STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495237	A. BUILDING _____ B. WING _____	C 12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA BEACH HEALTHCARE AND REHAB CENTER	1801 CAMELOT DRIVE VIRGINIA BEACH, VA 23454

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification from 12/27/21 through 12/30/21. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 12/27/21 to 12/30/21 Survey Census: 156 Sample Size: 34 Supplemental: 3 Deficiencies were cited related to Intake VA00053207. No deficiencies were issued related to Intakes VA00053237 and VA00053236.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		2/7/22

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

Electronically Signed | 01/25/2022

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 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of facility policy the facility failed to ensure dignity was maintained for one of thirty-four sample residents (Resident (R) 404)). Specifically, R404's foley catheter bag was	F 550	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited	

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F 550	Continued From page 2 uncovered and within view of individuals in the corridor. Findings include: Review of facility policy title "Suprapubic Catheter Reinsertion" dated 11/01/19 instructs staff to ". . . 18. Hang bag below level of the bladder and place privacy bag over the drainage bag." Review of the admission note, in the "Progress Notes" tab of electronic medical record (EMR), dated 12/24/21, revealed R404's diagnoses included metabolic encephalopathy in the setting of hyponatremia and acute cystitis. Review of R404's physician's orders in the "Orders" tab of EMR revealed R404 was admitted on 12/24/21 with an order for a Suprapubic Foley Catheter. Review of the R404's admission "Minimum Data Set (MDS)" dated 12/30/21 revealed R404 required extensive assistance with bed mobility; one person physical assist with dressing; two person physical assist with toilet use; one person physical assist with personal hygiene and had an indwelling catheter during the assessment period. Observation on 12/27/21 at 1:06 PM and on 12/29/21 at 10:59 AM revealed R404 was observed lying in his room. The door to his room was open and a foley catheter bag containing urine was hanging on the side of the bed within view of individuals in the hall/corridor. Observation on 12/29/21 at 10:59 AM revealed Certified Nursing Assistant (CNA) 13 was in the hallway outside of R404's room. CNA13 verified	F 550	in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F550 1- Resident #404 has a dignity cover for the foley catheter bag. 2- The DON or designee will review residents with foley catheter bags to ensure that a dignity cover is in place. 3-The DON or designee will educate licensed staff on providing a dignity cover for foley catheter bags. 4-The Unit Manager or designee will complete weekly audits of residents with foley catheter bags to ensure that a dignity cover is in place. Results of the audits will be presented to the QAPI Committee for review and recommendation. 5-Completion date 2/7/2022.	

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F 550	Continued From page 3 she could see the catheter bag partially full of urine from where she was in the hallway. CNA13 further stated she was not sure if the catheter bag was supposed to be in a dignity bag. During an interview on 12/29/21 at 12:35 PM, Assistant Director of Nursing (ADON) confirmed dignity bags were required per facility policy, and verified R404's urinary collection bag was hanging on the side of the bed within view of individuals in the hall/corridor. During an interview on 12/29/21 at 4:05 PM, Director of Nursing (DON) confirmed dignity bags are required per facility policy.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy, the facility failed to ensure one of 34 sampled residents (Resident (R) 85) had a physician's order and was screened/assessed for the self-administration of medications prior to medications being stored at the bedside and self-administered. Findings include: Review of the facility policy "Self-Administration Medication at Bedside," dated 11/01/19, revealed, ". . .physician's order in patient's chart for self-administration . . . complete	F 554	F554 1-Resident #85 has a physician□s order in place for self-administration of eye drops and lubricant, the self-administration of medication administration assessment was completed and the care plan was updated to reflect self-administration of medication. 2-The DON or designee will review residents who wish to self-administer medications and ensure that the physician order is in place for self-administration, a self-administration of medication	2/7/22

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F 554	Continued From page 4 self-administration screen . . . self-administration must be reviewed by interdisciplinary team . . . medications . . . to be self-administered will be identified on MAR [medication administration record]. . ." Review of R85's electronic medical record (EMR) under the "Profile" tab revealed R85 admitted to the facility on 11/04/19. Review of R85's EMR under the "Med Diag" tab revealed, multiple diagnoses to include congestive heart failure. Review of R85's "Orders" tab in the EMR revealed ". . .Muro 128 Ointment 5 % (Sodium Chloride (Hypertonic)) Instill 1 dose in right eye at bedtime for edema put 1/4 inch strip OD [right eye]" and "Muro 128 Solution 5 % (Sodium Chloride (Hypertonic)) Instill 1 drop in right eye four times a day for edema..." dated 10/19/21. R85's physician's orders did not include an order for R85 to self-administer medications. Review of R85's EMR under the "Misc" tab revealed, no documentation of a self-administration assessment. Review of R85's EMR under the "Care Plan" tab revealed, there was no documentation regarding the self-administration of medication. Review of R85's EMR under the "MAR" tab revealed facility's staff documented administering eye drops and lubricant for R85, for the month of December 2021. Review of R85's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date	F 554	administration assessment was completed and the care plan is updated to reflect self-administration of medication. 3-The DON or designee will educated Licensed Nurses on self-administration of medication requirements to include self-administration assessment, obtaining a physician order for self-administration and updating the care plan appropriately. 4-The Unit Manager or designee will complete random monthly audits of residents who prefer to self-administer medications to ensure that the physician order, self-administration of medication assessment was completed and the care plan is updated appropriately. Results of the audits will be presented to the QAPI Committee for review and recommendation. 5-Completion date 2/7/22.	

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F 554	Continued From page 5	F 554		

(ARD) of 11/17/21, revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated R85 was cognitively intact.

An observation on 12/27/21 at 12:08 PM revealed, two medication bottles on R85's bedside table, in her room (unsupervised and unattended by facility's staff) to include, 1. Sodium Chloride 5 % lubricant instill 1/4 inch at bedtime in right eye. The medication bottle was labeled "Refrigerate." 1/8-ounce tube. 2. Sodium Chloride 5% solution 1 drop right eye four times a day. 1/2-ounce bottle expires 11/23. R85 stated, "I administered these drops myself."

A second observation on 12/27/21 4:56 PM, two medication bottles were on 85's bed, in her room, (unsupervised and unattended by facility's staff) to include, the following, 1. Sodium Chloride 5 % lubricant instill 1/4 inch at bedtime in right eye. (The medication bottle was labeled "Refrigerate") 1/8-ounce tube. 2. Sodium Chloride 5% solution 1 drop right eye four times a day. 1/2-ounce bottle expires 11/23.

A third observation was conducted on 12/29/21 at 9:47 AM of two medication bottles (1. Sodium Chloride 5 % lubricant instill 1/4 inch at bedtime in right eye. The medication bottle was labeled "Refrigerate". 1/8-ounce tube. 2. Sodium Chloride 5% solution 1 drop right eye four times a day. 1/2-ounce bottle expires 11/23), were on R85's bedside table, in her room (unsupervised and unattended by facility's staff).

During an interview on 12/29/21 at 11:41 AM, Registered Nurse (RN) Unit Manager (UM), verified and confirmed there were two medications bottles (unattended by facility's staff)

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F 554	Continued From page 6 on R85's bedside table in her room on 12/29/21. RN UM confirmed the medication should not be stored in R85's room. During an interview on 12/29/21 2:52 PM with RN UM present, R85 stated she was self-administering eye drops for a month or two. During an interview on 12/29/21 at 2:57 PM, RN UM verified and confirmed R85 did not have a physician's order to self-administer medication, including the eye drops and lubricant stored at her bedside, in her room. RN UM further verified and confirmed, R85 was not assessed by the interdisciplinary team for self-administration of medication with a determination made, prior to R85 performing self-administration of medication. During an interview on 12/30/21 at 7:26 PM, the DON (Director of Nursing) confirmed, resident medications cannot be stored in resident's room without a physician's order and all staff are responsible for following physician orders.	F 554		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the	F 578		2/7/22

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F 578	Continued From page 7 requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy, the facility failed to ensure advanced directives were offered and periodically reviewed; and Do Not Resuscitate (DNR) forms were completed and accurate for ten residents out of 34 sampled residents (Resident (R) 51, R11, R33, R114, R67, R85, R407, R412, R126, and R107). Findings include:	F 578	F578 1-Resident #412 and #126 were discharged from the facility. The Advanced Directive acknowledgement was reviewed and updated for the following residents: #51, #33, # 114, #67, #85, #407 and #107. 2-The Admissions Director or designee will review current residents to ensure that the Advanced Directive acknowledgement	

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F 578	Continued From page 8 The facility's "Advance Directives Policy," titled "MFA [Medical Facilities of America] Policies Governing the Implementation of Self-Determination Rights" read, in pertinent part, "3. All Residents at the time of admission will be provided with this document entitled "MFA Policies Governing the Implementation of Self-Determination Rights" which summarizes the Health & Rehabilitation Center's policies and procedures regarding advanced directives . . . 8. The original or a Health & Rehabilitation Center verified copy of any advance directive that is appropriately signed and witnessed as permitted by Virginia state law will be filed by the Health & Rehabilitation Center with the Resident's permanent medical record and appropriately noted in the chart." revealed "Center will chart the Advance Directive Notification. . . in the Resident's permanent medical record . . . requiring the Resident to complete and sign the Advance Directive Notification and Acknowledgement form. . ." Review of facility policy "Physician's Orders," "Policy Number 203" dated 03/24/20 revealed in part ". . .12) Code status: If a state DDNR [Durable Do Not Resuscitate] order, legible photocopy of the DDNR, DNR jewelry (bracelet or necklace), or POST [Physician Orders for Scope of Treatment] form does not accompany the patient upon admission the patient will be considered a full code until a singed physician order is secured. . . Ensure that the physician's order is correct and that the DDNR form or POST form, if applicable, is complete." 1. Review of an "Admission Record" located in R33's electronic medical record (EMR) under the	F 578	was addressed with the resident and/or resident representative and any Advanced Directive documents provided were updated in the resident□s medical record. 3-The Administrator or designee will educate the Admissions department, Social Services Department and Nursing Management on the provisions to address Advanced Directives for residents and ensuring the Advanced Directives documents are provided in the medical record. 4-The DON or designee will complete weekly audits of any newly admitted residents to ensure that the Advanced Directive acknowledgment was reviewed and that the Advanced Directive documents were provided and updated in the resident medical record. Advanced Directives will be reviewed by The IDT team will review resident Advanced Directives on a Quarterly basis to ensure that the resident preference for Advanced Directives is accurately reflected in the medical record. Results of the audits will be presented to the QAPI Committee for review and recommendation. 5-Completion date 2/7/22.	

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"Profile" tab indicated she was admitted on 10/01/21 and was her own responsible party.

R33's "Physician Orders" dated 11/11/21 found in the EMR under the "Orders" tab included an order that the resident was to be a "full code," meaning resuscitation procedures would be provided in an emergency.

Review of R33's "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/07/21 revealed R33 had a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15, which indicated the resident was cognitively intact.

Review of R33's entire EMR revealed no documentation that advanced directive were offered or discussed with the resident by the facility staff.

During an interview on 12/28/21 at 11:35 AM, R33 said she did not recall the facility staff discussing an advanced directive with her upon admission. R33 said she wished to be resuscitated in an emergency and she would want to discuss advanced directives with someone.

During an interview on 12/28/21 at 3:05 PM, the Director of Nursing (DON) said there was no advanced directive or evidence it was discussed for R33. The DON said it should have been discussed and signed or declined upon R33's admission.

2. Review of an "Admission Record" located in R11's EMR under the "Profile" tab indicated he was admitted on 04/21/21 and was his own responsible party. His brother was also listed as a

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F 578	Continued From page 10	F 578		

contact.

R11's "Physician Orders" dated 04/21/21 found in the EMR under the "Orders" tab included an order that the resident was to be a "full code."

Review of R11's admission "MDS" with an ARD of 10/07/21 revealed the resident had a BIMS score of 99 out of 15, which indicated the resident could not be assessed. The staff assessment for mental status indicated R11 had short term and long-term memory problems.

