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	495155	A. BUILDING _____ B. WING _____	R-C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE HEALTHCARE CENTER	6700 COLUMBIA PIKE ANNANDALE, VA 22003

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{E 000}	Initial Comments	{E 000}	Annandale Healthcare Center is filing this document for the purposes of regulatory compliance. The submission of the plan of correction does not represent an admission or statement of agreement with respect to the alleged deficiencies.	
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 03/02/21 through 03/05/21, was conducted 04/20/21 through 04/23/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. One complaint was investigated during the survey, #VA00048077. The census in this 222 certified bed facility was 156 at the time of the survey. The survey sample consisted of 9 current Resident reviews (Residents 101 through 109) and 2 closed record reviews (Residents 110 through 111).	{F 000}		
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 a complaint investigation, observation, staff interview, record review and review of facility documents, the facility staff failed to initiate a new order by a wound doctor per treatment regimen for 1 resident (Resident #111), in a closed record sample out of 11 residents.	F 684	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #111 was discharge from the facility on 12/22/2019. How you will identify other residents having the potential to be affected by the same deficient practice? All current residents wound recommendation were reviewed by the DON and/or Executive Director to ensure that all orders were carried out as ordered by the attending physician. What measures will be put into place or what systemic changes you will make to	

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

Madona, LNHA 5/4/2021

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F 684	Continued From page 1 The findings included: The facility staff failed to follow a new wound treatment order of Medihoney and a dry dressing to a wound on resident #111's right shin. Instead they continued with former orders. Resident #111 was admitted to the facility on 06/05/2015 and discharged on 12/22/2019. Diagnosis for Resident #111 included but not limited to A History of Falling, Dementia and Dysphagia. The current Minimum Data Set (MDS), a discharged assessment with an Assessment Reference Date (ARD) of 12/22/20. In section " C " (Cognitive Patterns) C0100-Staff assessment for Mental Status coded resident as having memory problems. C1000-Cognitive Skills for Decision Making coded the resident as being moderately impaired for decision making. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing, toilet use and personal hygiene. Total dependence with bathing and requires supervision with eating. The care plan dated 11/19/19 indicated Focus Resident: Has skin tear/potential for skin tear to her right shin r/t post fall. Date Initiated: 11/19/19 Revision Date: 11/19/19. Goal: Will be healed by the next review date. Interventions: If skin tear occurs, treat per facility protocol and notify MD, family. Initiated on 11/19/19. Revision on: 12/16/19. Monitor/document location, size and	F 684	ensure that the deficient practice will not recur? The staff development nurse provided the RNs and LPNs education regarding recommendations given by consultants and carrying out physician orders. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DON and/or the ADON will audit wound recommendations and orders 3 times a week to ensure that orders are obtained and carried out. The results of the audit will be submitted to the QAPI committee on a monthly basis for a period of three months. The QAPI committee will determine if any additional interventions are necessary at the end of the three month period. Date of Compliance:	5/4/2021

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treatment of skin tear, report abnormalities, failure to heal, s/sx (Sign and symptoms) of infection, maceration. Date initiated: 11/19/19. Revision on: 12/16/19.

A review of the daily wound assessment for November and December 2019 (Right Shin) was completed by facility staff. No indication of signs and symptoms of infection, necrosis, odor or pain documented as No (N). Drainage present was documented as Yes (Y) on the WC (Wound Care assessment).

A review of the Physicians order summary from 11/01/19 to 12/31/2019 reveal the following:

Clean area on Right Lower Leg (RLL) with wound cleanser pat dry apply xeroform dressing cover with 4X4 gauze wrap with cling until healed every day shift. Order Date: 11/19/19. Start Date 11/20/29.

Clean area on RLL with wound cleanser pat dry apply xeroform dressing cover with 44 gauze wrap with cling until healed every day shift every three days for wound care. Order Date: 11/26/19. Start Date: 11/29/19.

Clean area on Right lower shin with wound cleanser pat dry apply bacitracin then xeroform then cover with dry dressing every day shift every three days for wound care. Order Date: 12/10/19. Start Date: 12/13/19.

*Clean area on right Shin with wound cleanser pat dry and apply bacitracin then xeroform then cover with dry dressing every day shift every three days for wound care. Per MAR and discontinue on 12/23/19.

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The above wound care treatments were completed on the MAR.

