STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid complaint survey was conducted on 1/25/22 through 1/28/22. Two (2) complaints, VA00054017 - substantiated, and VA00054127 - substantiated, were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in the 180 certified bed facility was 158 at the time of the survey. The survey sample consisted of two (2) current resident reviews and two (2) closed record reviews.	F 000	The filing of this plan of correction does not constitute an admission that the alleged deficiencies did, in fact, exist. This plan of correction is filed as evidence to comply with the requirements of participation and continue to provide high quality resident centered care.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580	1. Resident #1 discharged from the facility 12-28-21 2. All residents have the potential to be affected. An audit by the Unit Manager or designee will be conducted on current residents from 2-7-22 to verify physician was notified for falls with changes in neuro check assessments and for changes in condition in physical assessment with nausea and vomiting and/or diarrhea. 3. The Facility Educator or designee will in-service the Licensed Nurses on the process for physician notification and documentation for falls with changes in neuro check assessment and changes in condition in physical assessment with nausea and vomiting and/or diarrhea.	2/28/22

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FEB 23 2022

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

ADMINISTRATOR 2/15/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interviews, document review and clinical record review, the facility staff failed to notify the physician of changes in condition for one of four sampled residents, Resident #1. The facility staff failed to notify the physician of Resident #1's post-fall neurocheck assessment changes with decreased level of responsiveness; and episodes of diarrhea. The findings include: Resident #1's minimum data set (MDS)	F 580		

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F 580	Continued From page 2 assessment, with an assessment reference date (ARD) of 11/11/21, was signed as completed on 11/15/21. Resident #1 was assessed as usually being able to make self understood and as usually being able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) Summary Score was documented as a zero (0) out of 15 (indicating severe cognitive impairment). Resident #1 was assessed as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #1's diagnoses included, but were not limited to: high blood pressure, dementia, and a psychotic disorder (other than schizophrenia). a. According to the clinical record, Resident #1 experienced a fall on 12/23/21 at 5:30 p.m. The following information was found as part of Resident #1's post-fall neurocheck assessments: On 12/23/21 at 5:30 p.m., 5:45 p.m., 6:01 p.m., 6:25 p.m, the resident was assessed as: (a) able to follow finger with eyes; (b) able to respond to simple commands; and (c) able to verbalize appropriately. On 12/23/21 at 7:30 p.m., the resident was assessed as: (a) able to follow finger with eyes; (b) able to respond to simple commands; and (c) changed to not able to verbalize appropriately. On 12/23/21 at 8:00 p.m., the resident was assessed as: (a) able to follow finger with eyes; (b) able to respond to simple commands; and (c) continued to be unable to verbalize appropriately. On 12/23/21 at 9:30 p.m., the resident was assessed as: (a) able to follow finger with eyes; (b) able to respond to simple commands; and (c)	F 580	4. An audit will be conducted by the Unit Manager or designee to review for changes in neuro check assessments and review clinical documentation for changes in condition with nausea and vomiting and/or diarrhea to verify physician was notified weekly x 4 weeks then monthly x 2. The findings will be review or revised in the QAPI meeting x 3 months. 5. Date of compliance: 2-28-2022	

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F 580	Continued From page 3 continued to be unable to verbalize appropriately. On 12/24/21 at 1:22 a.m., the resident was assessed as: (a) changed to not able to follow finger with eyes; (b) changed to not able to respond to simple commands; and (c) continued to be unable to verbalize appropriately. On 1/26/22 at 9:50 p.m., Staff Member (SM) #10 was interviewed about a visit by two (2) of Resident #1's adult children. SM #10 reported they remembered a visit where one of the resident's adult children reported the resident "would not respond a lot." SM #10 reported they did not notify a medical a medical provider about the family's report. SM #10 stated the family member did not request a medical provider be notified. Resident #1's clinical record did not include documentation of this interaction between SM #10 and the resident's adult child; Resident #1's child reported this occurred on 12/26/21. There was no documentation in the clinical record to evidence the facility had notified the physician of the post-fall neurocheck assessment changes. On 1 /27/22 at 11:15 a.m., the failure of the facility staff to notify Resident #1's medical provider of a decline in resident being able to follow a finger with their eyes, respond to simple commands, and verbalize appropriately was discussed with the facility's Administrator and Assistant Director of Nursing (ADON). b. The following information was documented in Resident #1's progress notes: On 12/20/21 (a Monday) at 6:28 a.m., "resident was having diarrhea and vomiting episodes over	F 580		