Review of R11's entire EMR revealed there was no documentation that advanced directives were offered or discussed with the resident or family member by the facility staff.

During an interview on 12/28/21 at 3:05 PM, the DON said there was no advanced directive or evidence it was discussed for R11. The DON said it should have been discussed and signed or declined upon R11's admission.

3. Review of an "Admission Record" located in R51's EMR under the "Profile" tab indicated she was admitted on 10/16/21 and was her own responsible party.

R51's "Physician Orders" dated 04/21/21 found in the EMR under the "Orders" tab included an order that the resident was to be a "full code."

Review of the resident's admission "MDS" with an ARD of 10/22/21 revealed the resident had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact.

Review of R51's entire EMR revealed there was

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no documentation that advanced directives were offered or discussed with the resident or family member by the facility staff.

During an interview on 12/28/21 at 11:50 AM, R51 said she would want to be resuscitated and was not sure if anyone discussed it with her on admission. R51 said she thought it was an important issue and would want the staff to discuss it with her.

During an interview on 12/28/21 at 3:05 PM, the DON said there was no advanced directive or evidence it was discussed with R51. The DON said it should have been discussed and signed or declined upon R51's admission.

4. R407 was admitted to the facility on 12/16/21, according to the EMR under the "Medical Diagnosis" tab.

Review of R407's "MDS," with ARD of 11/16/21, revealed R407 was severely cognitively impaired, with a BIMS score of 99, indicating the resident could not complete the interview. The MDS indicated the resident had both short and long-term memory deficits, and her cognitive skills for daily decision making were severely impaired.

Review of R407's "MFA Policies Governing the Implementation of Self-Determination Rights Form," signed by the resident, dated 11/28/16, and provided by the facility, indicated the resident had not ". . .executed Advance Medical Directive(s). . ." and "I DO NOT WANT MORE INFORMATION regarding advance directives."

Review of R407's DDNR, dated 12/02/20 and

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located in the EMR under the "Miscellaneous" tab, left both boxes unchecked leaving for the form incomplete related to the following: "I further certify (must check 1 or 2): 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required); 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probably consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision." Review of document further revealed no "Patient's Signature" or "Signature of Person Authorized to Consent on the Patient's Behalf."

Review of R407's "Clinical Physician Orders," dated 12/16/21 and located in the EMR under the "Orders" tab, indicated the resident's code status was "DNR."

During an interview on 12/29/21 at 3:10 PM, the Director of Admissions confirmed incomplete Durable Do Not Resuscitate Order was signed by a physician on 12/02/20, which was missing resident or responsible party's signature for R407. The Director of Admissions also confirmed "there should be a signature in the area marked as patient's signature . . . I don't know if she had the capacity to sign at the time. If she did have the capacity in 2020 then she should of signed it, if she did not have capacity then the proxy or Power of Attorney should of signed it."

During an interview on 12/29/21 at 3:21 PM, the

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Director of Social Services (DSS) revealed R407's physician signature on Durable Do Not Resuscitate Order, dated 12/02/20 and "did not check off selecting stating whether patient was capable of making decisions . . . resident does not have Power of Attorney and in the past she signed everything on her own . . . current DNR is not valid."

During an interview on 12/30/21 at 11:40 AM, the DON revealed R407 currently discharged to hospital. DON confirmed DNR on file dated 12/02/20 was missing R407's signature.

5. R412 was admitted to the facility on 12/18/21, according to the EMR under the "Medical Diagnosis" tab.

Review of R412's MDS, with an ARD of 12/24/21 revealed R412 was cognitively intact with a BIMS score of 15 out of 15.

Review of R412s "Clinical Physician Orders," dated 12/18/21 and located in the EMR under the "Orders" tab, indicated the resident's code status was Full Code.

Review of R412's EMR revealed no documentation of advanced directives, or that facility staff discussed advanced directives with the resident.

Interview with DON on 12/28/21 at 3:23 PM, confirmed "there is no advanced directive on file" for R412.

Interview with the Director of Admissions on 12/29/21 at 2:56 PM, revealed the facility "asks the resident or responsible party if there is an

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advanced directive. If there is none, I am not sure what is the process. If resident is a DNR facility obtains a copy from the hospital or family, DNR is then scanned into the chart and placed under the miscellaneous tab in EMR." The Director of Admissions confirmed in document manager located in EMR, there was no Advanced Directive information for R412.

6. R126 was admitted to the facility on 11/28/21, according to the EMR under the "Medical Diagnosis" tab.

Review of R126's "Clinical Physician Orders," dated 12/30/21 and located in the EMR under the "Orders" tab, indicated the resident's code status was Full Code.

Review of R126's EMR revealed no documentation of advanced directives, or that facility staff discussed advanced directives with the resident.

Interview with DON on 12/28/21 at 3:23 PM, confirmed "there is no advanced directive on file" for R126.

Interview with R126 on 12/28/21 at 4:32 PM, revealed he did not recall being asked about Advanced Directives.

Interview with Director of Admissions on 12/29/21 at 2:56 PM, revealed facility "asks the resident or responsible party if there is an advanced directive. If there is none, I am not sure what is the process. If resident is a DNR facility obtains a copy from the hospital or family, DNR is then scanned into the chart and placed under the miscellaneous tab in EMR." The Director of

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Admissions confirmed in document manager located in EMR, there was no Advanced Directive information for R126.

7. R107 was admitted to the facility on 11/20/21, according to the EMR under the "Medical Diagnosis" tab.

Review of R107's "Clinical Physician Orders," dated 12/30/21 and located in the EMR under the "Orders" tab, indicated the resident's code status was Full Code.

Review of R107's EMR revealed no documentation of advanced directives, or that facility staff discussed advanced directives with the resident.

Review of R107's MDS with an ARD of 11/26/21 revealed R107 was cognitively intact with a BIMS score of 15 out of 15.

Interview with R107 on 12/28/21 9:02 AM, revealed she was not asked about advanced directives upon admission.

Interview with DON on 12/28/21 at 3:23 PM, confirmed "there is no advanced directive on file" for R107.

Interview with Director of Admissions on 12/29/21 at 2:56 PM, revealed facility "asks the resident or responsible party if there is an advanced directive. If there is none, I am not sure what is the process. If resident is a DNR facility obtains a copy from the hospital or family, DNR is then scanned into the chart and placed under the miscellaneous tab in EMR." The Director of Admissions confirmed in document manager

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located in EMR, there was no Advanced Directive information for R107.

8. Review of R114's undated "Admission Record" located in the EMR under the "Profile" tab indicated R114 was admitted to the facility on 11/23/21.

Review of R114's "Physician Orders" dated 11/23/21, located in the EMR under the "Orders" tab, revealed an order indicating R114 was full code.

Review of R114's "Medication Administration Record" (MAR) for December 2021, located in the EMR under the "Orders" tab under advance directives indicated R114 was full code.

Review of R114's EMR revealed no documentation of advanced directives or POST.

Review of R114's "U.S. Living Will Registry Registration Agreement," dated 10/16/21, provided by the facility after retrieving the document from the outpatient hospital records, revealed under "Section III- Specific Healthcare Instructions" R114 initialed each box indicating "no life-sustaining treatments; allow me to die naturally" for the following: "If I am unconscious, in a coma, or in a vegetative state and there are is little or no chance of recovery . . . If I have permanent, severe brain damage that makes me unable to recognize my family or friends (i.e., severe dementia, damage from stroke) . . . If I have a permanent condition where others must help me with my daily needs (such as eating and toileting) . . . If I have to be in bed and use a breathing machine 24/7 for the rest of my life . . . If I have severe pain or other severe symptoms

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that cause suffering and can't be relieved . . . and If I have a condition that will result in death soon, even with life-sustaining treatments."

During an interview on 12/28/21 at 4:01 PM, R114 was asked, what his wishes related to life sustaining interventions being initiated should he stop breathing and/or his heart would stop? R114 responded, "I want the staff to do nothing, they should have my paperwork stating that." R114 stated, "I informed the nurse practitioner [NP] that I don't want anything [life sustaining measures] done."

During an interview on 12/28/21 at 4:14 PM, Licensed Practical Nurse (LPN)17 was asked how she would know what R114's code status was? LPN17 stated, "I would look at the MAR under advance directive and it would tell me what his code status is." LPN17 proceeded to show this surveyor R114's MAR indicating R114 was listed as a full code.

During an interview on 12/28/21 at 4:15 PM, the Licensed Practical Nurse Unit Manager (LPN-UM1) was questioned how would the staff know what R114's code status was? The LPN-UM1 stated, "they would find it on the face sheet located in the resident's hard chart at the nursing station," which also reflected R114 was a full code.

During an interview on 12/30/21 at 8:35 AM, Admissions Assistant (AA) was questioned concerning the process of R114's advance directives. AA stated, "if a resident is admitted from the hospital, I will access the hospital system and print out the resident's advance directives and scan the documents into the

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resident's medical record." AA was asked, when R114's advance directive had been pulled from the hospital system and placed into R114's medical record? AA stated, "I forgot to do it for [R114], it was uploaded into the computer on 12/28/21." AA was asked who followed up with the resident/resident representative to ensure the advance directive were honored? AA replied, "the social worker/discharge planning person to review in the care plan meeting."

During an interview conducted with the Director of Social Services (DSS) on 12/30/21 at 8:56 AM, the DSS was questioned, who was supposed to ensure the resident's advance directives were reviewed and kept updated? The DSS responded, "Admission is supposed to review and obtain all advance directives with resident."

9. Review of R67's "Profile" tab in the EMR, revealed R67 admitted to facility on 10/13/17 and code status was full code.

Review of R67's "Orders" tab in the EMR, revealed "Full Code," dated 04/24/19.

Review of R67's "Care Plan" tab revealed no information regarding advance directives or code status.

Review of R67's EMR did not reveal any "Advance Directives," or documentation of a discussion of advanced directives.

Review of a quarterly MDS with an ARD of 11/01/21 revealed, R67 was assessed with a BIMS score of 15 out of 15, indicating R67 was cognitively intact.

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Review of paper document provided by the facility, titled "MFA POLCIES GOVERING THE IMPLEMENTATION OF SELF-DETERMINATION RIGHTS," under the heading, "ADVANCE DIRECTIVE ACKNOWLEDGEMENT," was not signed by R67 (signed by "Responsible party"), dated 10/13/17.

During an interview on 12/30/21 at 6:10 PM, R67 verified the facility had not reviewed advance directives or code status changes or continuation, with her since her admission to the facility in 2017.

An interview was conducted on 12/30/21 at 7:26 PM, the Director of Nursing (DON) confirmed the resident's code statuses were addressed at the time of resident's admission, and there was not a periodic review performed by the facility for resident's continuation or changes of advance directive instructions or code status. The DON denied knowing if resident's code status or advance directives were reviewed in care plan meetings.

10. Review of R85's EMR under the "Profile" tab revealed R85 admitted to the facility on 11/04/19, and code status was full code.

Review of R85's quarterly MDS with an ARD of 11/17/21 revealed a BIMS score of 15 out of 15, indicating R85 was cognitively intact.

Review of R85's "Orders" tab in the EMR, revealed full code physician order, dated 11/14/19.