A review of skin assessments reveal the following:

11/19/19 1 DAY 5 cm x 3.5 cm x 0.2 cm Surface area 17.50 cm- had cauterization for hypergranulation tissue. Dry protective dsg. Once daily x 30 days and xeroform sterile gauze once daily.

11/26/19 Length-3.4 cm Width- 3.2 cm Depth. 0.1 cm Wound Area 10.9 (Wound is stable, continue topical wound dsg- xeroform to wound and wrap with cling dressing q 3 days.

12/03/19 WOUND HAS INCREASED IN SIZE-L-4.0 cm W-4.2 cm Depth-0 Wound area-16.8 cm (xeroform to the wound, cover with cling wrap every 3 days)
12/10/19 WOUND HAS DECREASED IN SIZE ETIOLOGY-SHEAR INJURY L-3.6 cm W-4.0 cm D-0.2 cm Wound area 14.4 cm

12/17/2019 WOUND Improving. Wound measurements on Rt. Shin = 3 cm x 3 cm x 3 cm

*12/17/19 Surgical Note 3 cm x 3 cm x 0.2 cm Wound area 9.0 cm-overall prognosis is fair. (dressing medihoney and d/c xeroform and apply medihoney and dry dressing to the wound q day).

According to the wound care surgical note dated 12/17/19 the new wound care orders on Resident's right shin should be treated with medihoney and a dry dressing to the wound daily. Instead, the treatment was continued with the

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F 684	Continued From page 4	F 684		

following order as listed on the MAR (Medication Administration Record). Clean area on the right shin with wound cleanser, pat dry, apply bacitracin then xeroform then cover with dry dressing every shift every three days for wound care (Discontinue on 12/23/19).

A review of progress note revealed the following: Note Reads: 12/17/2019 at 14:29 (2:29 PM) Skin/Wound Note Text: Resident was seen by wound Doctor at the facility wound improved order to continue with same treatment MD and family aware. (Written per wound care nurse/LPN).

An interview was conducted on 4/21/21 at approximately, 5:00 PM with RN (Registered Nurse, Wound Care Nurse) She stated, " Resident #111 had a non pressure wound of the right shin, skin tear. The doctor gave the order on rt. Shin every 3 days to apply bacitracin and Xerofoam."

On 4/23/21 at approximately, 11:40 AM an interview was conducted with the Wound Care (WC, RN #3) concerning WC orders for 12/17/19 for Resident #111. She stated, " I was on vacation on 12/17/19. Normally the wound physician don't give it to us (WC orders). It takes a couple of days. The wound nurse is responsible for inputting the new orders on the MAR. The DON (Director of Nursing) intervened as the WC nurse was being interviewed by the surveyor. She stated, On the notes from 12/17/ 19. That new order was written on a Tuesday. She went to the hospital on 12/22/19 (Thursday)." The DON was asked if the the nursing staff should be following the new wound order? She stated, "Yes."

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F 684	Continued From page 5 Policy reads: Physician Orders: Effective: 8/03/2010. Revised: 12/01/18. Definitions: MAR/TAR Medication Administration Record/Treatment Administration Record-the legal medical record for recording medications and treatments. Procedure: Medical Orders Transcription: A.The provider may write the order in the medical record. B. A provider may give a medical order over the telephone. 1. The nurse will transcribe the order on the telephone order slip. 2. The nurse will provide a read-back to the provider for accuracy. 3. Fill out a change when there is a new order. C. The provider may send a signed and dated fax medical order. D. Verbal orders are accepted but will be written out by the nurse as soon as practicable. Tracking the order: A. Discontinue any previous contradicting order (ex. for dose changes, dressing treatments). Execution of the Order and Notifications: Update the MAR/TAR with changes or new orders. Notify attending or other providers as appropriate. On 4/23/21 at approximately 3:45 PM the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 684		
{F 689} SS=E	COMPLAINT DEFICIENCY 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	{F 689}	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #102 is currently residing in the facility. She is being supervised during smoking.	

