STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495155	A. BUILDING _____ B. WING _____	R-C 05/27/2021

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ANNANDALE HEALTHCARE CENTER	6700 COLUMBIA PIKE REVISED ANNANDALE, VA 22003

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{E 000}	Initial Comments	{E 000}	This center is submitting this plan of correction to comply with applicable laws and not as an admission or statement of agreement with the alleged deficiencies herein. To remain in compliant with all federal and state regulations, the Center has taken the following actions set forth in the following plan of correction. The following plan of correction constitute the Center's allegation of compliance such that all alleged deficiencies have been or will be corrected by dates indicated.	
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid second revisit to the standard survey, conducted 03/02/21 through 03/05/21, was conducted 05/25/21 through 05/27/21. The first revisit to the standard survey was conducted 04/20/21 through 04/23/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long-Term Care Requirements. Three complaints were investigated during the survey: VA00051712, VA00051827 and VA00047896. The census in this 222 certified bed facility was 143 at the time of the survey. The survey sample consisted of 14 Resident reviews: Eight current resident reviews (Residents 201 through 208) and 6 closed record reviews (Residents 209 through 214).	{F 000}		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 553	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident # 203 resides in the facility without any ill effects. On 6/14/2021, the resident declined to participate in a careplan meeting. An interview will be done with the resident to assure that her choices and/ or preferences were appropriately addressed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be put in place: 1. The EHR Nurse or designee	

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

Anadola, LNHA 6/17/2021

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F 553	Continued From page 1 (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and clinical record review the facility's staff failed to afford 1 of 14 residents (Resident #203) the opportunity to participate in their care plan meeting. The findings included: Resident #203 was originally admitted to the facility 8/18/17 and has never been discharged. Resident #203's diagnoses included; Parkinson's disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/11/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #203's cognitive abilities for	F 553	will audit all current care plans held over the last 30 days. This audit will assure that appropriate members of the IDT were in attendance, including the resident and RP, unless they declined to attend. Any discrepancy will require a new care plan to be scheduled to assure that the resident and RP were in attendance (unless a declination was obtained). What measures will be put in place to ensure that the deficient practice does not recur: 1. The Executive Director or Director of nursing will educate the IDT on the attendance expectation for each care plan. This education will highlight the importance of appropriate preferences and/ or choices becoming part of the comprehensive care plan. Additionally, this education will assure that sufficient documented evidence exist of the resident and their appropriate responsible party attendance, and/ or declination of attending the care plan. 2. Weekly, The Social Service Director will audit all signature sheets for care plan meetings to assure that all members from the IDT were present and/or that declination was documented. Any discrepancies noted will be corrected at the time of discovery. How will the corrective action be monitored: The Social Service Director or Director of Nursing will randomly audit 25% of the facility census to ensure that the required interdisciplinary team members are present at	

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F 553	Continued From page 2 daily decision making were intact. In section "E" (Behavior) the resident was coded for no behaviors. In section "G" (Physical functioning) the resident was coded as requiring total care of two people with toileting, total care of one with bathing, extensive assistance of two with bed mobility and transfers, extensive assistance of one person with locomotion, personal hygiene and dressing and supervision of one person after set-up with eating. An interview was conducted with Resident #203 on 5/25/21 at approximately 3:15 p.m. Resident #203 stated at no time had she intentionally sat on the floor. The resident stated often she loses her balance and slides from the wheelchair to the floor especially if reaching for items in the room such as those used to make jewelry in the bottom drawer of her bedside dresser. Resident #203 also stated she has not experienced injuries related to the falls but often her ankles are sore because of the way she lands on them when she slides out of the wheelchair. Resident #203 further stated the staff doesn't allow her to be out of bed as often because she slides from the wheelchair to the floor. The resident stated her preference is to be out of bed daily for 3-4 hours because it makes working on her jewelry easier when she's in the wheelchair in an upright position. Resident #203 also stated she didn't participate in her care planning meeting where she could voice her preferences and talk about the fall incidents with the Interdisciplinary team to because she wasn't aware of such a meeting. Review of the the 5/25/21 care plan meeting signature document revealed Resident #203 didn't participate in the care plan meeting therefore an interview was conducted with the	F 553	the residents' care plan meeting and that each care plan was evaluated to ensure the interventions are appropriate for the residents' condition weekly x 3, then monthly x 3. Findings of the audits will be shared by the Social Service Director or Director of Nursing at the QAPI Committee monthly x 3. Compliance will be met by 6/21/2021.	