Review of the "misc" tab in the EMR, under admission information contained a document,

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F 578	Continued From page 20 titled "MFA POLCIES GOVERING THE IMPLEMENTATION OF SELF-DETERMINATION RIGHTS," under the heading "ADVANCE DIRECTIVE ACKNOWLEGEMENT," the document was incomplete. There was no information entered on the document, including answers for questions regarding if R85 had an advance directive, the document was signed and dated 11/15/19. Review of the "Care Plan" tab in the EMR revealed, no information for R85's code status or advance directive instructions. An interview was conducted on 12/30/21 at 7:26 PM, the Director of Nursing (DON) confirmed the resident's code statuses were addressed at the time of resident's admission, and there was not a periodic review performed by the facility for resident's continuation or changes of advance directive instructions or code status. The DON denied knowing if resident's code status or advance directives were reviewed in care plan meetings.	F 578		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the	F 645		2/7/22

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F 645	Continued From page 21 State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and	F 645		

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F 645	Continued From page 22 (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure an accurate Level 1 pre-screening of the resident for a mental disorder (MD) or intellectual disability (ID) prior to admission to the facility was completed for two of three residents (Resident (R) 13 and R133) reviewed for Level 1 Pre-Admission Screening and Resident Review (PASRR). Findings include: Review of the facility's policy titled, "Discharge Planning Policies and Procedures" dated 01/06/20, indicated, "Prior to the arrival of a planned admission the Discharge Planner will collaborate with the Admissions Director to preview the transferring hospital's Level 1 PASRR (Level 1 Screening for Mental Illness, Intellectual Disability, or Related Conditions) and/or initiate completion of the Level 1 PASRR if not completed by the transferring hospital."	F 645	F645 1-The Level 1 PASRR for Resident #13 was updated to reflect the current mental illness. Resident #133 was referred to the appropriate state designated authority for PASAAR Level II evaluation and completion. 2-The Social Services Director will complete an audit of current residents to ensure a Level 1 PASRR was completed if required. 3-The Administrator will educate the Social Services Department on the Level 1 and Level II PASRR requirements. 4-The Social Services Director, or designee will complete an audit of newly admitted residents to ensure that the PASRR form is completed as indicated. Results of the audits will be presented to the QAPI Committee for review and recommendation. 5-Completion date 2/7/22.	

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1. Review of R13's "Face Sheet" located in the electronic medical record (EMR) under the "Profile" tab, revealed an admission date of 08/11/04 and included, but was not limited to, the following diagnoses: obsessive compulsive disorder, schizoaffective disorder, borderline personality disorder, anxiety disorder, and major depressive disorder.

Review of R13's "Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions" located in the EMR under the "Misc" tab, dated 05/24/19, documented R13 did not have a current mental illness. The document reviewed is also referred to as a Level 1 PASRR.

During an interview on 12/30/21 at 1:49 PM with the Director of Social Services (DSS), she stated the Level 1 PASRR that was completed in 2019, was incorrect due not indicating R13's mental illness. She further stated if the Level 1 PASRR had been completed, R13 would have been referred for a Level II PASRR in order to receive specialized services.

2. Review of R133's "Med Diag" tab in the EMR revealed R133 was admitted to the facility on 09/04/92 with multiple diagnoses to include major depressive disorder, delusional disorder, anxiety disorder, and intracranial brain injury.

Review of R133's "Order" tab in the EMR revealed R133 received antipsychotic medication and antidepressant medication.

Review of R133's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/06/21 revealed a Brief Interview

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F 645	Continued From page 24 Mental Status (BIMS) score of 9 out of 15, which indicated R133 was cognitively impaired. Review of the "Misc" tab of the EMR, did not reveal a Level 1 PASARR. A review of a paper, photocopy of document, provided by DSS, titled "SCREENING FOR MENTAL ILLNESS RETARDATION/INTELLECTUAL DISABILITY, OR RELATED CONDITIONS", dated and signed 02/08/10, revealed "...2. INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS..." yes was marked and "...5. RECOMMENDATION...", the box beside "...MI [Mental Illness] (#2 above is checked "Yes")" was empty and not marked. Instead, the box beside "...Does not meet the application criteria for serious MI . . ." was marked with a line. The box besides, "...No referral for active treatment needs assessment required. . ." was marked with a line. During an interview on 12/30/21 at 11:11 AM, the DSS verified and confirmed there was no PASAAR on R133's electronic medical record, the screening form was completed incorrectly and the facility failed to refer R133 to appropriate state designated authority for PASAAR Level II evaluation and determination.	F 645		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655		2/7/22

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

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

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, F655

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F 655	Continued From page 26 and policy review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours of admission to the facility for one resident of eight residents (Resident (R)404) reviewed for baseline care plans in a total sample of 34 residents. Findings include: Review of facility policy titled, "Care Planning," dated 11/01/19, revealed, "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient. The computerized baseline Care Plan is initiated and activated within 48 hours. The Center will provide the patient and representative(s) with a summary of the baseline care plan that includes but is not limited to: . . . any services and treatments to be administered by the Center and personnel acting on behalf of the Center." Review of the "admission note," in the "Progress Notes" tab of the electronic medical record (EMR), dated 12/24/21, revealed R404's diagnoses included metabolic encephalopathy in the setting of hyponatremia and acute cystitis. Review of R404's physician's orders in the "Orders" tab of the EMR revealed R404 was admitted on 12/24/21, with orders dated 12/24/21 for Suprapubic foley catheter (20 French (fr) 30 milliliters (ml)) monitor every shift; flush suprapubic catheter with 60ml of normal saline every shift; Check Foley anchor placement every	F 655	1-The care plan for Resident #404 was updated to reflect the suprapubic foley catheter. 2-The DON or designee will review residents admitted in the past 14 days to ensure that the baseline care plan is developed and implemented appropriately. 3-The DON or designee will educate Licensed Nurses on the requirements for the development and implementation of a baseline care plan. 4-The Unit Manager or designee will complete weekly audits of residents admitted or re-admitted to ensure that a baseline care plan was developed and implemented appropriately. 5-Completion date 2/7/22.	

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shift; Change suprapubic catheter insertion site dressing every day and as needed using split gauze.

Review of R404's "Admission Assessment/Screening V.1.2," dated 12/24/21 under the "Progress Notes" tab of EMR, revealed in section H. "GU/Bladder. . .1. Nondistended bladder 3. Incontinent of bladder." "6a. Type of catheter b. Suprapubic Catheter" was left blank and did not document that R404 had a catheter.

Review of R404's admission "Minimum Data Set (MDS)" dated 12/30/21 revealed R404 required extensive assistance with bed mobility; two person physical assist with toilet use; one person physical assist with personal hygiene and had an indwelling catheter during the assessment period.

Review of R404's "Baseline Care Plan," found in the EMR under the "Care Plan" tab and dated 12/24/21, revealed the care plan did not address suprapubic indwelling catheter status.

During observation on 12/27/21 at 1:06 PM and on 12/29/21 at 10:59 AM, R404 was observed lying in his room. The door to his room was open and a foley catheter bag containing urine was hanging on the side of the bed within view of individuals in the hall/corridor.

During an interview on 12/30/21 at 11:05 AM, the Director of Nursing (DON) said it was her expectation that baseline care plans addressed all issues residents needed assistance with. The DON confirmed R404 admitted on 12/24/21 with indwelling suprapubic catheter. DON also confirmed the "Admission Assessment/Screening V.1.2" dated 12/24/21 was inaccurate and did not

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F 655	Continued From page 28 document R404's suprapubic catheter. The DON indicated the assessment was used to create the Baseline Care Plan. The DON confirmed the Baseline Care Plan dated 12/24/21 in EMR, under "Care Plan" tab, did not include suprapubic catheter status and should have.	F 655		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and	F 660		2/7/22

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resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident

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F 660	Continued From page 30 information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to develop, assist, and follow through to completion with discharge plans for one of 34 sampled residents (Resident (R) 133) reviewed for discharge planning. The facility did not have a person-centered discharge plan for R133. Findings include: Review of the facility policy, titled "Discharge Planning Policies and Procedures," dated 01/06/20 revealed, "Discharge planning will review extended care (long-term care) patients for discharge planning needs and pursue placement . . . Communicate with patient. . . discharge plans . . . Discharge planning staff will proactively spearhead the discharge planning process and follow through to completion to ensure a discharge. . ." Review of R133's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/06/21, revealed a Brief Interview for Mental Status (BIMS) score of nine out of 15, which indicated R133 had moderate cognitive impairment. Review of R133"s "Profile" tab in the electronic medical record (EMR), revealed R133 was admitted to the facility on 09/04/92. Review of R133's "Care Plan" tab revealed ". .	F 660	F660 1-The Social Services Director addressed Resident #133 desire to be discharged with the family and the resident and determined the appropriate discharge plan is to remain LTC at the faciliy. 2-The Social Services Director or designee will review the discharge plan for current residents to ensure that the discharge preference is noted. 3-The Administrator will educate the Social Services Department on requirements to develop, assist and follow through with discharge plans for residents. 4-The Social Services Director, or designee will complete quarterly audits of the discharge plan for residents to ensure that the resident preference discharge is noted and addressed appropriately. Results of the audits will be presented to the QAPI Committee for review and recommendation. 5-Completion date 2/7/22.	

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F 660	Continued From page 31 .The patient's preference for discharge is: LTC [long term care] at [the facility] Created on: 09/16/2014. . ." During an interview on 12/27/21 at 12:29 PM, R133 expressed desire/wish to be discharge from the facility to go home to Georgia. R133 stated she had told facility staff, but no one had talked to her about her desire to discharge. During an interview on 12/30/21 at 2:44 PM, the Director of Social Services (DSS) confirmed and verified, the facility was aware of R133's desire to have a discharge plan from the facility and no discharge plan had been addressed with R133. The DSS further confirmed and verified, the facility did not develop or assist R133 with discharge plans and the facility should develop and assist R133 with a discharge plan (according to her wishes/desires). The DSS confirmed, the facility did not proactively spearhead a discharge plan process or follow through to ensure a discharge from the facility for R133.	F 660		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced	F 679		2/7/22

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by:
Based on observation, interview, record review, and review of facility policy the facility failed to provide an individualized activity program for two of 34 sampled residents (Resident (R) 33 and R51).

Findings include:

Review of the facility's policy titled "Activities Policies and Procedures" dated January 2020 documented "activities staff will monitor, evaluate and record patient's activities participation and response to activities. . ." and ". . .utilize the patient record to determine whether the patient's participation in activities and/or independent activities pursuits achieves the stated goals on the patient's plan of care."

1. Review of an "Admission Record" located in R33's electronic medical record (EMR) under the "Profile" tab indicated she was admitted on 10/01/21 with diagnoses including major depressive disorder

Review of a care plan dated 10/06/21 found in R33's EMR under the "Care Plan" tab indicated she would "engage in independent leisure pursuits 2-4x's [times] weekly." The leisure activities listed included "listening to music on her TV, visiting with family and friends and reading." The care plan indicated R33 needed assistance with leisure at times due to her diagnosis.

Review of R33's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/07/21 revealed R33 had a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15, which indicated the resident was

F679
1- Resident #33 and #51 are receiving activities per their preferences as indicated on resident care plan.
2-The Activities Director will complete an audit of current residents to ensure that activities are offered according to the resident preferences as indicated on the care plan.
3-The Administrator will educate the Activities Department on implementation of individualized activities and documentation of activities offered and activity denials.
4-The Activities Director, or designee will complete weekly audits of the Activity participation log to ensure activities are offered according to the resident preferences as indicated on the care plan. Results of the audits will be presented to the QAPI Committee for review and recommendation.
5-Completion date 2/7/22

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cognitively intact. Some of the activities R33 listed as "very important" to her included pets, keeping up with the news, religious activities, and going outside.

Review of the "Activity Log," provided by the facility from 10/17/21 to 12/30/21 indicated R33 was coded "-97" on 10 days which meant "not applicable." It showed R33 participated in one "1:1" activity and was "actively engaged." R33 participated in one "seasonal/special event" activity in 74 days. There was no documentation on the log that R33 was offered an activity and refused.

During an interview on 12/28/21 at 11:23 AM, R33 said "they don't seem to have a lot to do around here. I'm not sure what I would want to do. They haven't brought me anything that I know of. I do have a book here, but I don't watch much tv. It would be nice to be asked what I would like to do."

R33 was observed on 12/29/21 at 3:18 PM sitting at the Unit 1 nurses station asking repeatedly "what should I be doing? Am I just supposed to sit here?"

R33 was observed on 12/30/21 at 11:45 AM sitting in her wheelchair at the Unit 1 nurses station asking what she was supposed to be doing and if she should just sit there. R33 was tearful and seemed confused about why she was sitting in the hallway. R33 said she liked to read sometimes.