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F 580	Continued From page 4 the weekend. all [sic] night has been covering (their) mouth with (their) hand as if (they) would vomit but hasn't. resident [sic] hasn't voided in the last 12 hours." On 12/21/21 at 2:16 p.m., "Loose watery diarrhea stools noted (twice) this shift." On 12/22/21 at 10:08 a.m., "... 12/19/21 developed vomiting and diarrhea. Vomiting resolved but still having diarrhea." On 12/23/21 at 6:46 a.m., "Resident had loose watery stool (once) this shift. Will continue to monitor." On 1/25/22 at 3:20 p.m., the absence of documentation of a medical provider notification of Resident #1 experiencing diarrhea was discussed with the facility's Administrator and Director of Nursing (DON). On 1/26/22 at 8:17 a.m., the DON reported the only evidence of provider notification of the vomiting and diarrhea was the documentation of a Phenergan order received on 12/18/21 at 10:45 p.m. The following information was found in a facility document titled "Guidelines for Notifying Physicians of Clinical Problems" (with a revised date of September 2017): "These guidelines are intended to help ensure that 1) medical care problems are communicated to the medical staff in a timely, efficient and effective manner and that 2) all significant changes in resident / patient status are assessed and documented in the medical record....The following symptoms, signs, and laboratory values (which are not all-inclusive)	F 580		

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F 580	Continued From page 5 should prompt immediate notification of the physician, after an appropriate nursing evaluation. Immediate implies that the physician should be notified as soon as possible, either by phone, pager, text messaging, or other means. These situations include: ... 2. Rapid decline or continued instability (for example, markedly fluctuating vital signs), unless the individual is receiving palliative care and has declined workup or treatment. 3. The following symptoms: a. Sudden in onset OR a marked change (for example, much more severe or frequent) compared to usual (baseline) status..." The following information was found in a facility policy and/or procedure titled "Change in a Resident's Condition or Status" (with a revised date of May 2017): "Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payment, resident rights, etc.) ... The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): ... significant change in the resident's physical/emotional/mental condition ..." The failure of the facility staff to assure a medical provider was notified of the aforementioned changes in condition was discussed during a meeting with the facility's Administrator, Director of Nursing, and Director of Rehab on 1/27/22 at 3:15 p.m. No further information was provided prior to exit.	F 580		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		

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F 610	Continued From page 6 §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 interviews and document reviews, it was determined the facility staff failed to investigate an injury of unknown origin for one of four sampled residents, Resident #1. For Resident #1, the facility staff failed to ensure a chest wall bruise was investigated. The findings include: Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 11/11/21, was signed as completed on 11/15/21. Resident #1 was assessed as usually being able to make self understood and as usually being able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) Summary Score was documented as a zero (0) out of 15 (indicating severe cognitive	F 610	F 610 Investigate/Prevent/Correct Alleged Violation 1. Resident #1 discharged from the facility 12-28-21 2. All residents have the potential to be affected. An audit by the DON or designee will be conducted on current residents for changes in condition with bruising to assess cause with documentation and if cause cannot be identified a facility reported incident will be submitted. 3. The Facility Educator or designee will in-service the Licensed Nurses on the process for assessments of bruises, skin tears or injuries to determine cause with documentation. If cause cannot be identified a facility reported incident will be submitted for injury of unknown origin. The Administrator will be informed of injuries of unknown origin.	2/28/22