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F 553	Continued From page 3 Social Worker (SW) on 5/27/21 at approximately 1:55 p.m. The SW stated the Responsible Party for Resident #203 was invited and participated in the care plan meeting 5/25/21 but the resident didn't because she wasn't aware the resident should be included in the planning process but since she now knows she will invite the resident to participate going forward. The above information was addressed with the Administrator, the Director of Nursing and the Regional Director on 5/27/21 at approximately 1:20 p.m. The Director of Nursing stated all resident should be afforded the opportunity to participate in their care plan meetings.	F 553		
F 558 SS=D	COMPLAINT DEFICIENCY Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and clinical record review the facility's staff failed to make reasonable accommodation according to resident's needs and preferences for 1 of 14 residents (Resident #203), in the survey sample. The findings included: Resident #203 was originally admitted to the facility 8/18/17, and had never been discharged.	F 558	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident # 203 resides in the facility without any ill effects. On 6/14/2021, the resident declined to participate in a careplan meeting. An interview will be done with the resident to assure that her choices with reasonable accommodations were documented as part of her comprehensive plan of care. An Occupational Therapy Evaluation will be done to assist the resident with her needs and preferences in maneuvering safely. The resident was given an anti-thrust cushion for her wheelchair. This was recommendation from the therapy department.	

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F 558	Continued From page 4 Resident #203's diagnoses included; Parkinson's disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/11/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #203's cognitive abilities for daily decision making were intact. In section "E" (Behavior) the resident was coded for no behaviors. In section "G" (Physical functioning) the resident was coded as requiring total care of two people with toileting, total care of one with bathing, extensive assistance of two with bed mobility and transfers, extensive assistance of one person with locomotion, personal hygiene and dressing and supervision of one person after set-up with eating. Review of the clinical record revealed Resident #203 sustained falls 9/27/19 and 12/21/19. There is no record of further falls or behaviors of the resident placing herself on the floor. Review of the clinical record also revealed multiple provider progress notes which revealed the resident had experienced many falls. Review of the current care plan revealed a problem dated 12/27/17 which read; (name of the resident) has a behavior of putting herself on the floor to look for items in her drawer. The goal read; Resident will not experience a significant fall related injury through the next review, 8/12/21. The interventions included; staff to assist resident in removing her jewelry from her drawer as and when needed. Staff to constantly remind resident to not put herself on the floor. Staff will put	F 558	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be put in place: 1. The Activity Director or designee will interview all current residents to assure that they are satisfied with their current plan of care. In the case, that they prefer reasonable accommodations to be implemented, a plan of care meeting will be scheduled with the entire IDT (including the resident and RP) to address the preferences, and make reasonable accommodations as part of the plan of care. What measures will be put in place to ensure that the deficient practice does not recur: 1. The Regional Director of Nursing and/or Regional director of Clinical Operations will educate clinical staff on the importance and the expectation of making reasonable accommodations according to residents needs and preferences and including these accommodations in the plan of care. 2. The Executive Director and/or Regional Director of Nursing and/or Regional Director of Clinical Operations will educate the clinical staff regarding the RAI Manual definition of falls. How will the corrective action be monitored: The Social Service Director or Director of Nursing will randomly interview 25% of the facility census to ensure that the residents are satisfied with the plan of care. Additionally,	