R33 was observed on 12/30/21 at 2:46 PM sitting in her wheelchair at the Unit 1 nurses station asking what she should be doing. R33 seemed

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confused at times but was oriented to herself and where she was.

During an interview on 12/30/21 at 4:54 PM, the Director of Recreation (DOR) said the activity department needed to improve their documentation. The DOR stated they determined if residents were independent with leisure activities based on their interests. The DOR said they always try to invite residents to group activities and try to be supportive if they decline. The DOR said R33 had not gotten a lot of visitors and she did not do Zoom calls with family. The DOR said ideally one on one activities would be held three times a week for 15 minutes, but it was not always documented. The DOR stated R33 had not had any activities related to her interests of pets, keeping up with the news, religious activities, and going outside. She said due to R33's intermittent confusion and behaviors they try not to ask her too many times a day about activities, but it was not documented.

2. Review of an "Admission Record" located in R51's EMR under the "Profile" tab indicated she was admitted on 10/16/21.

Review of a care plan dated 10/16/21 found in R51's EMR under the "Care Plan" tab indicated she would "actively engage in independent leisure pursuits 2-4x a week." The care plan also indicated "Staff provided materials for independent leisure such as a channel guide, magazines, and a devotional. Staff also provided puzzle books to do with family visitors."

Review of R51's "MDS" with an ARD of 12/17/21 revealed the resident had a "BIMS" score of 14 out of 15, which indicated the resident was

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cognitively intact. Some of the activities R51 listed as "very important" to her included pets, doing things with groups of people, religious activities, and going outside.

Review of the "Activity Log," from 11/01/21 to 12/30/21 located in R51's EMR under the "Tasks" tab indicated R51 participated in four activities. R51 had two, one on one visits where she was "actively engaged," one "seasonal event," and one "guest visit."

Review of an "Activities Note" dated 10/19/2021 found in R51's EMR under the "Progress Notes" tab indicated the Director of Recreation (DOR) "contacted [local church] to add Pt [patient] to prayer and visitation list." The staff also informed the church to call ahead to check for any changes with COVID restrictions.

During an interview on 12/28/21 at 11:36 AM, R51 said she was unable to attend group activities currently because she was non-weight bearing due to a possible fracture since 12/10/21. R51 said she had to wait until her follow up appointment before could move around. R51 said, "I suppose it would be nice to have something to do" and the staff "don't bring things that I can do."

During an interview on 12/30/21 at 11:11 AM, the Director of Recreation (DOR) said if it was a resident's preference to stay in bed, they would document it as an independent activity. The DOR said R51 had not done any of her preferred activities since admission. The DOR said according to the documentation there was no way to know if staff were having one on one visits with R51. The DOR said they had a Bible study but

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F 679	Continued From page 36 R51 did not participate, and it was not documented it was offered to her. The DOR said she had not reached back out to the clergy to arrange a religious visit for R51. The DOR said she was advised not to document if a resident declined an activity, but she had no way to show it was offered and they chose not to participate. The DOR said she was aware of R51's non-weight bearing situation and her daughter going to Greece so she should have scheduled one on one visits with her.	F 679		
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 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 interview and record review the facility failed to ensure treatment and care in accordance with professional standards of practice was provided for two of 34 sampled residents (Resident (R) 51 and R47). Specifically, the staff failed to ensure R51 was transported to her cardiologist follow up appointment on two different occasions. In addition, the staff failed to follow physician's orders for R47. Findings include: 1. Review of an "Admission Record" located in	F 684	F684 1-Resident #51 has a rescheduled Cardiology appointment for 1/31/22. Resident #47 is receiving medications as ordered. 2-The DON or designee will complete an audit of scheduled appointments to verify if there were any transportation issues associated with the scheduled appointment. The DON or designee will complete an audit of missed medication administration to determine if the residents received their medications as	2/7/22

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F 684	Continued From page 37 R51's electronic medical record (EMR) under the "Profile" tab indicated she was admitted on 10/16/21 with diagnoses including acute and chronic respiratory failure, type II diabetes, atrial fibrillation, and heart failure. Review of R51's "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/17/21 revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15, which indicated the resident was cognitively intact. Review of the "Progress Notes" found in R51's EMR under the "Assessments" tab indicated she missed a cardiologist follow up appointment on 10/27/21 and 12/27/21 due to lack of transportation. During an interview on 12/28/21 at 11:37 AM, R51 said she had a cardiologist appointment scheduled for 12/27/21 at 1:00 PM but she missed it. She said there was no transportation for her to get there. R51 said this happened before and she did not understand why the facility was not making sure she got to her appointment. She said there was a problem with the transportation company, and she was unsure what they are doing about it. During an interview on 12/29/21 at 3:24 PM, family member (F) 1 said she was concerned about R51 missing her cardiologist appointment again that week. F1 said the facility had a problem with transportation and told her it was out of their hands. During an interview on 12/29/21 at 3:30 PM, the Medical Records Assistant (MRA) said when a	F 684	ordered. 3-The DON will educate the Medical Records/Transportation department on tracking of scheduled appointments and addressing any missed appointments due to transportation issues. The Licensed Nurses will be educated on the requirements for accurately documenting medication administration. 4-The Unit Manager or designee will audit resident appointments on a weekly basis to ensure that the resident was able to go to the appointment without any transportation issues. The Unit Manager or designee will complete weekly audits of Missed Administration of Medications to ensure that the administered medications are documented appropriately on the Administration record. Results of the audits will be presented to the QAPI Committee for review and recommendation. 5-Completion Date 2/7/22.	

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F 684	Continued From page 38	F 684		

resident required an appointment, the nursing staff made her aware and she called to set up the appointment. Once she did that, she called the insurance provider or Medicaid to set up the transportation. The MRA said she did not directly deal with the transportation companies for residents with Medicaid. The MRA said the facility had a reoccurring problem with residents missing their appointments due to lack of transportation. The MRA said the facility had a paid transportation provider they used for residents on skilled care but not long-term care residents. She said using the paid transport was not discussed for R51 even though she missed two cardiologist appointments. The MRA said she would reschedule her appointment and transport and "hope" they show up. She said the facility had no way to track or trend when residents missed appointments. She said the administration was aware of the issue and it had been going on a long time.

During an interview on 12/30/21 at 7:17 PM, the Administrator, who came to the facility in September 2021, said she was made aware medical transport to resident appointments was not reliable. The Administrator said she developed a tool to track the resident information, their appointment date/time, which transport company was used and pickup/drop off time. The Administrator stated she thought the medical records department was using the tool but found out this week they were not, and she was unsure why. She said the facility would utilize paid transport for urgent appointments or scheduled procedures but not for follow up appointments. The Administrator said they could use the paid transport for resident follow up appointments if the tracker tool was in place so they could petition

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F 684	Continued From page 39	F 684		

Medicaid for reimbursement. She said ultimately the facility was responsible for ensuring residents made it to their appointments.

The facility did not have a policy related to the transportation of residents.

2 A review of the policy provided by the facility, titled "Medication Management," dated 11/01/19 revealed, ". . .Nursing . . . are to reference . . . promote . . . consistency in medication administration and standards of best practices." A medication administration policy was not provided by the facility for review.

During an interview on 12/27/21 at 4:06 PM, R47 was upset about missing doses of medication and reported staff had run out of her oxybutynin before.

Review of R47's EMR, under the "Clinical" tab, revealed R47 was admitted to the facility on 07/27/20.

Review of R47's EMR under the tab, "Med Diag [Medical Diagnosis]," revealed multiple diagnoses to include multiple sclerosis.

Review of R47's EMR under the "Orders" tab, revealed, "Urea Cream 10 %, Apply to bilateral feet topically at bedtime for dry skin . . . Oxybutynin Chloride 5 MG Tablet GIVE 3 TABLET (sic) BY MOUTH THREE TIMES A DAY FOR BLADDER SPASMS," dated 12/26/21.

R47's Medication Administration Record (MAR) located in the EMR under the "MAR" was reviewed for the months of October, November, and December 2021. There was no

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F 684	Continued From page 40 documentation for administration (no initials for dose given) for the following medications. a. Oxybutynin 5 mg tablet on 10/22/21 at 2:00 PM, 11/21/21 at 2:00 PM, two incidents of not administered per physician orders. b. Urea Cream 10 % on 10/15/21 at 9:00 PM and on 11/06/21 at 9:00 PM, two incidents of not administered per physician orders. An interview was conducted on 12/30/21 07:26 PM, the DON (Director of Nursing), confirmed medication administered should be documented on the resident's MAR by the nurse and all the facility's staff are responsible for following physician's orders.	F 684		
F 686 SS=D	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 interview, record review, and facility policy review, the facility failed provide treatment as ordered for prevention for pressure ulcer/skin injury for one of nine residents (Resident (R) 138)	F 686	F686 1-Resident #138 is receiving his wound care treatment as ordered. 2-The DON or designee will complete an	2/7/22

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F 686	Continued From page 41 reviewed for pressure ulcers. Findings include: Review of the facility's policy titled, "General Wound Care/Dressing Changes" dated 11/01/19 indicated, "Provide treatments as ordered." Review of R138's "Face Sheet" located in the electronic medical record (EMR) under the "Profile" tab, revealed an admission date of 11/17/15 and included, but was not limited to, the following diagnoses: quadriplegia and diabetes. Review of R138's "Wound Evaluation" located in the EMR under the "Misc" tab, dated 09/21/21, indicated an etiology of Moisture-Associated Skin Damage (MASD). Review of R138's "Order Summary Report" located in the EMR under the "Orders" tab, revealed the following orders: 09/22/21 Hibiclens Liquid 4 % - Apply to bilateral buttocks topically every day and evening shift for MASD cleanse with hibicleanse, pat dry, apply Silver Sulfadiazine (SSD), cover with Abdominal (ABD) pad; 09/22/21 Hibiclens Liquid 4 % - Apply to bilateral rear thighs topically every day and evening shift for MASD cleanse with hibicleanse, pat dry, apply ssd, cover with ABD pad; 9/22/21 SSD Cream 1 % - Apply to bilateral buttocks topically every day and evening shift for MASD cleanse with hibicleanse, pat dry, apply ssd, cover with ABD pad; 9/22/21SSD Cream 1 % - Apply to bilateral rear thighs topically every day and evening shift for MASD cleanse with hibicleanse, pat dry, apply ssd , cover with ABD pad. Review of R138's October 2021 "Treatment	F 686	audit of missed treatment administration to determine missed documentation of the treatments. 3-The DON will educate the Licensed Nurses on the requirements for accurately documenting treatment administration. 4-The Unit Manager or designee will complete weekly audits of Missed Administration of Treatments to ensure that the treatments completed are documented appropriately.. Results of the audits will be presented to the QAPI Committee for review and recommendation. 5-Completion Date 2/7/22.	

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F 686	Continued From page 42	F 686		

Administration Record (TAR)" located in the EMR under the "Orders" tab, revealed R138 did not receive ordered treatment to buttocks on evening shifts on 10/18/21, 10/20/21, or 10/22/21or the morning shifts on 10/09/21, 10/14/21, 10/18/21, 10/19/21, 10/26/21. R138 did not receive ordered treatment to rear thighs on evening shifts on 10/18/21, 10/20/21, or 10/22/21 or the morning shifts on 10/09/21, 10/14/21, 10/18/21, 10/19/21, or 10/26/21.

Review of R138's November 2021 "TAR" located in the EMR under the "Orders" tab, revealed R138 did not receive ordered treatment to buttocks on morning shifts on 11/02/21, 11/07/21 or 11/17/21. R138 did not receive ordered treatment to rear thighs on morning shifts on 11/02/21, 11/07/21, or 11/17/21.

Review of R138's December 2021 "TAR" located in the EMR under the "Orders" tab, revealed R138 did not receive ordered treatment to buttocks on evening shifts on 12/02/21, 12/03/21, or 12/21/21 or the morning shift on 12/27/21. R138 did not receive ordered treatment to rear thighs on evening shifts on 12/02/21, 12/03/21, or 12/21/21 or the morning shift on 12/27/21.

