5/2021. Goal: (Resident #6) will not have any complications related to Depression or Bi-Polar through the next review. Date Initiated: 10/05/2021. Revision: 01/19/2022. Target Date: 04/04/2022. Interventions: Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT (each shift). Encourage (Resident #6) to verbalize her feelings/moods and give emotional support. Monitor/document/report PRN (as needed) adverse reactions to ANTIDEPRESSANT therapy; change in behavior/mood/cognition; hallucinations/delusions; social isolation; suicidal thoughts, withdrawal, decline in ADL(activities of

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daily living) ability, continence, no voiding; constipation, fecal impaction, diarrhea, gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps; falls; dizziness/vertigo; fatigue, insomnia, appetite loss, wt. loss, n/v (nausea/vomiting), dry mouth, dry eyes. Date Initiated: 11/24/2021."

Observed within the EHR was a Medication Regimen Review dated 12/15/2021 that documented the following: "Resident is taking Trazodone 50 mg, 1 QD (each day), to manage behavior, stabilize mood, or treat a psychiatric disorder. Recommend review Resident's current condition and consider tapering medication to evaluate if Resident is on the lowest possible dose, or continues to need the medication. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing the symptoms." Physician/Prescriber Response: "Disagree" was checked. There was no rationale for not completing a gradual dose reduction for the Trazadone or if the GDR would be contraindicated for Resident #6.

A review of Resident #6's medication administration record (MAR) for the period of October 2021 - March 2022, documented Resident #6 received the Trazodone as ordered. The MAR did not document any specific moods or behaviors when administering the medication.

A review of the progress notes for the period of October 2021 - March 2022, did not document Resident #6 displaying any moods or behaviors.

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F 758	Continued From page 36	F 758		

A review of the nurse practitioner's note dated 3/3/2022 documented the following: "...Psychiatric: She is alert and oriented to self, nature of this facility. She is disoriented to time and situation. Judgment and insight are certainly impaired..."

On 03/09/2022 at 9:45 a.m., the unit manager (RN #2) was interviewed regarding Resident #6's moods and behaviors. RN #2 stated Resident #6 remained unchanged and she did not display any moods or behaviors.

Resident #6 was interviewed on 03/09/2022 at 11:00 a.m. regarding her quality of care and quality of life since being admitted to the facility. Resident #6 stated things were good at the facility and everyone treated her nice. Resident #6 was asked if staff assisted her with her ADLs (activities of daily living). Resident #6 stated, "Yes". Resident #6 was asked if staff treated her with dignity and respect. Resident #6 stated, "Yes". Resident #6 was asked if participated in activities. Resident #6 stated, "Yes, I go to the dining room and the day room." Resident #6 was asked if she had visits with her family. Resident #6 shared her family lived in Alaska and she had weekly video visits/calls with her family.

The above findings were reviewed with the Administrator, director of nursing (DON),corporate consultant, and unit manager during a meeting on 03/09/2022 at 5:00 p.m. The administrative staff was asked what behaviors Resident
#6 displayed as there were none documented in the record and if the Trazodone remained clinically necessary at the current dose. The DON

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F 758	Continued From page 37 stated she would follow-up. On 03/10/2022 at 8:57 a.m., the DON stated, "...within the last month, we have found a concern regarding psychotropic medications. We have a new provider who needs resources and understanding regarding the regulations. It is a work in progress and we are all learning together." On 03/10/2022 at 9:30 a.m., RN #1 who routinely provided care and administered medications for Resident #6 was interviewed. RN #1 stated, (Resident #6) has a very flat affect. You have to pull information out of her even when she has Facetime visits with her children. She doesn't display any specific moods or behaviors, but she definitely has a flat affect." No additional information was received by the survey team prior to exit on 03/10/2022 at 12:45 p.m.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		4/1/22