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{F 689}	Continued From page 6 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews, facility documentation and review of the facility's plan of correction (POC), the facility staff failed to ensure adequate supervision and assistive devices were in place to prevent accidents/falls for 2 of 11 residents (Resident #102 and #101) in the survey sample. The findings include: 1. Resident #102, who was assessed at risk for falls, was not provided adequate supervision during a scheduled smoking hour that resulted in a fall from her wheelchair while reaching for a dropped cigarette. The resident was admitted on 7/16/16 with diagnoses that included chronic obstructive pulmonary disease (COPD), high blood pressure, muscle weakness, abnormal gait, fall history, cognitive deficits/dementia and nicotine dependence (cigarettes). The most recent Minimum Data Set (MDS) assessment was an annual dated 3/1/21 and coded the resident with adequate hearing, clear speech and understood by the staff and always understood them. The resident scored a 4 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in the cognitive skills for daily decision making. The resident did not have any mood or behavior problems. The resident was coded occasionally incontinent of bowel and	{F 689}	Resident #101 was discharge on 4/24/2021. How you will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents were checked during designated smoking time to ensure that residents were supervised by 2 staff at all times. Staff with preexisting respiratory conditions were excluded from the list of staff that will supervise the smokers. An audit of all rooms were done to ensure that 10 foot cords were being used for their call light. An audit of all current residents were done to ensure that call lights are within their reach while in their room. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? A sign-in sheet will be utilized to ensure that 2 staff are monitoring the residents while smoking. An inservice will be done to nursing staff, department heads, and activity staff to ensure that residents are monitored while smoking by 2 staff at all times. An audit of all rooms were done to ensure that each bed have a 10 foot cord call bell.	

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{F 689}	Continued From page 7 bladder. The resident was assessed with nicotine dependence. The resident was assessed to require supervision from one staff for med mobility, transfers, walking in and out of the room in corridors, moving from a seated to standing position. The MDS coded the resident as "using no mobility devices." The MDS assessed the resident as having no falls since admission to the nursing facility. The MDS's Care Area Assessment (CAA) triggered for falls with a decision to care plan for them. The care plan dated 7/17/16, revised on 3/1/18 and on 3/10/21 identified Resident #102 at risk for falls and a history of falls. The goal the staff set for the resident was that she would be free from falls through the next review. Some of the approaches the staff would use to accomplish this goal included educate the resident to use call light and alert staff that assistance is needed, personal items available and in easy reach or provide reacher, grab bars to enhance bed mobility, turning, repositioning and or to provide grip. Although the MDS failed to assess the resident with the use of the wheelchair and walker as a mobility device, the care plan identified both with the assistance and supervision of staff. It was identified in the care plan that the resident attempted to ambulate without the walker and had exit seeking behaviors. One of the approaches to maintain her safety was the use of a wanderguard. The care plan dated 8/11/16, revised on 7/28/17, 5/14/19, 2/27/21, 3/1/21 and 3/3/21 identified Resident #102 with alteration in respiratory status due to episodes of shortness of breath and smoking. The resident was identified as a supervised smoker. The goal set by the staff for	{F 689}	Zone rounds will be done by the department heads and submitted to the executive director. The rounds will be done three times a week and will consist of hazard checks, call light checks and safety checks. An inservice will be done to staff regarding accidents and hazards. The inservice will be done by the executive director, and/or the director of nursing and/or the staff development nurse. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The executive director and/or the director of nursing will make rounds to three times a week to ensure that call lights are within reach and residents are supervised by 2 staff during smoke break. The audit will be submitted to the QAPI committee on a monthly basis for a period of three months. The QAPI committee will determine if any additional interventions are necessary at the end of the three month period. Date of Compliance: 5/4/2021	

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the resident was that she would smoke safely with supervision without injuries. Some of the approaches to accomplish this goal included completion of smoking assessments, quarterly, annually and with changes in condition that affects the resident's ability to smoke. Complete smoking evaluation, educated the resident and representative to designated smoking areas, provide smoking devices such as smoke aprons and provide supervision during designated smoke times.

The Smoking Safety Evaluation dated 3/3/21 indicated that the resident required supervision during designated smoking times and the evaluation would be utilized for the resident's smoking care plan on admission and as indicated. The evaluation noted that the resident had insufficient fine motor skills needed to securely hold a cigarette, thus a smoking apron was suggested. No problems were identified with vision, balance while sitting or standing, dropping ashes on self, lethargy, Range of Motion (ROM) of arms/ hands, and lighting, holding, extinguishing a cigarette in an ashtray.