During an interview on 12/27/21 at 5:45 PM, R138 stated that he did not receive treatments to his "backside" twice a day as ordered.

During an interview on 12/30/21 at 3:10 PM with the Registered Nurse (RN) Unit Manager, she stated R138's treatments needed to be completed as ordered to prevent further skin breakdown.

During an interview on 12/30/21 at 5:31 PM with

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F 686	Continued From page 43 the Director of Nursing (DON), she stated treatments should be completed as ordered.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to ensure one of four residents (Resident (R) 67) reviewed for limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Specifically, staff did not apply R67's right hand splint per physician's orders to maintain range of motion. Findings include: Upon request of a policy regarding residents'	F 688	F688 1 Resident #67 has been issued a new right- hand splint and this is being worn as ordered. 2-The DON or designee will audit current residents with ordered splints to ensure that the splint is in place as ordered. 3-The DON will educate Nursing staff on the provisions to follow for splint application and wearing schedules for residents. 4-The Unit Manager or designee will complete weekly audits to ensure that the	2/7/22

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F 688	Continued From page 44 splints, the facility provided a documented titled, "Assisting with Activities of Daily Living," undated, that revealed, ". . .Splints keep . . . wrist, thumbs, fingers . . . in normal position. . ." Review of R67's electronic medical record (EMR), revealed R67 admitted to facility on 10/13/17. Review of the "Med diag [Medical Diagnosis]" tab in the EMR revealed multiple diagnoses to include hemiplegia (paralysis on one side of the body) and hemiparesis (loss of strength on one side of the body) following cerebral infarction (ischemic stroke, result of disrupted blood flow to the brain) affecting right dominate side. Review of the "Orders" tab in the EMR revealed "R [right] hand splint to be worn at all times with skin checks QS [every shift]. . ." dated 01/31/18. Review of the column "Interventions under the "Care Plan" tab in the EMR, revealed, ". . .r hand splint to be worn at all times. . ." Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 11/01/21 revealed, R67 was assessed with a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, indicating R67 was cognitively intact. The MDS revealed an end date for physical therapy services of 11/01/21. An observation was conducted on 12/28/21 at 9:10 AM of R67. R67 was not wearing a splint on her right hand. Her right hand was closed, like a fist. A second observation was conducted on 12/29/21 at 9:44 AM of R67 revealed there was no brace	F 688	residents have their splints in place as ordered. Results of the audits will be presented to the QAPI Committee for review and recommendation. 5-Completion date 2/7/22.	

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F 688	Continued From page 45 or splint on her right hand. R67's hand was closed like a fist. A third observation was conducted on 12/29/21 at 10:57 AM of R67 revealed there was no brace on her right hand. An interview was conducted on 12/27/21 at 1:16 PM, R67 revealed the facility was not applying or maintaining splint for her right hand. An interview was conducted on 12/29/21 at 9:14 AM, Certified Nurse Aide (CNA) 9 confirmed R67 should wear a right-hand brace. A fourth observation was conducted on 12/29/21 at 11:56 AM with Registered Nurse (RN) Unit Manager (UM) who verified and confirmed R67 was not wearing a brace on her right hand as ordered by the physician. RN UM further revealed not wearing a splint as per physician orders could cause muscle loss and contractures. During an interview on 12/29/21 at 3:00 PM, RN UM verified there was a physician's orders for R67's splint at all times for right hand.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		2/7/22

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F 689	Continued From page 46	F 689		

by:
Based on interview, record review, and facility policy review, the facility failed prevent accidents by failing to safely transfer a resident and perform neurological assessments for one of three residents reviewed for accidents (Resident (R) 42).

Findings include:

Review of the facility's policy titled, "Falls Management Program" dated 11/01/19 indicated, "Evaluate, monitor, and document patient response for the first 24 hours (3 consecutive shifts) post fall, include a neurological assessment if the fall was unwitnessed and/or the patient hit his/her head."

Review of R42's "Face Sheet" located in the electronic medical record (EMR) under the "Profile" tab, revealed an admission date of 5/30/13 and included, but was not limited to, the following diagnoses: epilepsy, flaccid hemiplegia affecting left nondominant side, and anoxic brain damage.

Review of R42's "Minimum Data Set" (MDS) with an Assessment Reference Date (ARD) of 10/17/21 indicated that R42 was to be transferred with a one-person assist.

During an interview on 12/27/21 at 5:16 PM, R42 stated that she had a fall about a week ago and hit her head against the wall. R42 stated the staff transferred her without using a "gait belt or leverage from her pants."

Review of R42's EMR did not contain any neurological assessments for December 2021.

F689
1-Resident #42 has not had any falls and a gait belt is available for use with resident transfers.
2-The DON or designee will review resident falls in the past 14 days to ensure that neurological assessments were completed, as indicated and if any falls were related to transfers.
3-The DON will educate Nursing staff on the provisions for completion of Neurological assessments at the time of a fall and the use of gait belts when transferring residents.
4-The Unit Manager or designee will complete weekly audits of resident falls to ensure that Neurological assessments are completed, as indicated. The Unit Manager or designee will complete random weekly observation audits of staff transferring residents to ensure that safety measures are taken, to include the use of a gait belt. Results of the audits will be presented to the QAPI Committee for review and recommendation.
5-Completion Date 2/7/22.

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During an interview on 12/30/21 at 10:15 AM, Certified Nurse Aide (CNA) 10 stated she was in the room when another CNA assisted R42 with a transfer to the bed and she saw R42 fall forward and hit her head on the wall. The Director of Nursing (DON) was present during this interview.

During an interview on 12/30/21 at 10:25 AM, CNA15 confirmed she transferred R42 on 12/22/21. CNA15 stated she transferred R42 using her incontinence brief and R42 fell forward and hit her head on the wall. CNA 15 acknowledge she should have used a gait belt during the transfer. The DON was present during this interview.

During an interview on 12/30/21 at 10:28 AM, the DON stated R42 was inappropriately transferred by staff holding on to R42's incontinence brief. The DON and Regional DON stated when R42 returned from the hospital, neurological assessments should have been completed for 24 hours post fall.

During an interview on 12/30/21 at 3:18 PM, the Registered Nurse (RN) Unit Manager stated R42 should not have been transferred using her incontinence brief. The RN Unit Manager stated the CNAs should use a gait belt or the resident's pants for leverage.

During a follow up interview on 12/30/21 at 4:33 PM, the RN Unit Manager stated that neurological assessments should completed on a Neurological Assessment form. The RN Unit Manager confirmed there were no neurological assessments completed for R42 following her fall on 12/22/21 when she hit her head.

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VIRGINIA BEACH HEALTHCARE AND REHAB CENTER	1801 CAMELOT DRIVE VIRGINIA BEACH, VA 23454

(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 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary, and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 690	F690	2/7/22

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F 690	Continued From page 49 and review of facility policy, the facility failed to follow physician's orders to maintain the suprapubic urinary catheter for one resident of two residents (Resident (R) 404) reviewed for catheters. Specifically, the facility failed to ensure R404's suprapubic urinary catheter was flushed every shift and daily dressing change per physician's orders. Findings include: Review of facility policy titled "Suprapubic Catheter Care" dated 11/01/19 revealed "It is the Center's policy to provide safe and proper care of a patient with a suprapubic catheter by evaluating elimination status, minimizing risk of bladder infection and maintaining skin integrity in accordance with the physician's order." Review of the admission note, in the "Progress Notes" tab of electronic medical record (EMR), dated 12/24/21, revealed R404's diagnoses included metabolic encephalopathy in the setting of hyponatremia and acute cystitis. Review of R404's physician's orders in the "Orders" tab of EMR revealed R404 was admitted on 12/24/21 with an order for a Suprapubic Foley Catheter (20 french (fr) 30 milliliters (ml)), Check Foley anchor placement every (q) shift, and change suprapubic catheter insertion site dressing q day and as needed (prn) using split gauze. Review of R404's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of revealed R404 required extensive assistance with bed mobility; two-person physical assist with toilet use; one person physical assist	F 690	1-Resident #404 is receiving orders to care for the foley as ordered. 2-The DON or designee will complete an audit of missed treatment administration to determine missed documentation of the treatments. 3-The DON will educate the Licensed Nurses on the requirements for accurately documenting treatment administration. 4-The Unit Manager or designee will complete weekly audits of Missed Administration of Treatments to ensure that the completion of treatments is documented appropriately. Results of the audits will be presented to the QAPI Committee for review and recommendation. 5-Completion Date 2/7/22.	

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F 690	Continued From page 50	F 690		

with personal hygiene and had an indwelling catheter during the assessment period.

Review of R404's Baseline Care Plan dated 12/24/21, located in EMR under the "Care Plan" tab did not address suprapubic catheter status.

Review of R404's "Treatment Administration Record" (TAR) dated 12/01/21 through 12/31/21 located in R404's EMR under "Reports" tab revealed on 12/29/21, 7AM-3PM shift the treatment orders: "Change suprapubic catheter insertion site dressing Q day and prn using split gauze every shift for maintenance" and "Flush suprapubic catheter with 60ml of normal saline Q (shift) for protocol" were not signed off as completed.

On 12/27/21 at 1:06 PM, R404 was observed to have a suprapubic catheter. R404 was not interviewable.

During an interview on 12/30/21 at 11:05 AM, the Director of Nursing (DON) was shown R404's physician's order and current TAR and asked what her expectations of her staff were when it came to following the physician's orders. The DON confirmed R404 was admitted 12/24/21 with a suprapubic catheter and treatment orders should be carried out per physician's orders. DON confirmed TAR entries were blank for 12/29/21, 7AM-3PM shift for "Change suprapubic catheter insertion site dressing Q (every) day and prn (as needed) using split gauze every shift for maintenance" and "Flush suprapubic catheter with 60ml of normal saline Q (shift) for protocol." DON further stated, Licensed Practical Nurse (LPN) 14, R404's nurse on 12/29/21, notified her of not getting a chance to obtain vital signs but

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F 690	Continued From page 51 made no mention of not being able to perform suprapubic catheter care.	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for one of one resident (Resident (R) 58) reviewed for dialysis. The facility failed to ensure R58 had reliable transportation to and from dialysis and the facility did not demonstrate ongoing communication to the dialysis center and assessment of the resident prior to dialysis. Findings include: Review of R58's electronic medical record (EMR) under the "Profile" tab revealed R58 admitted to the facility on 09/30/17. Review of R58's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/22/21, revealed R58 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, indicating she was cognitively intact. The MDS revealed R58 had end stage renal disease and received dialysis.	F 698	F698 1-Resident #58 is going to Dialysis as scheduled. The Dialysis communication form is presently in place and is being utilized for communication with the Dialysis center. 2-The DON or designee will review Dialysis residents to ensure that a Dialysis communication form is in place and is being used and will determine that the residents are going to the scheduled Dialysis appointments appropriately. 3-The DON will educate the Licensed Nurses on the requirements to implement and utilization of the Dialysis communication form. The DON will educate Medical Records/Transportation department on monitoring residents with scheduled appointments/Dialysis to ensure that the residents are transported accordingly. 4-The Unit Manager or designee will complete weekly audits of Dialysis residents to ensure that the Dialysis communication form is implemented and	2/7/22

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F 698	Continued From page 52 Review of R58's "Med Diag" tab in the EMR revealed multiple diagnoses to include end stage renal disease and congestive heart failure. Review of R58's "Orders" tab in the EMR revealed the following order dated 06/14/19, ". . .Dialysis M-F [Monday and Friday]. . . Check-in at 10:45am for 11:15am. . ." 1. Review of the "Progress Note" tab in the EMR revealed ". . .patient was not pick [sic] up for dialysis. . ," dated 12/20/21 at 1:06 PM. During an interview on 12/29/21 at 9:26 AM, R58 confirmed transport was late and she missed her dialysis treatment appointment. During an interview on 12/30/21 at 10:19 AM, the Manager of the outpatient dialysis center confirmed, on 12/20/21 ". . .we contacted the facility . . . was informed there were transport issues . . . transport arrived at the facility after scheduled appointment time . . . her scheduled appointment was already missed. . ." During an interview on 12/30/21 at 4:06 PM, Medical Record Assistant (MRA) confirmed the facility did not provide transportation for R58 to the dialysis clinic for her scheduled appointment time on 12/20/21 and R58 did not receive dialysis treatment on 12/20/21 as ordered by the physician. MRA revealed, residents missing schedule dialysis treatment could be potentially life or death situation for the residents residing at the facility. During an interview on 12/30/21 at 7:26 PM, the DON (Director of Nursing) confirmed the dialysis center scheduled appointment times for residents	F 698	utilized appropriately and that the residents go to their scheduled Dialysis appointment. Results of the audits will be presented to the QAPI Committee for review and recommendation. 5-Completion Date 2/7/22.	