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F 761	Continued From page 38 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to label medications stored in one of one medication cart. Three bottles of eye drops stored in the unit's medication cart had no pharmacy label and no label indicating date opened. The findings include: On 3/9/22 at 8:25 a.m., accompanied by registered nurse (RN #1), the unit's medication cart was inspected. Stored in the cart were the following: Timolol 0.5% eye drops, Azopt 1% eye drops and Latanoprost 0.005% eye drops. There was no pharmacy label on any of the eye drops indicating a resident name or dosing instructions for administration. The bottles had no legible date opened written on the bottles. RN #1 was interviewed at this time about the eye drops with no label. RN #1 stated the eye drops were found in the Resident #10's belongings after admission. RN #1 stated the drops were expensive and the resident wanted to use them instead of wasting them. When asked about the eye drops stored	F 761	Step I Resident #10 unlabeled eye drops were removed from cart on 3/9/22 as there was one appropriately labeled eye drop container already in the med cart. Step II The Medication Cart was checked by Administrator for any other unlabeled medications. Step III Nursing staff will be educated on the requirement that medications for residents must be properly labeled by the facility pharmacy to ensure compliance. Step IV The DON will check the med cart when doing rounds on the floor for the next 5 weeks. and re-educate staff as needed. The Unit Manager will be responsible that this process continues and will report to the DON any variances found. Variances or deficient practices found will be brought to Monthly Performance Improvement meetings which are called Clinical Operations Report Review and	

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F 761	Continued From page 39	F 761		

without a pharmacy label, RN #1 stated they kept the drops in the top drawer of the cart and she thought Resident #10 was the only resident taking these medications.

On 3/9/22 at 10:37 a.m., the unit manager (RN #2) was interviewed about the unlabeled medications stored in the cart. RN #2 stated any medications brought in by residents from home were supposed to be sent to pharmacy for proper labeling. RN #2 stated all medications administered required a pharmacy label and eye drops were supposed to be labeled with the date opened.

Resident #10's clinical record documented physician orders dated 1/19/22 for: Azopt one drop in left eye three times per day for eye health; Timolol 0.5% one drop in both eyes two times per day for eye health; and Lumigan 0.1% one drop in both eyes at bedtime for eye health. Resident #10 had no current physician's order Latanoprost 0.005% drops.

The facility's policy titled Pharmacy Services for Nursing Facilities (revised August 2014) documented, "...In order to safeguard the quality and stability of medications used within the facility, medications brought to the facility by other than the designated pharmacist or agent can be accepted only if there is current order for use, the medication container is properly labeled, in an (a) proper container, has not expired and has been positively identified by the Physician or Pharmacist prior to use..."

The facility's policy titled Medication Administration in the Skilled Nursing Center (revised 9/18/19) documented, "...All multiple

brought to Quarterly Quality Assurance meeting

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F 761	Continued From page 40 dose containers will be dated and initialed when opened, and discarded in 30 days from opening unless otherwise specified by pharmacy label or manufacturer..." This finding was reviewed with the administrator and director of nursing during a meeting on 3/9/22 at 4:30 p.m.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility staff failed to store food in a sanitary manner on one of one nursing unit and in the main kitchen. Milk and homemade food items were stored in the unit's nourishment refrigerator with no date or resident name.	F 812	Step I The three food items with either an old date or no date were discarded on 3/8/22 and containers sanitized properly. The bench mounted can opener was cleaned on 3/8/22.	4/1/22