The nurse's notes dated 4/10/21 (Saturday) at 10:16 a.m. indicated the following: "Nurse called to report pt had fall and reportedly hit her head. Pt assessed and went outside to smoke. Per nurse no noted hematoma or lacerations to head...Nurse will start neuro checks and call if any issues...Assessment: fall with head injury. Plan: neuro checks." The nurse's notes dated 4/10/21 at 12:45 p.m. indicated a smoking evaluation was conducted as a result of the fall. The most significant changes in the evaluation from the previous one on 3/3/21 were now problems in the areas of balance problems while

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sitting or standing.

The nurse's note dated 4/10/21 at 2:31 p.m. indicated the resident stated at the time of the fall that she was fine and that she wanted to finish her cigarette. The resident stated she was trying to pick up something from the ground.

The "Falls Details Report" dated 4/10/21 at 9:50 a.m., completed by the Wing I Charge Nurse Licensed Practical Nurse (LPN) #3, indicated there was a visually observed fall where the resident was observed sitting in the smoking area as witnessed by the Lead Activities Employee (LAE), and trying to pick something up from the floor (ground). The report indicated there were no visible injuries based on the head to toe assessment by the aforementioned LPN. The follow-up recommendation was "Activities staff to ensure that resident is always seated while smoking to prevent falls and to ensure safety."

On 4/21/21 at 1:15 p.m., an interview was conducted with the aforementioned LPN #3. She stated that the LAE called her and said the resident had a fall on the ground in the smoking area trying to pick something up from the ground and that she may have hit her head. She stated she did not assess Resident #102 for any visible injuries.

On 4/21/21 at 2:51 p.m., an interview was conducted with the LAE. She stated Resident #102 was trying to pick up something when she fell out of her wheelchair onto the ground during a smoke break. She added that the activities staff were the responsible staff to supervise resident smoke breaks. She stated she had Asthma and could not be close to smoke and the resident was

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on the ground before she could get to her to prevent the fall and she was the only staff supervising residents during their smoke breaks on the weekend. She stated, "You know it was the weekend. Monday through Friday there are two activities staff to supervise 7 smoking residents and on the weekend when this fall occurred there was only one. There has never been two on the weekend to supervise resident smoking breaks. We alternate weekends."

The activities punch detail report was reviewed for the month of April 2021 and validated alternate weekends with only one staff to supervise residents during their smoke breaks.

On 4/21/21 at approximately 3:30 p.m., the Director of Nursing (DON) was interviewed to say, "All smoke breaks are supervised by two staff persons during the week and even on the weekends." She stated she reviewed the fall incident as recorded in the Falls Details Follow-up Report on 4/12/21 that summarized the incident. The DON stated to this surveyor that when she interviewed Resident #102, the resident stated she could not remember what she dropped on the ground and that it was probably due to her dementia diagnosis.

On 4/22/21 (Thursday) at 9:30 a.m., this surveyor observed Resident #102 during the smoke break. Two activities staff were present during the smoke break. The resident was sitting in her wheelchair, in a smoking apron. She was able to flick the ashes from the cigarette into the smoking tower reservoir. On 4/22/21 at 10:15 a.m., Certified Nursing Assistant (CNA) #4 escorted the resident back to her room through the hallways via her rolling walker. During the walk, when

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asked how and why she fell out of the wheelchair, Resident #102 said, "I dropped my cigarette and went to pick it up and I fell out of the wheelchair. I hit my head on this side (touching left side of her head), but it did not hurt at that time. It hurt a week later."

On 4/22/21 at 4:25 p.m., the aforementioned incident was re-reviewed with the Administrator, DON, and Regional Director of Operations. They stated education was starting regarding the supervision of smokers and that 2 persons would be required at all times to include weekends. They stated they were not aware the the LAE had a health condition that caused her to stand a distance from smokers.

The facility's policy and procedures titled Resident/Patient Smoking dated 3/25/16 and revised on 4/1/16. The policy indicated that the facility would promote resident centered care by providing a supervised safe smoking area for residents/patients that request to smoke and are capable of safe smoking behaviors.

2. Resident #101, who had a fall history with injury, was not consistently provided her call bell assistive device while sitting in her wheelchair to alert staff as needed to prevent subsequent falls.

Resident #101 was admitted to the nursing facility on 3/29/21 with diagnoses that included post left femur fracture, diabetes mellitus and renal dialysis.