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F 698	Continued From page 53 receiving dialysis treatment and everyone was responsible for ensuring resident's transportation to dialysis for scheduled appointment. The DON further confirmed residents missing scheduled dialysis treatment could potentially cause resident to have respiratory issues. The facility did not have a policy regarding transportation. 2. Review of the facility's policy titled, "Hemodialysis," dated 11/01/19 revealed, "The Dialysis Communication Form will be initiated prior to sending patient to dialysis. . ." The facility did not provide communication forms, for review for R58 to the outpatient dialysis center. The facility did not provide sign in or sign out logs for review for residents, leaving the facility for scheduled appointments. The facility did not provide contract for review with the outpatient dialysis center. During an interview on 12/30/21at 5:29 PM, Registered Nurse (RN) Unit Manager (UM) confirmed and verified there were no completed communication forms for R58 for his dialysis appointments. RN UM verified the staff did not complete the documentation for communication with dialysis clinic.	F 698		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;	F 806		2/7/22

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F 806	Continued From page 54 §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide alternatives to residents who did not like what was served and failed to provide alternatives of similar nutritive value when alternatives were provided for three of 34 sampled residents (Resident (R)131, R405, R412). Findings include: Review of facility policy titled "Dining and Food Preferences" dated October 2019 documented, "It is the center policy that individual dining, food, and beverage preferences are identified for all residents/patients." Observation on 12/27/21 at 11:00 AM, revealed menu with alternative foods posted in main hallway. 1. R131 was admitted to the facility on 12/13/21, according to the electronic medical record (EMR) under the "Medical Diagnosis" tab. Record review of R131, revealed a "Dietary Progress Note" in EMR, under "Progress Notes" tab, dated 12/07/21 revealed R131 typically consumed 26%-100% of meals. Review of the EMR under "Tasks" tab revealed for month of December 2021 meal intake varied from 26%-100%.	F 806	F806 1-Resident #131, #405 and #412 were discharged from the facility. 2- The Dietary Manager or designee will review the food preferences for current residents to ensure that the food preferences are correctly indicated on the meal ticket. The Alternate menu will be provided for all residents. 3-The Regional Dietician will educate the Dietary Manager on the correct procedure to input diet preferences into the electronic meal ticket system and the requirements for providing the food alternate menu to all residents. The DON or designee will educate Nursing staff on notifying the Dietary Department of alternate food requests and location of alternate menu items. 4-The Dietary Manager or designee will audit the new admitted resident meal tickets on a weekly basis to ensure that the resident food preferences are indicated on the meal ticket and will audit each unit to ensure that the alternate food menu is available to the residents. Results of the audits will be presented to the QAPI Committee for review and recommendation. 5-Completion date 2/7/22.	

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F 806	Continued From page 55	F 806		

Observation on 12/27/21 at approximately 4:30 PM, revealed R131 eating food that her family brought to her in her room.

During an interview on 12/28/21 at 10:00 AM, R131 stated she was on a special diet due to disease process; no replacement foods were offered, repetitive foods were served such as sausage was served almost every day, "sometimes foods are cool" that should be warm/hot; "it's really bad, sometimes they give us tomato sauce with rice or hamburgers with pasta, it's just weird things that don't make sense . . . little pieces of fish, every meal has a lot of carbohydrates." R131 further stated she had spoken with Registered Dietitian (RD) who made notes of her preferences, but she still did not receive fresh foods.

2. R405 was admitted to the facility on 12/20/21, according to the EMR under the "Progress Notes" tab, "Admission Assessment/Screening V.1.2" dated 12/20/21.
Record review of R405, revealed a "Dietary Progress Note" in the EMR, under "Progress Notes" tab, dated 12/27/21 revealed R405 ". . .not eating well due to repetitive meals, refuses meals at times and then is hungry later in evening; she requests menu alternatives. . ."

Observation on 12/27/21 at 1:11 PM, revealed R405 eating lunch in her room with door open; percentage of meal consumed unknown.

During an interview on 12/28/21 at 11:22 AM, R405 stated repeated menu items were served such as chicken served for dinner will be served the following day for lunch; foods were frequently served cold, 12/28/21 breakfast meal was two

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F 806	Continued From page 56	F 806		

French toast sticks with bacon, and both were cold. R405 further revealed the first few days she was at the facility she did not eat and decided to order out. Resident stated she was not offered an alternative meal choice if she did not like what was served; Resident further stated she was currently in quarantine and unable to go to the nurses' station to look at the menu.

3. R412 was admitted to the facility on 12/18/21, according to the EMR under the "Medical Diagnosis" tab.
Record review of R412, revealed Dietary Progress Note in EMR, under "Progress Notes" tab, dated 12/23/21 revealed R412's meal intake 51%-100%.
Record review of R412's "Minimum Data Set (MDS)" dated 12/24/21 in EMR, under "MDS" tab, revealed in part R412 requires total dependence for locomotion on/off unit; "only able to stabilize with staff assistance", and requires wheelchair as mobility device.

During an interview on 12/27/21 at 5:00 PM, R412 stated food was bland and she would like to be able to pick her food.

During an interview on 12/30/21 at 9:53 AM, the Dietary Manager stated she made rounds every Thursday to Saturday on Units 1 through 3 and filled out weekly preference sheets that determined what would be served to each resident. The Dietary Manager stated weekly preference sheets were not available for Unit 4 where R131, R405 and R412 resided. The Dietary Manager stated the RD or charge nurse would send a note to the kitchen if a resident requested something special. Dietary Manger further stated she did not make rounds to Unit 4

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F 806	Continued From page 57 and there was no particular reason for this. The Dietary Manager further stated alternative meals may be requested by residents through the charge nurse at any given time. During an interview on 12/30/21 at 10:24 AM, the RD stated on admission she met with every resident/family to determine preferences, likes, and dislikes. During admission dietary assessment RD stated she told residents they could request alternate menu items if needed. The RD confirmed alternative menus were posted at nurses' stations and in the hallways; menus were not sent to resident rooms and staff did not make rounds to Unit 4 to determine if each resident wanted the main meal or alternative for breakfast, lunch, or dinner each day. Meal trays were sent based off preferences voiced during the admission meeting. The RD confirmed bed bound, quarantined, or isolated residents did not have alternative menus available to them. The RD further stated alternative meals may be requested by residents at any given time to their charge nurse, which was voiced to residents at admission. During an interview on 12/30/21 at 3:01 PM, the Director of Nursing (DON) stated she was aware that a lot of residents order out their meals but have not told her why; no nurses/certified nurse aides had notified her of food concerns.	F 806		
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	F 812		2/7/22

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F 812	Continued From page 58 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, interview, and facility policy review, the facility failed ensure food was stored safely for three of four unit refrigerators. This failure could possibly lead to cross contamination and food-borne illness for the residents on three units. Findings include: During an observation of Unit 2 refrigerator with the Dietary Manager on 12/29/21at 12:25 PM, the following items were unlabeled and undated in the refrigerator: two bags of food in plastic grocery bags, two containers of lean cuisine frozen meals, one slice of pizza in a Ziploc bag. Additionally, there was a bottle of French dressing with an expiration date of 11/03/21. During an observation of Unit 3 refrigerator with the Dietary Manager on 12/29/21at 12:30 PM, the following items were unlabeled and undated in the refrigerator: two opened bottles of water, one	F 812	F812 1 -The Dietary Manager discarded all unlabeled food items and the food items that exceeded the use by date in the unit refrigerators. 2- The Dietary Manager or designee will inspect the refrigerators on each unit to ensure that all food items are labeled, dated and stored properly. 3-The Regional Dietician will educate Dietary staff and Nursing staff on properly labeling, dating and storage of food in refrigerators located on the units. 4-The Dietary Manager or designee will inspect the unit refrigerators on a weekly basis to ensure that all foods are labeled, dated and stored properly. Results of the audits will be presented to the QAPI Committee for review and recommendation. 5-Completion date 27/22.	

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F 812	Continued From page 59 bottle of Frappuccino, a bag of apples, a bag of oranges, and a bottle of Gatorade. During an observation of Unit 1 refrigerator with the Dietary Manager on 12/29/21at 12:35 PM, the following items were unlabeled and undated in the refrigerator: blue and white lunch bag, a opened bottle of Pepsi, an opened bottle of Gold Peak Tea, a Ziploc bag containing cornbread, and an unopened container of Quaker Oats grits. During an interview with the Dietary Manager, on 12/29/21 at 12:36 PM, she confirmed the presence of all above listed items. The Dietary Manager stated only items belonging to residents should be in the fridge and should always be dated and labeled. During an interview with the Registered Nurse (RN) Unit Manager, on 12/29/21 at 1:13 PM, she stated food in the unit refrigerators should be labeled and dated. The RN Unit Manager further stated it is nursing staff and the dietary staff's responsibility to ensure the unit refrigerators are in compliance. Review of the facility's policy titled, "Food Storage: Cold" dated October 2019 indicated, "It is the center policy to insure all Time/Temperature Control for Safety (TCS), frozen and refrigerated food items, will be appropriately stored in accordance with guidelines of the FDA Food Code." The policy further indicated, "The Dining Services Director/Cook(s) insures [sic] that all food items are stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination"	F 812		
F 842	Resident Records - Identifiable Information	F 842		2/7/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842 SS=E	Continued From page 60 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted 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	F 842		

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F 842	Continued From page 61 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §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 interview, record review, and review of facility policy, the facility failed to maintain a complete and accurate medical record for six of thirty-four sampled residents (Resident (R) 107, R126, R199, R402, 407, and 412). Specifically, the nursing staff failed to document the completion of physician orders on the resident's medication administration records (MAR). Findings Include:	F 842	F842 1-Residents #126, #199, #402 and #412 were discharge from the facility. The completion of the physician orders are documented appropriately on the Administration Record for Resident #107, #407. 2-The DON or designee will complete an audit of missed treatment and medication administration to determine missed	

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F 842	Continued From page 62 Review of facility policy titled "Documentation Summary" dated 11/01/19 indicated "Licensed Nurses and CNAs [Certified Nurse Aides] will document all pertinent nursing assessments, care interventions, and follow up actions in the medical record." Review of facility policy titled "Monitoring" dated 11/01/19 indicated "Licensed nurses will complete blood glucose monitoring as ordered by the physician . . .4. Blood glucose checks will be documented on the eMAR [Electronic Medication Administration Record]." 1. R107 was admitted to the facility on 11/20/21, according to the electronic medical record (EMR) under the "Medical Diagnosis" tab, with diagnoses in part including Severe Calorie Malnutrition. R107's "Physician Orders" found in the EMR under the "Orders" tab included blood sugar checks twice daily (dated 11/22/21) and respiratory assessment every four hours (dated 11/20/21). Review of R107's Treatment Administration Record (TAR) dated 12/01/21-12/31/21, located in the EMR under the "Reports" tab revealed missing documentation of blood sugar level on 12/28/21 at 6:30 AM; and Respiratory Assessment documentation missing from 12/19/21 at 4:00 AM. During an interview on 12/30/21 at 3:40 PM, the Director of Nursing (DON) confirmed R107's TAR had the following missing information: blood level was not recorded for 12/28/21 at 6:30 AM and	F 842	documentation of the completion of physician orders. 3-The DON will educate the Licensed Nurses on the requirements for accurately documenting the completion of physician orders on the administration record. 4-The Unit Manager or designee will complete weekly audits of Missed Administration report to ensure documentation of the completion of physician orders on the Administration record. Results of the audits will be presented to the QAPI Committee for review and recommendation. 5-Completion Date 2/7/22.	