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F 558	Continued From page 5 frequently used items within easy reach. Staff will round on the resident frequently. Staff to ensure resident's cushion is properly placed in the wheelchair. Re-educate resident to call for assistance with items needed from the drawer. An interview was conducted with Resident #203 on 5/25/21 at approximately 3:15 p.m. Resident #203 stated at no time had she intentionally sat on the floor. The resident stated often she loses her balance and slides from the wheelchair to the floor especially if reaching for items in the room such as those used to make jewelry in the bottom drawer of her bedside dresser. Resident #203 also stated she has not experienced injuries related to the falls but often her ankles are sore because of the way she lands on them when she slides out of the wheelchair. Resident #203 further stated the staff doesn't allow her to be out of bed as often because she slides from the wheelchair to the floor. The resident stated her preference is to be out of bed daily for 3-4 hours because it makes working on her jewelry easier when she's in the wheelchair in an upright position and she would like to have her items for jewelry making moved to a location more accessible to her as well as more access to her closet. An interview was also conducted with Licensed Practical Nurse (LPN) #1 on 5/27/21 at approximately 10:46 a.m. LPN #1 stated Resident #203 was a fall risk resident therefore she ensured the resident had the call light within reach whenever she was in her presence. LPN #1 also stated Resident #203 often enjoyed looking through her personal items, making jewelry and using her computer and often she would get too close to the edge of the wheelchair	F 558	This audit will assure that reasonable accommodations as requested by the resident and/or IDT were placed in the plan of care weekly x 3, then monthly x 3. Findings of the audits will be shared by the Social Service Director or Director of Nursing at the QAPI Committee monthly x 3. Compliance will be met by 6/21/2021.	

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F 558	Continued From page 6 and start sliding out. LPN #1 also stated she felt Resident #203 could benefit from having frequently used items closer to her as well as reorganization of her personal possessions. An interview was conducted with the Social Worker (SW) on 5/27/21 at approximately 1:55 p.m. The SW stated after speaking with other staff she was informed today (5/27/21), that the resident continues to be observed on the floor during rounds but she was unaware of it until just now and she feels to declutter the resident's room, a project she is currently working on and obtaining a reacher for the resident may be methods of preventing the fall incidents. The above information was addressed with the Administrator, the Director of Nursing and the Regional Director on 5/27/21 at approximately 1:20 p.m. The Director of Nursing stated the staff is currently working with the resident's Responsible Party on removing excessive items and rearranging the resident's room, then they will be able to modify the environment to address needs and presences as well as maintain a safe environment.	F 558		
F 607 SS=D	COMPLAINT DEFICIENCY Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		

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F 607	Continued From page 7 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and the investigation of a complaint the facility staff failed to implement written policies and procedures that prohibit and prevent and include screening of prospective residents for one resident (Resident #210) in the survey sample of 14 residents. The findings included: Resident #210 was admitted to the facility on 04/30/21 and discharged on 05/03/21. The facility staff failed to screen prospective resident for Sex Offender Search, in accordance with the facility's written policies and procedures. Resident #210 was admitted with diagnoses which included cyst of bone on left shoulder, anxiety, muscle weakness, GERD, deep vain thrombosis, psychotic disorder and a registered sex offender. A review of the clinical records dated 5/3/21 indicated: "Change of Condition Evaluation- 1. Things that make the condition or symptoms unchanged, sex offender. 2. This condition, symptom or sign has occurred before, yes. 2-A. Treatment for last episode, none. 3. Have you reviewed and acknowledged the notification- yes. Provider Notification and Feed back 1. Were the changes in condition and notification	F 607	Past noncompliance: no plan of correction required.	