The most recent Minimum Data Set (MDS) was an Admission dated 4/5/21 and coded the resident with a 12 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which

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indicated the resident was moderately impaired in the cognitive skills for daily decision making. The resident was not coded to resist care and did not have any mood or behavioral problems. The resident was coded to required extensive assistance of one person for bed mobility, dressing, toilet use and personal hygiene. The resident was assessed to require extensive assistance from two staff for transfers and totally dependent on one staff for bathing. Resident #101 was impaired in the range of motion on one side in lower extremities. The MDS coded the resident as having "no" falls in the last month prior to admission, and "no" falls after her admission.

The care plan dated 3/29/21 and revised on 4/1/21 identified that Resident #101 was at risk for falls related to gait and balance issues, history of falls and status post left hip arthroplasty. The goal set by the staff for the resident was that the resident would no sustain significant injury related to falls due to environmental issues through the next review on 4/20/21. Some of the approaches the staff would use to accomplish this goal included use of the call light to alert staff that she needed assistance to ambulate to the bathroom or when she needed any assistance.

The Admission Falls Assessment dated 3/29/21 at 11:05 p.m. identified that the resident had diminished safety awareness, wheelchair/ambulation assistance needed and had a history of falls in the last 30 days which was contrary to the MDS assessment. The resident was assessed as a potential risk for falls.

The nurse's notes dated 3/31/21 at 6:15 p.m., the nursing supervisor was called to the room based

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on the resident's fall to the floor. The nurse's note indicated that the resident stated she was attempting to toilet self at the time of the fall. Teaching was done regarding using the call light for assistance. No injuries were noted.

The physician's /Nurse Practitioner's progress note dated 3/31/21 at 6:30 p.m. indicated that the resident stated she was trying to ambulate to the fall because she could not wait for assistance, last her balance and landed in the floor with impact to her buttocks. A "Stat" left hip and pelvic x-ray was ordered to check status of left hip repair and any further fractures. It was determined there were no further fractures

The "Falls Details Report" dated 3/31/21 at 6:25 p.m. noted the same information as documented in the aforementioned nurse's notes. The Post Falls Evaluation dated 3/31/21 indicated the resident continued to be at risk for falls and needed to use the call bells for assistance with transfers.

The following observations were made of Resident #101:

On 4/20/21 from 12:00 p.m. to 3:00 p.m., Resident #101 was observed in her wheelchair that was positioned at the foot of the resident's bed. The resident was watching a television that was positioned on a dresser on the right wall in front of the resident between both beds. The call bell was observed attached to her bed's right side rail. The resident's door remained shut, out of sight from the nursing staff. The resident had a walker in her room and stated she could use it when she needed to. She gave a re-count of her original fall where she lost her footing in the mat

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in front of the store. She stated she got up to use the the bathroom when she fell to the floor in the nursing facility, but could not recall whether she had the call bell within reach or not. She pointed to the call light on the bed rail and stated she would have to try to wheel herself over to the side rail to push the call light, but said, "I don't think that is a good idea. I may fall again and I will never let that happen again." The resident's re-count of the her falls were accurate based on the "Falls Details Report" dated 3/31/21.

On 4/21/21 at 9:00 a.m., Resident #101 was again observed in her wheelchair positioned at the foot of the bed watching television. The call light was attached to the resident's right side rail as previously observed on 4/20/21. The resident's door remained shut. Certified Nursing Assistant (CNA) #2 was assigned to the resident.

On 4/21/21 at 10:50 a.m., an Occupational Therapy Assistant (OTA) entered the room to place the resident's roommate in bed. The OTA was asked if she thought there was anything obvious about Resident #101's position in her wheelchair. The OTA asked CNA #2, "Where is her call bell?" The CNA repeatedly stated, "She can't see her TV." Regardless of the OTA's attempt to explain to the CNA that the call bell was not accessible to the resident and that she may attempt to rise, walk and potentially fall, the CNA repeatedly stated, "She can't see her TV." The CNA unwrapped the call bell from the bed's side rail and attempted to stretch it to the resident who was positioned at the foot of the bed when the call light pulled out from the wall outlet. The CNA stated, "It is too short. How will she see TV if I move her any place else?" The OTA re-positioned the resident in the middle of the two

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beds and attached the call light to the left side of the wheelchair. CNA#2 said, "How will she see her TV? Should I turn it?" The OTA responded, "I need you to understand this is not about her TV, but about her safety. She needs to be able to alert staff that she needs help when she needs it." The OTA asked the resident if she could use the call bell, at which time the resident picked up the call bell and pushed the call bell red button which activated the call light.