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F 812	Continued From page 41 The findings include: On 3/8/22 at 11:20 a.m., accompanied by the certified dietary manager (other staff #2), the food storage areas for the main kitchen were inspected. In the dry food storage area was a plastic container of brown rice, a container of wheat flour and a container of breadcrumbs. The food items were not in their original packaging. The plastic container of brown rice was dated 4/30/19. The containers of flour and breadcrumbs were not labeled with a date opened or use-by date. When the top was removed from the brown rice container, the rice had a rancid-type smell. The dietary manager was interviewed at this time about storage of the rice, crumbs and flour. The dietary manager stated the 4/30/19 date written on the brown rice container was the day the rice was opened/removed from the original packaging. The dietary manager stated the brown rice had a "strong odor" and should have been previously discarded. The dietary manager was not sure how long the flour and breadcrumbs had been stored. The dietary manager stated the food items should have been labeled with a use-by date from the original packaging. On 3/8/22 at 11:30 a.m., the bench mounted can opener was inspected. The can opener blade had an accumulation of dried black/brown debris. There was a build-up of black residue on the top surface of the can opener bracket. The dietary manager stated the can opener was supposed to be cleaned in the dishwasher at least daily. On 3/8/22 at 11:51 a.m., accompanied by the dietary manager, the nursing unit's nourishment	F 812	The nursing unit's nourishment refrigerator was inspected for unlabeled items which were discarded. Any resident item which might be missed; the resident or his/her family member was notified of the need to discard. Non-resident food items removed. Step II The dietary manager and the dietitian inspected the kitchen for any other equipment which needed to be cleaned and inspected dry storage to double-check there were no other unlabeled items. Step III The Dietary Manager educated kitchen staff on policy "Sanitation-Can Openers" on 3/9/22. The Dietary Manager educated kitchen staff on labeling per requirements. The dietician educated the dietary manager on following protocols and monitoring systems in place for kitchen sanitation. The DON and Administrator spoke with nursing staff and labeled the nursing unit refrigerator regarding not using for staff items and the need to name/date items appropriately. The dietitian will work with the dietary manager on updating policies and procedures in the kitchen. Step IV The dietitian or administrator or Executive Director will make rounds on weekly visits to the kitchen for the next 5 weeks, and will educate the dietary manager and kitchen staff as needed on any variances found.	

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F 812	Continued From page 42 refrigerator was inspected. Stored in the refrigerator was a plastic bag containing two homemade tamales. There was no resident name or use-by date labeled on the tamales. There were two Styrofoam cups of milk stored in the refrigerator. The milk had no resident name or use-be date. The dietary manager stated nursing was responsible for discarding food items from the refrigerator and that all food items were supposed to be labeled with resident name and a use-by date. The facility's policy titled Food Storage (revised 9/27/19) documented, "...Plastic containers with tight-fitting covers must be used for storing bulk rice, flour, sugar, and breads. These containers must be legibly and accurately labeled...Dating of items assists in proper rotation of foods...Any dry food leftovers to be stored need to be properly labeled and dated..." The facility's policy titled Food Storage in Common Area Refrigerator (revised 10/21/19) documented, "Food brought in by outside sources for residents is discouraged due to potential problems of contamination resulting from unsafe storage practices...Food brought in for Skilled Nursing residents by family members are labeled and dated for three days after opening and stored in the Health Care kitchenette refrigerator. Dates to discard are monitored by Nursing Staff..." These findings were reviewed with the administrator and director of nursing during a meeting on 3/8/22 at 5:00 p.m.	F 812	The Dietitian will continue thereafter to monitor on her visits to the building and report any findings to the administrator or Executive Director. The DON or designee will check refrigerator on the Unit during daily rounds and correct any deficient practice and re-educate staff during the next 5 weeks. Issues will be brought to monthly performance improvement and to quarterly quality assurance as needed. The Administrator or Executive Director will be involved in action plans for any continued variances.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		4/1/22

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F 883	Continued From page 43 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 883		

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F 883	Continued From page 44 already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to offer the influenza vaccine, and failed to document education and/or refusal for the vaccine, for one of five resident records reviewed, Resident #15. The findings include: Resident #15 was admitted to the facility on 11/12/2021 with diagnoses that included gastro-esophageal reflux disease (GERD), hypothyroidism, hyperlipidemia, hypertension, gait abnormalities, muscle weakness and depression. The most recent minimum data set (MDS) dated 2/8/2022 was a quarterly assessment and assessed Resident #15 as moderately impaired for daily decision making with a score of 12 out of 15. Resident #15's clinical record was reviewed for the immunization status of influenza (flu), pneumonoccocal, and COVID vaccines on 3/10/22. Documented under the "Immunization"	F 883	Step I Resident #15 and family member were educated about risks of Influenza and a documented declination form was inserted in the electronic medical record. Step II A review to validate consent or declination forms for Influenza and Pneumonia vaccines will be completed and any resident not having been educated on risks of vaccine refusal will be corrected so resident can make knowledgeable decisions. Step III The DON has been re-educated that seasonal Influenza vaccine must be offered so residents understand the risks of declining; a consent or declination form is then obtained and scanned into the EMR. Residents who decline the past year must still be offered and educated each year as he/she may change his/her mind.	