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Respiratory Assessment was not recorded for 12/19/21. The DON further stated every TAR should be filled out completely every shift and "If it wasn't documented, it wasn't done."

2. R126 was admitted to the facility on 11/28/21, according to the EMR under the "Orders" tab, with diagnoses in part including congestive heart failure (CHF).

R126's "Physician Orders" dated 11/30/21 found in the EMR under the "Orders" tab included the following:
a. daily weights for congestive heart failure monitoring,
b. vital signs every shift,
c. respiratory assessment every 4 hours,
d. Continuous Positive Airway Pressure (CPAP) to be worn at night,
e. oxygen 2 liters per minute (LPM) via nasal canula every shift, and
f. 2-step tuberculosis (TB) screening upon admission.

Review of R126's TAR dated 12/01/21-12/31/21, located in the EMR under the "Reports" tab revealed the following missing documentation.
a. Daily weights for CHF monitoring on 12/01/21, 12/03/21 and 12/09/21.
b. Vital signs on 12/10/21 night shift.
c. Respiratory assessment (temperature and oxygen saturation level) on 12/11/21 at midnight and 4:00 AM, as well as 12/19/21 at 4:00 AM.
d. CPAP administration on 12/10/21 at bedtime.
e. Oxygen 2 LPM on 12/10/21 on night shift.
f. TB readings missing documentation on 12/01/21 and 12/08/21.

During an interview on 12/30/21 at 3:18 PM, the

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DON confirmed R126's TAR had the following missing information and the expectation was for treatment record to be filled out every shift per physician orders.
a. Daily weights for CHF monitoring on 12/1/21, 12/3/21 and 12/9/21. The DON stated, "if the nurse doesn't weigh resident, they will not know if patient has 3+ pound (lbs) weight gain in 24-hour period ...R126 has daily weights for CHF monitoring."
b. Vital signs for the 11 PM-7 AM shift on 12/10/21. The DON stated since Covid pandemic started they instituted vital sign monitoring every shift.
c. The respiratory assessment for 12/11/21 at midnight and 4:00 AM, and 12/19/21 at 4:00 AM.
d. CPAP not documented for 12/10/21.
e. Oxygen 2 LPM via nasal canula every shift for 12/10/21 night shift.
f. TB readings missing documentation on 12/01/21 and 12/08/21. The DON stated it was the facility's policy to do a TB test upon admission, read results two days later, then administer a second TB test seven days later, with results read two days later. The DON further reported, the initial TB test was performed on 11/29/21 and results should have been entered in TAR or progress note on 12/01/21; DON confirmed no documentation existed with TB results; second TB test performed on 12/6/21, results were not recorded on 12/8/21 and should have been per the DON.

3. R402 was admitted to the facility on 12/21/21, according to the EMR under the "Medical Diagnosis" tab, with diagnoses in part including unspecified diastolic (congestive) heart failure.

R402's "Physician Orders" dated 12/21/21 found

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in the EMR under the "Orders" tab included:
a. daily weights for three days upon admission and
b. vital signs every shift.

Review of R402's care plan dated 12/21/21 located in EMR under the "Care Plan" tab indicated R402 had constipation due to decreased mobility and congestive heart failure with orders to obtain weights as ordered.

Review of R402's TAR dated 12/01/21-12/31/21, located in the EMR under the "Reports" tab revealed the following missing documentation:
a. daily weight monitoring on 12/22/21 and 12/23/21, and
b. vital sign monitoring on 12/29/21, day shift.

Interview on 12/30/21 at 2:59 PM with DON, confirmed R402's TAR had the following missing information, and the expectation is for treatment record to be filled out every shift per physician orders:
a. daily weight not documented in TAR or nursing progress note for 12/22/21 and 12/23/21, and
b. vital signs every shift not documented for 12/29/21 day shift.

4. R404 was admitted to the facility on 12/24/21, according to the admission "Physician Orders," in the "Orders" tab of EMR, dated 12/24/21, with diagnoses in part including indwelling suprapubic catheter.

R404's "Physician Orders" dated 12/24//21-12/25/21 found in the EMR under the "Orders" tab included the following:
a. change suprapubic catheter insertion site dressing every day and as needed using split

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gauze,
b. flush suprapubic catheter with 60 milliliters (ml) normal saline,
c. vital signs every shift,
d. respiratory assessment every four hours (temperature and oxygen saturations), and
e. droplet precautions in place 12/25/21 through 01/08/22.

Review of R404's TAR dated 12/01/21-12/31/21, located in the EMR under the "Reports" tab revealed the following orders had missing documentation:
a. change suprapubic catheter dressing on 12/29/21 day shift,
b. flush suprapubic catheter with 60ml of normal saline on 12/29/21 dayshift,
c. vital signs on 12/29/21 day shift,
d. respiratory assessment 12/29/21 at 12:00 PM,
e. maintaining droplet precautions 12/26/21, 12/27/21, 12/28/21, 12/29/21, and

Interview on 12/30/21 at 2:59 PM with DON, confirmed R404's TAR had the following missing information, and the expectation is for treatment record to be filled out every shift per physician orders:
a. changing suprapubic catheter dressing on 12/29/21 day shift;
b. flushing suprapubic catheter with 60ml of normal saline on 12/29/21 dayshift;
c. vital signs on 12/29/21 day shift;
d. respiratory assessment on 12/29/21 at 12:00 PM; and
e. maintaining droplet precautions on 12/26/21, 12/27/21, 12/28/21, and 12/29/21.

5. R412 was admitted to the facility on 12/18/21, according to the EMR under the "medical

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diagnosis" tab, with diagnoses in part including congestive heart failure.

R412's "Physician Orders" dated 12/21/21 found in the EMR under the "Orders" tab included daily weight notify Medical Doctor (MD) of weight gain of 3lbs in day or 5lbs in week and vital signs every shift.

Review of R412's care plan dated 12/18/21, revised 12/27/21 located in EMR under the "Care Plan" tab included "CHF flare requiring therapeutic diet. Underweight BMI ...resident will avoid significant weight change through next review. Gradual weight gain is desired ...weekly weights ...weights as ordered (daily)."

Review of R412's MDS with an ARD of 12/24/21 revealed the resident had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.

Review of R412's TAR dated 12/01/21-12/31/21, located in the EMR under the "Reports" tab revealed missing documentation of daily weight on 12/24/21, 12/25/21, and 12/26/21; and vital signs on 12/19/21 dayshift.

Interview on 12/30/21 at 2:59 PM with DON, confirmed R404's TAR had the following missing information, and the expectation is for treatment record to be filled out every shift per physician orders: daily weight on 12/24/21, 12/25/21, 12/26/21 and vital signs on 12/19/21 dayshift.

6. Review of R199's undated "Administration Record" located in the electronic medical record (EMR) under the profile tab indicated the resident was admitted to the facility on 06/29/21.

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F 842	Continued From page 68 Diagnoses included diabetes, closed fracture of lower end of the left femur, and orthopedic aftercare. Review of R199's "physician orders" located in the EMR under "Orders" tab revealed the following orders: a. skin prep right (R) heel every day for prevention; b. assess skin to left knee related to left knee immobilizer; c. check movement, color, capillary refill of left toes related to immobilizer; d. derma care to buttocks/sacral every shift for redness; e. flush biliary drainage catheter on right side every shift, f. keep dressing in place to left knee until follow up with [surgeon] in ten days; g. TTWB [toe-touch weight bearing] LLE [left lower extremity] with TROM [total range of motion] knee immobilizer in lace; h. TROM type locking hinged knee brace locked at 40 degrees of flexion; i. and respiratory assessment every four hours for temperature and oxygen. Review of R199's treatment administration record (TAR) for revealed on 07/01/21, 07/07/21, 07/17/21, there was no documentation indicating the nurse had completed the following physician's orders a. skin prep (R) heel every day for prevention; b. assess skin to left knee related to left knee immobilizer c. check movement, color, capillary refill of left toes related to immobilizer; d. derma care to buttocks/sacral every shift for redness,	F 842		

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F 842	Continued From page 69 e. flush biliary drainage catheter on right side every shift; f. keep dressing in place to left knee until follow up with [surgeon] in ten days; g. TTWB, LLE with TROM knee immobilizer in lace; h. TROM type locking hinged knee brace locked at 40 degrees of flexion; i. and respiratory assessment every four hours for temperature and oxygen. During an interview with Licensed Practical Nurse (LPN) 8 conducted on 11/29/21 at 11:02 AM, LPN 8 was asked what is the process for documenting a resident's treatments and/or medication administration? LPN 8 responded whenever a medication or treatment is completed, we initial off on the MAR. LPN8 was asked what does it mean if the box on the MAR is empty, without initials? LPN8 responded if it is not initialed it was not done. During an interview on 12/30/21 at 4:42 PM, the DON confirmed the lack of documentation on the TAR related to the physician's orders. The DON was questioned how would anyone know if these physician's orders was completed? The DON confirmed and stated, "if it is not documented, it wasn't done."	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		2/7/22

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diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility

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F 880	Continued From page 71 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, review of facility policy, and review of Centers for Disease Control and Prevention (CDC) guidance, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases for six residents of nine residents (Resident (R) 403, R404, R405, R406, R407, and R408) reviewed for transmission-based precautions; three of seven residents (R37, R51, and R105) observed during the observation of medication administration; and three of seven residents (R3, R138, and R144) reviewed for catheter care. Specifically, "enhanced droplet precautions" were not followed for R403, R404, R405, R406, R407, and R408. Staff did not perform hand hygiene between R37,	F 880	F880 1-LPN #5 was educated on proper handwashing procedures during resident care. Resident #3 was discharged from the facility. Proper catheter care related to infection control provisions are being provided for Resident #138 and #144. Proper protocols and set up are in place for the Transmission Based Precaution rooms. 2-Current residents in the center have the potential to be affected. 3-The DON or designee will educate Nursing staff on infection control measures for the care of catheter bags. The Infection Preventionist or designee will educate Licensed Nurses on proper handwashing procedures. The Infection	

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F 880	Continued From page 72 R51, and R105. Additionally, R3, R138, and R144's catheter bags were observed lying on the ground. Findings include: 1. Review of the CDC's "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes," updated 09/10/21, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html on 01/06/21 stated, "In general, all unvaccinated residents who are new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission." Review of the CDC's "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated 09/10/21, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html on 01/06/21 stated, "2. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected . . . SARS-CoV-2 infection. . . Place a patient with suspected . . . SARS-CoV-2 infection in a single-person room . . . The door should be kept closed (if safe to do so) . . . HCP [Health Care Professionals] who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). . ."	F 880	Preventionist or designee will educate all staff on proper procedures to follow for Transmission Based Precaution rooms, to include proper PPE use. 4-The Infection Preventionist will complete random weekly observations of staff to ensure that proper PPE use and procedures are being followed for Transmission Based Precaution room. The IP will complete random weekly observation audits to ensure that staff are following proper handwashing protocols during resident care and audits of foley catheters to ensure that the catheter bags are not touching the floor. Results of the audits will be presented to the QAPI Committee for review and recommendation. 5-Completion date 2/7/22.	

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Review of "United States COVID-19 County Level of Community Transmission as Originally Posted" retrieved from https://data.cdc.gov/Public-Health-Surveillance/United-States-COVID-19-County-Level-of-Community-T/8396-v7yb on 01/06/21 on 12/29/21 the county level of community transmission for the facility was "high" at 18.06%.

Review of R403's electronic medical record (EMR) under the "Profile" tab revealed an admission date of 12/15/21. Treatment record under "Reports" tab of EMR revealed orders for enhanced droplet precautions from 12/16/21 through 12/29/21. Review of the "Immunization Report," provided by the facility, revealed no COVID-19 immunization information for R403.