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F 610	Continued From page 7 impairment). Resident #1 was assessed as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #1's diagnoses included, but were not limited to: high blood pressure, dementia, and a psychotic disorder (other than schizophrenia). The following information was found in Resident #1's documentation from a hospital visit, in an Emergency Department (ED) provider note dated 12/28/21 at 4:51 p.m.: "... Skin: ... Findings: Bruising (Overlying right chest wall, yellowish discoloration, appears old and healing) present." A right rib x-ray was completed on 12/28/21 with the following results: "There is anatomic alignment. There is age-related bone density. No acute fracture ... No acute findings." On 1/26/22 at 8:17 a.m., the Director of Nursing (DON) was asked for information about Resident #1's yellow colored chest bruise the ED provider documented as being present on 12/28/21. No documentation of an assessment or investigation of a this bruise was found by or provided. During an interview on 1/26/22 at 10:00 a.m., Staff Member (SM) #11 was asked about Resident #1's care and condition. SM #11 reported remembering a "yellow" bruise somewhere on Resident #1. SM #11 reported it was possibly on the resident's hip. SM #11 stated they reported it to the nurse but could not remember which nurse. During an interview on 1/26/22 at 1:39 p.m., SM #16 reported seeing a yellow bruise on Resident #1's chest. SM #16 reported they notified the nurse of the bruise but was unsure which nurse they notified. SM #16 reported they had no way	F 610	4. An audit will be conducted by the DON or designee to review clinical documentation of bruises, skin tears or injuries have assessment and cause. If cause cannot be identified a facility reported incident was submitted and the Administrator was informed of injuries of unknown origin weekly x 4 weeks, then monthly x 2. The findings will be reviewed or revised in the QAPI meeting x 3 months. 5. Date of compliance: 2-28-2022	

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F 610	Continued From page 8 to document that they had notified the nurse of the bruise. The following information was found in a facility policy titled "Resident Rights" (with a revised date of December 2016): "Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: ... be free from abuse, neglect, misappropriation of property, and exploitation ..." The following information was found in a facility policy titled "Abuse Investigation and Reporting" (with a revised date of July 2017): "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management." The failure of the facility staff to assess and investigate Resident #1's aforementioned bruise was discussed during a meeting with the facility's Administrator, Director of Nursing, and Director of Rehab on 1/27/22 at 3:15 p.m. No evidence of an investigation of this bruise was provided prior to exit.	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		

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F 684	Continued From page 9 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews, document reviews, and during the course of a complaint investigation, the facility staff failed to provide care and treatment to address the needs and/or assessment changes of one of four sampled residents, Resident #1. The facility staff failed ensure changes in Resident #1's condition was communicated to and addressed by a medical provider, and failed to complete post-fall neurocheck assessments as required by the facility's process. The findings include: Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 11/11/21, was signed as completed on 11/15/21. Resident #1 was assessed as usually being able to make self understood and as usually being able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) Summary Score was documented as a zero (0) out of 15 (indicating severe cognitive impairment). Resident #1 was assessed as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #1's diagnoses included, but were not limited to: high blood pressure, dementia, and a psychotic disorder (other than schizophrenia). a. The following information was documented in Resident #1's progress notes: On 12/20/21 (a Monday) at 6:28 a.m., "resident	F 684	F 684 Quality of Care 1. Resident #1 discharged from the facility 12-28-21 2. All residents have the potential to be affected. An audit by the Unit Manager will be conducted on current residents with falls from 2-7-22 to verify physician was notified for changes in neuro check assessment and for changes in condition in physical assessment with nausea and vomiting and/or diarrhea to obtain physician orders for interventions. 3. The Facility Educator or designee will in-service the Licensed Nurses on the process of physician notification and documentation for residents with post fall changes in neuro check assessments and changes in condition in physical assessment with nausea and vomiting and/or diarrhea to obtain physician orders for interventions.	2/20/22

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F 684	Continued From page 10 was having diarrhea and vomiting episodes over the weekend. all [sic] night has been covering (their) mouth with (their) hand as if (they) would vomit but hasn't. resident [sic] hasn't voided in the last 12 hours." On 12/21/21 at 2:16 p.m., "Loose watery diarrhea stools noted (twice) this shift." On 12/22/21 at 10:08 a.m., "...12/19/21 developed vomiting and diarrhea. Vomiting resolved but still having diarrhea." On 12/23/21 at 6:46 a.m., "Resident had loose watery stool (once) this shift. Will continue to monitor." The was no documentation found that Resident #1's physician was aware the resident was experiencing diarrhea or that any treatment was ordered. On 1/25/22 at 3:20 p.m., the absence of documentation of medical provider notification that Resident #1 was experiencing diarrhea was discussed with the facility's Administrator and Director of Nursing. The absence of a medical provider evaluation of Resident #1 related to the continued diarrhea was also discussed. During an interview on 1/27/22, the ADON reported they did not see treatment for diarrhea; the ADON reported treatment for diarrhea was not found on Resident #1's orders and not found on Resident #1's medication administration records (MARs). b. According to the clinical record, Resident #1 experienced a fall on 12/23/21 at 5:30 p.m.	F 684	4. An audit will be conducted by the Unit Manager or designee to verify physician was notified for falls with changes in neuro check assessments and changes in condition with nausea and vomiting and/or diarrhea to obtain physician orders for interventions weekly x 4 then monthly x 2. The findings will be review or revised in the QAPI meeting x 3 months. 5. Date of compliance: 2-28-2022	