On 4/21/21 at 1:00 p.m., Wing I Licensed Practical Nurse (LPN) #2 stated the resident fell with fracture prior to admission to the facility and fell trying to go to the bathroom on another unit. She stated it was her expectation that the call bell was close to the resident's reach in order to call for a nurse or CNA if she needed anything. She said, "If she can't call us, she may try to get up. We don't want her to fall. Also her hip is in the process of healing."

On 4/22/21 at 1:25 p.m., an interview was conducted with the Administrator and the Director of Nursing (DON). The aforementioned observations were shared with them. They stated that the resident must be able to have access to her call bell at all times. When asked if all call bell cords were the same length, they stated they thought so. This surveyor requested to speak to the Maintenance Director who arrived at 1:55 p.m. He stated all call bell cords were the standard 10 ft length. It was requested by this surveyor to check the length of Resident #101's call bell cord. The Maintenance Director returned and stated Resident #101's call bell was 8 feet long and the reason was that there were no problems with her call cell. According to the Maintenance Director, call bell cords were traded

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{F 689}	Continued From page 16 out for a 10 ft. once there was a problem with the call bell or cord. On 4/22/21 at approximately 4:25 p.m., a debriefing was conducted with the Administrator, DON and Regional Director of Operations. They stated re-training of all staff was in the process regarding call bell placement for resident safety. The facility's policy and procedures titled Fall Prevention Program Guidelines dated 2013 indicated care goals should include prevention of falls when possible, a decrease in the number of falls and a decrease in the risk and severity of injury. It is unrealistic to expect to eliminate all falls, but an appropriate goal for many patients may be to reduce the number of falls and the risk of injury.	{F 689}		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions	F 700	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #111 was discharge on 12/22/2019. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current residents were checked to ensure that they have a current bed safety assessment. Assessments were done as needed. What measures will be put into place or what systemic changes you will make to	

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F 700	Continued From page 17 are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, observation, staff interview, and review of facility documents, the facility staff failed to conduct a quarterly bed safety assessment for 1 resident (Resident #111), in a closed record sample out of 11 residents. The findings included: Resident #111 was admitted to the facility on 06/05/2015 and discharged on 12/22/2019. Diagnosis for Resident #111 included but not limited to A History of Falling, Dementia and Dysphagia. The current Minimum Data Set (MDS), a discharged assessment with an Assessment Reference Date (ARD) of 12/22/20. In section " C " (Cognitive Patterns) C0100-Staff assessment for Mental Status coded resident as having memory problems. C1000-Cognitive Skills for Decision Making coded the resident as being moderately impaired for decision making. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing, toilet use and personal hygiene. Total dependence with bathing and requires supervision with eating. In section "P" (Restraints) Bedrail- Coded as not	F 700	ensure that the deficient practice does not recur? An inservice will be done to RNs, LPNs regarding the quarterly bedrail assessments due for all residents. The inservice will be done by the staff development nurse. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DON will audit bedrail assessments due on a weekly basis. The result of the audit will be given to the QAPI committee for a period of three months. The QAPI will determine if any additional interventions are necessary at the end of the three month period. Date of Compliance: 5/4/2021	

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used.

During the course of a complaint investigation the complainant complained that his grandmother fell from her bed and hurt her legs because the bedrails had been removed. As a result of Resident #111 falling, records showed that only two bed safety assessments were completed on the following dates: 3/06/2018 and 6/15/18 since Resident was admitted on 6/15/2015.

The assessment for 3/06/18 reads: Section (C) After completing the device decision tree assessment does the current device meet requirements of an enabler or a restraint? The box was Marked (Enabler). Section (D) Education- Reads: Resident and Resident Representative have been educated on the use of the device as well as the risk and benefits. Marked (Yes). Section (F) 10. Reads: Bed assist rails present? Marked (No) 10a. Reads: Bed assist rails present on each side. Marked (left blank). 10b. Reads: Bed assist rails installed per manufacturer guidelines? Marked (Left blank). Section G (Consents) Risk factors discussed with use of restraints. Dated: 3/01/18. RP (Responsible Party informed).