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F 883	Continued From page 45 tab of the electronic health record (EHR) was the following, " Influenza - High Dose/Quad Date Given: 11/7/2019." The EHR also included Resident #15's official immunization record uploaded from the "Virginia Immunization Information System" that documented Resident #15's most recent Influenza vaccine was 11/7/2019. Further review of the EHR failed to reveal Resident #15's current influenza vaccine status. The admission MDS dated 11/19/2021 and the quarterly MDS 2/8/2022 under section "O0250: Influenza Vaccine" documented, "Did the resident receive the influenza vaccine in this facility for this year's Influenza vaccination season?. 0. No. If influenza vaccine not received, state reason: 4. Offered and declined..." On 3/10/2022 at 10:00 a.m., the director of nursing (DON) was interviewed regarding Resident #15's Influenza vaccine status. The DON stated Resident #15 transferred from the onsite assisted living unit and she would reach out to the clinical staff on that unit to see if they had any documentation regarding Resident #15's flu vaccine. On 03/10/2022 at 11:19 a.m., the DON stated from her understanding Resident #15 had declined the Influenza vaccine while she resided on the assisted living unit. The DON was asked if Resident #15 was offered the Influenza vaccine when she was admitted to the long-term care/skilled unit. The DON stated, "No, because it was during the same month and time period that she was offered and declined it on the assisted living unit and then she transferred over to us." The DON was advised Resident #15's EHR did	F 883	Admissions for the next 5 weeks will be reviewed for Influenza and pneumonia vaccine consent or declination forms to validate residents have be educated as needed. Also, those residents who decline must be offered a chance at least yearly to reconsider the risks of refusal and become vaccinated. Step IV Clinical Consultants will be asked to audit 2 random charts in April and May and will submit findings to DON and Administrator/Executive Director for review. The DON and Administrator will monitor and discuss vaccines at performance improvement and quarterly quality assurance.	

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F 883	Continued From page 46	F 883		

not reflect any refusals and/or education regarding the flu vaccine. The DON was asked if at anytime after the admission would anyone else have offered and discussed the vaccine with Resident #15. The DON stated, "No I don't believe so because I would have offered it to her. We had discussions about the COVID vaccine with the resident and her son, but I'm not knowledgeable about the flu vaccine being offered again." The DON was asked if there was any documentation regarding Resident #15's refusal/decline of the flu vaccine. The DON stated, "No."

A review of the facility's Infection Control Policy (revised 11/03/2021) documented the following: "L. Influenza Vaccinations for Skilled Nursing Residents. c. A member of the Nurse Management Team will be responsible for providing the resident/POA with written education material about the influenza vaccine, as well as a form to be signed and returned. The form provides the opportunity for the resident/POA to grant Summit Square permission to administer the influenza vaccine or to refuse the influenza vaccine. When returned, this form will be placed in the resident's permanent medical record... f. The vaccine will ordinarily be administered to Health Care Residents by the Health Care charge nurse during the month of October; however, it may be administered from October 1 to March 31 of each year.... In the case of residents who refuse the influenza vaccine, the Director of Health Services of Charge Nurse will make a note of the refusal in the resident's permanent medical record..."

The above findings were reviewed with the Administrator, corporate consultant and unit

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F 883	Continued From page 47 manager during a meeting on 03/10/2022 at 12:15 p.m.	F 883		