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F 684	Continued From page 11 The following information was found as part of Resident #1's post-fall neurocheck assessments: On 12/23/21 at 5:30 p.m., 5:45 p.m., 6:01 p.m., 6:25 p.m, the resident was assessed as: (a) able to follow finger with eyes; (b) able to respond to simple commands; and (c) able to verbalize appropriately. On 12/23/21 at 7:30 p.m., the resident was assessed as: (a) able to follow finger with eyes; (b) able to respond to simple commands; and (c) changed to not able to verbalize appropriately. On 12/23/21 at 8:00 p.m., the resident was assessed as: (a) able to follow finger with eyes; (b) able to respond to simple commands; and (c) continued to be unable to verbalize appropriately. On 12/23/21 at 9:30 p.m., the resident was assessed as: (a) able to follow finger with eyes; (b) able to respond to simple commands; and (c) continued to be unable to verbalize appropriately. On 12/24/21 at 1:22 a.m., the resident was assessed as: (a) changed to not able to follow finger with eyes; (b) changed to not able to respond to simple commands; and (c) continued to be unable to verbalize appropriately. On1/27/22 at 11:15 a.m., the failure of the facility staff to notify Resident #1's medical provider and responsible party of a decline in resident being able to (a) follow a finger with their eyes, (b) respond to simple commands, and (c) verbalize appropriately was discussed with the facility's Administrator and Assistant Director of Nursing (ADON).	F 684		

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	495133	A. BUILDING _____ B. WING _____	C 01/28/2022

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F 684	Continued From page 12 The following information was found in a facility document titled "Neurological Assessment" (with a revised date of October 2010): "The purpose of this procedure is to provide guidelines for a neurological assessment... when following an unwitnessed fall ...Reporting... Notify the physician of any change in a resident's neurological status." The ADON reported that the neurocheck assessments were supposed to be completed as follows: (a) every 15 minutes for an hour; (b) every 30 minutes for four (4) hours; (c) every hour for two (2) hours; and (d) every shift for 72 hours. The ADON provided a facility document titled "NEUROCHECKS" (this document was not dated) which included the aforementioned neurocheck assessment schedule. During an interview on 1/27/22 at 11:10 a.m., the ADON reported one of Resident #1's every hour neurocheck assessments had not been completed and that Resident #1's every shift neurocheck assessments for 72 hours had not been completed. Review of Resident #1's clinical documentation from the local hospital indicated the Emergency Department (ED) provider documented the resident's mouth had dry mucous membranes. Laboratory test completed at the local hospital revealed the following elevated results: (a) a sodium level of 157 mmol/L; (b) a chloride level of 112 mmol/L; (c) a BUN level of 71 mg/dL; and (d) a Creatinine level of 228 mg/dL. The hospital discharge summary indicated the resident presented with altered mental status; the resident was found to have an elevated sodium, be	F 684		

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F 684	Continued From page 13 "profoundly dehydrated", and have a urinary tract infection (UTI). The History and Physical (H&P) completed, at the hospital on 12/29/21 at 8:59 a.m., included the following information in the "History of Present Illness" section: "Patient presents a [sic] skilled nursing facility with concerns for hypotension and hypoxia. Per the SNF (skilled nursing facility) (blood pressure) was 70/40 and patient was poorly responsive. At the scene EMS (emergency medical services) (found the resident) to be normotensive but was hypoxic requiring approximately 5 (liters) (oxygen) and responsive only to noxious stimuli. Earlier in the day the patient received a bath and at that time the vital signs were normal. For the past week leading up to this event the patient had been affected by virus according to the family which has been present in the skilled nursing facility with symptoms including nausea, vomiting, diarrhea [sic]. (The resident's adult children) who visited (the resident) on Sunday denied any of these symptoms however they did notice the patient was more confused." The assessment/plan of the H&P indicated the resident had Acute Kidney Injury "in the setting of solitary kidney ... Suspect prerenal given (history) of diarrhea and dehydration". The ED provider documentation indicated the resident's history on arrival at the ED included nausea, vomiting, and diarrhea for four days, which had resolved. During a meeting with the facility's Administrator, ADON, and Director of Rehab, on 1/27/22 at 3:15 p.m., the above findings for Resident #1 were discussed. No further information was provided prior to exit.	F 684		