The assessment for 6/-6/18 reads: Section (C) After completing the device decision tree assessment does the current device meet requirements of an enabler or a restraint? The box was Marked (Enabler). Section (D) Education- Reads: Resident and Resident Representative have been educated on the use of the device as well as the risk and benefits. Marked (Yes). Section (F) 10. Reads: Bed assist rails present? Marked (No) 10a. Reads: Bed assist rails present on each side. Marked (left

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F 700	Continued From page 19	F 700		

blank). 10b. Reads: Bed assist rails installed per manufacturer guidelines? Marked (Left blank). Section G (Consents) Risk factors discussed with use of restraints. Dated: 6/04/18. RP (Responsible Party informed).

The above Bed safety assessments reveal that although Resident #111 and her RP were educated on the risks of having bed safety rails-no rails were in use on the dates listed above.
Interviews conducted with staff show that bed safety assessments should be conducted on a quarterly basis. No quarterly assessments were completed after 6/15/18.

On 04/22/2021 at 6:37 PM an email was received from the Administrator: "Resident only had 1 fall in 2019. There were no side rail assessments for 2019. The only side rail assessments were done in 2018."

On 4/22/21 at approximately10:55 AM an interview was conducted with LPN (Licensed Practical Nurse) #6 concerning bed safety assessments. She stated, "The nurses usually do it. The schedule will populate quarterly for the nurses to do it."

An interview was conducted on 4/22/21 at approximately, 3:27 PM with CNA (Certified Nurses Aide) #6 concerning resident #111. She stated, " She had a mat on the floor, a low bed. She had the top bedrails up, 1 on each side. She always tried to transfer herself even though we told her not to. Floor mats are always on the floor in front of her bed."

The facility's policy: A review of the side rail

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F 700	Continued From page 20 assessment and consent policy Effective: 1/12/2004. Revised: 4/23/18 reads: This policy is applicable to all adult living centers. Some residents desire to use bedrails as assistive and/or transfer devices and are not considered restraints. On 4/23/21 at approximately 3:45 PM the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 700		
{F 755} SS=D	COMPLAINT DEFICIENCY Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all	{F 755}	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The expired medication was immediately discarded. The resident was assessed to ensure no side effects were noted from the medication administration. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All medication carts were checked to ensure that there are no expired medications. What measures will be put into placed or what systemic measures you will make to ensure that the deficient practice does not recur?	

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{F 755}	Continued From page 21 aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on the observation of 3 medication carts and review of the facility's plan of Correction (POC), the facility staff failed to dispose of expired medication in 1 of the 3 medication carts that were inspected on Wing 1 unit. The findings include: On 4/22/21 at approximately 2:30 p.m., one of the medication carts on Wing 1 was inspected with Licensed Practical Nurse (LPN) #3. Upon visual inspection with the LPN, Quetiapine 200 milligrams (mg) tab blister pack was expired 4/1/21. The LPN stated the medication was being actively administered to the resident. She stated that it was all of the nurse's job to check for expired medications and remove them from use. She stated the pharmacy should have been called and the medication refilled. The facility's policy and procedure dated 8/3/10 and revised on 4/20/17 indicated it was the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents.	{F 755}	An inservice will be done to RNs and LPNs to ensure that medication carts are checked every shift for expired medications. The inservice will be done by the staff development nurse. The medication carts, and the medication rooms will be checked by the charge nurse every shift. The unit manager and/or the supervisor will check carts daily. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The ED and/or the DON will audit medication carts and medication rooms three times a week to ensure that there are no expired medications in the carts. The audit will be submitted to the QAPI committee monthly for a period of three months. At the end of the three month period, the QAPI committee will determine if additional interventions are necessary. Date of Compliance:	5/4/2021

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{F 755}	Continued From page 22 The purpose of this policy is to provide guidance for the process for providing monitoring that all medications are received and administered in a timely manner. Medication Administration. Basic safety in administration: Check expiration dates 1. Do not administer expired medications. On 4/22/21 at 4:25 p.m., an interview was conducted with the Administrator, Director of Nursing (DON) and the Regional Director of Clinical Services. It was mentioned by the Administrator that their audits performed on 4/1/21 to current revealed there were no expired medications in the medication carts or medication refrigerators.	{F 755}		