Review of the admission note, in the "Progress Notes" tab of EMR, dated 12/24/21, revealed R404's admitted to the facility on 12/24/21. Treatment record under "Reports" tab of EMR revealed orders for enhanced droplet precautions from 12/25/21 through 1/07/22. Review of the "Immunization Report," provided by the facility, revealed R404 had received "SARS-COV-2 (COVID-19) (STEP 1)" on 12/23/21.

R405 was admitted to the facility on 12/20/21, according to the EMR under the "Progress Notes" tab, "Admission Assessment/Screening V.1.2" dated 12/20/21. Physician's orders, under "Orders" tab of EMR revealed orders for enhanced droplet precautions from 12/20/21 through 1/04/22. Review of the "Immunization Report," provided by the facility, revealed R405 had received "SARS-COV-2 (COVID-19) (STEP 1)" on 12/20/21.

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Review of R406's entry tracking "Minimum Data Set (MDS)," dated 12/18/21 revealed R406 admitted to the facility on 12/18/21. Review of the "Immunization Report," provided by the facility, revealed R406 had received "SARS-COV-2 (COVID-19) (STEP 1)" on 01/19/21.

R407 was readmitted to the facility on 12/16/21, according to the EMR under the "Medical Diagnosis" tab with primary diagnosis ileus. Physician orders located in EMR, under "Orders" tab revealed enhanced barrier precautions as of 12/16/21 with no end date. Review of the "Immunization Report," provided by the facility, revealed R407 had refused the COVID-19 vaccination.

Review of an "Admission Record" located in R408's EMR under the "Profile" tab indicated she was admitted on 12/16/21 with diagnosis including acute eczema exacerbation. Review of the "Immunization Report," provided by the facility, revealed R408 was fully vaccinated and had received "SARS-COV-2 (COVID-19) (STEP 1)" on 12/20/20 and received "SARS-COV-2 (COVID-19) (STEP 2)" 01/10/21.

The following observations were made on Unit 4A, which served as the quarantine hall for COVID-19 for new admissions to the facility. During the following observations on 12/27/21 from 12:51 to 1:44 PM the plastic curtain hanging from the ceiling on Unit 4 A, separating the quarantine rooms from non-quarantine rooms, was not zip closed, leaving it open from top to bottom.

a. On 12/27/21 at 12:54 PM, R403's bedroom door was open with green sign indicating

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"Enhanced Droplet-Contact Precautions" posted on the front of the door and a personal protective equipment (PPE) cart in the hallway outside of bedroom door. Review of the undated sign included instructions to perform hand hygiene, wear N95 mask, gown while in room, gloves when entering room, keep door closed, remove PPE and perform hand hygiene before exiting room. R403 was sitting in her wheelchair being served lunch tray by Certified Nurse Aide (CNA) 22 who was wearing gloves, gown, N95 mask, and eye protection

b. On 12/27/21 at 1:06 PM, R404's door was open with the green sign indicating "Enhanced Droplet-Contact precautions" posted on the front of the door and a PPE cart in the hallway outside of bedroom door. R404 was in bed feeding himself. CNA22 observed serving meal tray to R404 who was wearing gloves, gown, N95 mask, and eye protection.

c. On 12/27/21 at 1:11 PM, R405's door was open with no sign on door indicating she was on transmission-based precautions (TBP). Resident was eating lunch.

d. On 12/27/21 at 1:13 PM, R406's door was open with green sign indicating "Enhanced Droplet-Contact Precautions." R406 was sitting up in her wheelchair feeding herself lunch during observation.

e. On 12/27/21 at 1:18 PM, R407 was resting in her bed, watching television with the bedroom door open; observed green sign on door stating, "Enhanced Droplet-Contact Precautions," PPE available outside the bedroom door, no PPE bins available in the room for disposing of PPE.

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Regular trashcan available next to the sink.

f. On 12/27/21 at 1:44PM, R408's bedroom door was open with sign indicating "Contact Precautions" posted on the door. Review of the undated, sign revealed "Contact Precautions ...Visitors must report to nursing station before entering. Perform hand hygiene ..., wear gown, gloves, bag linen to prevent contamination of self, environment or outside bag, discard infectious trash to prevent contamination of self, environment or outside bag."

An observation on 12/28/21 at 11:11 AM, revealed the plastic curtain in Unit 4A dividing the quarantine and non-quarantine rooms was no longer in place. On 12/29/21 at 1:46 PM, an observation was made of the plastic curtain in Unit 4A being installed. During the following observations on 12/28/21 and 12/29/21 resident rooms were observed open while the plastic sheeting dividing the quarantine and non-quarantine rooms was not present.

a. On 12/28/21 at 11:22 AM, R403's bedroom door was open with a sign on door stating "Enhanced Droplet-Contact Precautions" and R403 was sitting up in her wheelchair next to her bed.

b. On 12/28/21 11:21 AM, R404's bedroom door was open with "Enhanced Droplet-Contact Precautions" sign hanging on outside of door; PPE cart in the hallway outside of bedroom also observed while resident slouched over in bed resting with eyes closed.

c. On 12/29/21 at 10:35 AM, R408's bedroom door was open and sign indicating "Contact

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Precautions" was posted on the door. Psychiatrist who was wearing N95 mask and no other PPE, entered the room of R408 who was on contact precautions. Psychiatrist entered room without donning PPE or performing hand hygiene. At approximately 10:38 AM, LPN14 notified Psychiatrist that R408 was on contact precautions and that PPE was required prior to entering the room. Psychiatrist stated he did not see the sign on the door, then excused himself.

d. On 12/29/21 at 10:40 AM, R405's bedroom door was open. There was not a sign posted on the door indicating R405 was on TBP. CNA13 was in the room making the bed and R405 was in her wheelchair next to the bed. CNA13 was wearing an N95 mask and eye protection.

e. On 12/29/21 10:59 AM, R404's bedroom door was open with "Enhanced Droplet-Contact Precautions" sign hanging on outside of door; PPE cart in the hallway outside of bedroom also observed. CNA13 was wearing an N95 mask and eye protection and was observed donning gown and gloves to enter room to administer bed bath.

During an interview on 12/27/21 at 12:54 PM, CNA22 confirmed R403, R404, R405, R406, R407, and R408 were on transmission-based precautions and a N95 mask, gown, gloves, and eye protection were required in the rooms. CNA22 was not sure if bedroom doors should be closed or not, CNA22 further indicated that the doors had been open all morning.

During an interview on 12/27/21 at 1:10 PM, Registered Nurse (RN) 3 verified all residents beyond the plastic sheeting were on enhanced droplet precautions and stated anyone not fully

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vaccinated must quarantine 14 days per facility policy. RN3 verified R403, R404, R405, R406, R407, and 408 were on enhanced-droplet precautions. RN3 verified R405 was also on enhanced droplet-contact precautions but did not have a sign on her door indicating transmission-based precautions were in place nor did she have PPE available in front of her room.

During an interview on 12/27/21 at 1:28PM, RN3 confirmed R407 was on enhanced droplet-contact precautions and that there were no PPE disposal bins available in the room. RN3 stated "I need to get her some bins ... you can put your PPE in regular trash as long as it's not contaminated." RN3 stated she was not sure if bedroom door is supposed to be shut due to plastic curtain in place.

During an interview on 12/28/21 at 11:22 AM, R405 confirmed she was on "quarantine" for 14 days due to recent admission.

During an interview on 12/29/21 at 10:35 AM, LPN14 confirmed Psychiatrist entered the room of R408 with only a N95 face mask. LPN14 confirmed R408 was on contact precautions and all staff must wear PPE while inside the room.

During an interview on 12/29/21 at 10:40 AM, CNA13 verified she entered the room of R405 wearing an N95 and eye protection, but without a gown and gloves. CNA13 confirmed R405 was on enhanced droplet-contact precautions and that she should have donned a gown, and gloves prior to entering the room.

During an interview on 12/29/21 at 1:28 PM, Assistant Director of Nursing (ADON) confirmed

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all doors to resident bedrooms that had signs indicating "enhanced droplet-contact precautions" should remain closed if there was no curtain up; if curtain was open or not in place, all doors should remain closed. ADON confirmed staff were currently moving residents for a "quarantine and hot area" due to multiple positive Covid cases in the building. The ADON confirmed all new admissions to the facility were quarantined and placed on "enhanced droplet-contact precautions."

2. Review of a document provided by the facility titled "Standard Precautions," dated 02/06/20 stated "The Center promotes the fundamental guidelines for standard precautions, as recommended by the Center for Disease Control [CDC]. The Center utilizes standard precautions for all patients . . . Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces and before going to another patient. Perform hand hygiene upon removing gloves."

During a medication pass observation on 12/29/21 from 9:22 AM to 9:54 AM, Licensed Practical Nurse (LPN) 5 administered ophthalmic medication to R37 with gloved hands. LPN5 then adjusted R105's nasal canula without removing her gloves or performing hand hygiene. LPN5 was immediately interviewed and verified she did not perform hand hygiene and should have between R37 and R105. LPN5 then exited the room and doffed her gloves. LPN5 did not use Alcohol Based Hand Rub or wash her hands. LPN5 moved the medication cart and began dispensing medications for R51. At 9:54 AM, when asked if she had sanitized her hands, LPN5 stated she thought she had. LPN5 then

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performed hand hygiene with Alcohol Based Hand Rub and continued to dispense the rest of R51's medications.

3. Review of R3's "Face Sheet" located in the EMR under the "Profile" tab, revealed an admission date of 9/29/12 and included, but was not limited to, the following diagnoses: chronic kidney disease and benign prostatic hyperplasia.

During an observation on 12/30/21 at 11:34 AM, R3's urinary catheter drainage bag was observed to be on the floor on the right side of his bed.

During an interview on 12/30/21 at 11:36 AM, CNA16 stated the urinary catheter drainage bag should not be on the floor. CNA16 proceeded to secure the urinary catheter drainage bag to R3's bed.

4. Review of R138's "Face Sheet" located in the EMR under the "Profile" tab, revealed an admission date of 11/17/15 and included, but was not limited to, the following diagnoses: quadriplegia and neuromuscular dysfunction of bladder.

During an observation on 12/30/21 at 11:38 AM, R138's urinary catheter drainage bag was observed to be uncovered, on the floor, and under R138's bed.

During an interview on 12/30/21 at 11:40 AM, CNA16 stated the urinary catheter drainage bag should not be on the floor or exposed. CNA16 proceeded to secure the urinary catheter drainage bag to R138's bed and placed the drainage bag in a privacy cover.

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During an interview on 12/30/21 at 3:10 PM, the Registered Nurse (RN) Unit Manager stated the urinary catheter drainage bags should not be on the floor. The RN Unit Manager stated when the urinary catheter drainage bags were on the floor, microorganisms could be introduced into the urine.

During an interview on 12/30/21 at 5:31 PM, the Director of Nursing (DON) stated urinary catheter drainage bags should not be on the floor.

5. Review of R144's undated "Admission's Record" located under the "Profile" tab in the EMR indicated the resident was initially admitted on 12/04/19 with a re-admission on 12/01/19 with diagnoses including urinary tract infection, down syndrome, dementia, and retention of urine.

During an observation conducted on 12/28/21 at 9:50 AM and on 12/29/21 at 7:32 AM, R144's urinary catheter bag was observed laying on the floor next to her bed. There was no barrier between the urinary catheter bag and the floor.

During an interview on 12/29/21 at 10:27 AM, at R144's bedside, CNA11 stated "[R144's] catheter must be below the bladder level and covered with a dignity bag." CNA11 confirmed the catheter must be kept off the floor. CNA11 stated the urinary catheter bag would become dirty if left on the floor.

An attempt to interview the unit manager on was unsuccessful due to testing positive for COVID-19.

Facility policies for catheter care related were requested, policies did not address bag

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F 880	Continued From page 82 placement and infection control.	F 880		