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F 684	Continued From page 14 This is a complaint deficiency.	F 684		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and during the course of a complaint investigation, the facility staff failed to ensure a provider ordered CMP (comprehensive metabolic panel) laboratory test was obtained for one of four residents in the sample, Resident #1. Findings include: Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 11/11/21, was signed as completed on 11/15/21. Resident #1 was assessed as usually being able to make self understood and as usually being able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) Summary Score was documented as a zero (0) out of 15 (indicating severe cognitive impairment). Resident #1 was assessed as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #1's diagnoses included, but were not	F 770	F 770 Laboratory Services 1. Resident #1 discharged from the facility 12-28-21 2. All residents have the potential to be affected. An audit by the Unit Manger or designee will be conducted on residents from 2-7-2022 to verify physician orders for (Lab) laboratory test was obtained. The physician will be notified for labs not obtained and will reorder per physician and obtained. 3. The Facility Educator or designee will in-service the Licensed Nurses on the process for obtaining laboratory test per physician order with documentation. If the laboratory test not obtained, the physician will be notified and reordered per physician.	2/28/22

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F 770	Continued From page 15 limited to: high blood pressure, dementia, and a psychotic disorder (other than schizophrenia). Resident #1's clinical documentation contained a provider order dated 12/15/21 for a Comprehensive Metabolic Panel (CMP) laboratory test to be obtained on 12/17/21. Review of Resident #1's December 2021 MAR indicated the CMP had been completed. The results of the CMP were not found in the resident's chart. During an interview with the facility's Administrator and Assistant Director of Nursing (ADON), on 1/25/22 at 3:20 p.m., Resident #1's provider ordered Comprehensive Metabolic Panel (CMP) laboratory test was discussed. The ADON confirmed the CMP ordered on 12/15/21 to be completed on 12/17/21 had not been obtained. On 1/26/22 at 8:17 a.m., the facility's ADON confirmed the CMP had not been obtained but a staff member had documented it was completed on the MAR because the laboratory had the paperwork to do the CMP. During a meeting with the facility's Administrator, assistant director of nursing, and Director of Rehab, on 1/27/22 at 3:15 p.m., the failure to obtain a provider ordered CMP laboratory test was discussed. No further information was provided prior to exit.	F 770	4. An audit will be conducted by the DON or designee to review clinical documentation and lab results to verify the lab test ordered were obtained and if not, the physician notified the lab was not obtained and reordered per physician weekly x 4 weeks, then monthly x 2. The findings will be reviewed or revised in the QAPI meeting x 3 months. 5. Date of compliance: 2-28-2022	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842	F 842 Resident Records - Identifiable Information 1. Resident #1 discharged from the facility 12-28-21. Resident #3 expired 12-4-2022.	2/28/22

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F 842	Continued From page 16 (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or	F 842	2. All residents have the potential to be affected. An audit by the Unit Manager or designee will be conducted on residents from 2-7-2022 to verify the E-MAR (electronic medication administration record) has accurate documentation by the Licensed Nurse for labs not obtained. An audit by the Unit Manager or designee will be conducted on residents from 2-7-2022 to verify the fall assessment form has been completed. 3. The Facility Educator or designee will in-service the Licensed Nurses on the process for documentation on the E-MAR when the lab is obtained and how to document if the lab was not obtained on the E-Mar. The Licensed Nurses will in-service on the process for the assessment and completion of the fall assessment form.	

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F 842	Continued From page 17 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interviews, facility document reviews, and clinical record reviews, it was determined the facility staff failed to maintain complete and accurate clinical documentation for two of four sampled residents, Resident #1 and Resident #3. For Resident #1, the facility staff incorrectly documented the completion of a Comprehensive Metabolic Panel (CMP) laboratory test on the resident's Medication Administration Record (MAR). For Resident #3, the facility staff failed to document assessment information after an unwitnessed fall.	F 842	4. An audit will be conducted by the Unit Manager or designee to verify documentation on the E-MAR if the lab was not obtained is accurate by the licensed nurse and audit residents that fall have an assessment and completion of the fall assessment form weekly x 4 weeks, then monthly x 2. The findings will be reviewed or revised in the QAPI meeting x 3 months. 5. Date of compliance: 2-28-2022	

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F 842	Continued From page 18 The findings include: 1. Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 11/11/21, was signed as completed on 11/15/21. Resident #1 was assessed as usually being able to make self understood and as usually being able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) Summary Score was documented as a zero (0) out of 15 (indicating severe cognitive impairment). Resident #1's diagnoses included, but were not limited to: high blood pressure, dementia, and a psychotic disorder (other than schizophrenia). Resident #1's clinical documentation contained a provider order dated 12/15/21 for a Comprehensive Metabolic Panel (CMP) laboratory test to be obtained on 12/17/21. Review of Resident #1's December 2021 MAR indicated the CMP had been completed. The results of the CMP was not found in the resident's chart. During an interview with the facility's Administrator and Assistant Director of Nursing (ADON), on 1/25/22 at 3:20 p.m., Resident #1's provider ordered Comprehensive Metabolic Panel (CMP) laboratory test was discussed. The ADON confirmed the CMP ordered on 12/15/21 to be completed on 12/17/21 had not been obtained. On 1/26/22 at 8:17 a.m., the facility's ADON confirmed the CMP had not been obtained but a staff member had documented it was completed on the MAR because the laboratory staff member had the paperwork to do the CMP.	F 842		

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F 842	Continued From page 19 The incorrect documentation of Resident #1's CMP laboratory test being obtained was discussed during a meeting with the facility's Administrator, Director of Nursing, and Director of Rehab on 1/27/22 at 3:15 p.m. No further information was provided prior to exit. 2. Resident #3's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/10/21, was signed as completed on 12/13/21. Resident #3 was assessed as being able to make self understood and as being able to understand others. Resident #3's Brief Interview for Mental Status (BIMS) Summary Score was documented as a 13 out of 15 (indicating intact/borderline cognition). Resident #3 was assessed as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #3's diagnoses included, but were not limited to: anemia, high blood pressure, kidney disease, and depression. Resident #3's clinical documentation included an "eINTERACT SBAR Summary for Providers" note dated 1/23/22 at 10:30 a.m. This note indicated the resident had experienced a fall but did not include details about how the resident was found after the unwitnessed fall. This note indicated a medical provider was notified but did not detail what the provider was told or the provider's response. The note included a section titled "Outcomes of Physical Assessment" which indicated no change was observed with mental status evaluation. The area for "Nursing observations, evaluations, and recommendations are:" was left blank. The facility's Assistant Director of Nursing	F 842		

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F 842	Continued From page 20 (ADON) was interviewed, about Resident #3's fall documentation, on 1/28/22 at 9:50 a.m. The ADON confirmed Resident #3's documentation did not include information about what Resident #3 was doing at the time of their 1/23/22 fall and did not include details of how the resident was found after the fall. On 1/28/22 at 9:57 a.m., Staff Member (SM) #4 (a unit manager) was interviewed about Resident #3's 1/23/22 fall. SM #4 confirmed details of the fall had not been documented. SM #4 reported the employee who had cared for Resident #3 at the time of the fall was being telephoned about the fall. On 1/28/22 at 9:59 a.m., SM #4 (after speaking to the staff member who cared for Resident #3 at the time of the fall) reported the resident was found sitting on the floor after taking themself to the bathroom. The following information was found in a facility document titled "Guidelines for Charting and Documentation" (dated as revised on April 2012): "Purpose ... The purpose of charting and documentation is to provide: 1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., and the progress of the resident's care...General Rules for Charting and Documentation ... 1. Chart all pertinent changes in the resident's condition, reaction to treatments, medication, etc., as well as routine observations. 2. Be concise, accurate, and complete and use objective terms ... 8. All entries must reflect the date, the time and the signature and title of the person recording the data ... 12. Miscellaneous Documentation ... Documentation should also include: a. Any time the physician or family is called about the resident and their response..."	F 842		

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F 842	Continued From page 21 On 1/28/22 at 11:00 a.m., Resident #3's aforementioned incomplete documentation was discussed with the facility's Administrator and DON. No further information was provided prior to exit.	F 842		