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F 607	Continued From page 8 reported to primary care clinician- yes. 2. Date and Time: 5/3/21- 11:00 a.m.; 3. Recommendation of primary clinician: Transfer to hospital Resident Representative Notification: wife-date-5/3/21 - Time -11:00 a.m. During an interview with the complainant at 1:00 p.m. on 5/26/21 she stated, discharge planning for Resident #210 started on 4/16/21 with the facility. Additional discharge planning dates with the facility included: 4/19/21, 4/20/21, 4/21/21, 4/22/21, 4/23/21, 4/27/21, 4/28/21, 4/29/21, 4/30/21. The complainant stated not once during the pre-discharge planning did the facility check the sex offender registry. Resident #210 was discharged from the hospital to the nursing facility on 4/30/21." During an interview at 3:15 p.m. on 5/25/21 with the facility Admission's Director she stated: "Working with the hospital discharge team, never mentioned that Resident #210 was a "sex offender." The Admission's Director stated, she was off on 4/30/21 and her replacement admitted Resident #210 on 4/30/21. The Admission's Director stated, when she arrived to work on Monday morning, she inquired about the sex registry search for Resident #210. The Admission's Director stated a sex registry search was launched and Resident #210 was found to be on the Sex Offender Registry."The Admission's Director stated, the administrator was immediately notified of the incident. The hospital from which this resident was discharged from was notified. Inservice Training was held on Sex Registry Search prior to admissions. Cooperate office instituted a check the checker process for Sex Registry Search.	F 607		

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F 607	Continued From page 9 A Plan of Action was instituted to ensure facility admission team does not admit residents who are identified on state sexual offender registry. Facility policy and procedure dated 3/1/17 indicated: Procedure: Referral Process 1. C- Admission Director or designee will complete the sex offender register for each referral. 1. In the event the referral is a registered sex offender, further review will be completed and a finial determination made by the Executive Director and the Regional Director of Operations. 2. For each admission, the Admission Director or designee will complete the sex offender log. A facility Action Plan dated 05/03/2021 Indicated: Effective screening of referrals for sex offender history Recommendations: Ensure facility admission team does not admit residents who are identified on state sex offender history. Issue identified: Approaches Responsible Person Completion Date Progress/Resolution 4/30/21 Resident listed on sex offender registry was admitted to facility Executive Director Admission team educated by ED 05/03/21 to ensure facility screening process for sex offender History is completed at the time of referral review. Executive director will	F 607		

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F 607	Continued From page 10 Executive Director 05/10/21 review referrals weekly to ensure newly admitted residents sex offender registry is completed. Weekly audit will validate Executive Director 05/17/21 residents listed on state/ federal sexual offender registry is not admitted to facility. Weekly audit 05/24/21 A review of all audits shows the facility to be in compliance. Past noncompliance was given for this deficient practice.	F 607		
F 641 SS=D	COMPLAINT DEFICIENCY Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and clinical record review the facility's staff failed to accurately code the Minimum Data Set (MDS) assessment to include behavioral symptoms not directed toward others (resident placing herself on the floor) for 1 of 14 residents (Resident #203), in the survey sample.	F 641	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident # 203 resides in the facility without any ill effects. On 6/11/21, the Quarterly MDS ARD 2/11/21 section E0200C was modified to reflect Other behavioral symptoms not directed toward others including, the behavior of placing self on floor.	

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F 641	Continued From page 11 The findings included: Resident #203 was originally admitted to the facility 8/18/17, and had never been discharged. Resident #203's diagnoses included; Parkinson's disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/11/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #203's cognitive abilities for daily decision making were intact. In section "E" (Behavior) the resident was coded for no behaviors. In section "G" (Physical functioning) the resident was coded as requiring total care of two people with toileting, total care of one with bathing, extensive assistance of two with bed mobility and transfers, extensive assistance of one person with locomotion, personal hygiene and dressing and supervision of one person after set-up with eating. An interview was conducted with a former employee on 5/27/21 at approximately 8:45 a.m. The former employee stated Resident #203 had falls every other day from her wheelchair to the floor due to poor trunk control related to Parkinson's disease but the falls were not addressed as falls by the nursing staff to include interventions to prevent falls but the incidents were care planned as behavior in which the resident intentionally places herself on the floor to obtain access to her personal possessions. Review of the current care plan revealed a problem dated 12/27/17 which read; (name of the	F 641	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be put in place: 1. The MDS Coordinator or designee will audit all current residents most recent (within the last quarter) completed and transmitted MDS section E0200C to assure that behavior is accurately coded, according to the RAI guidelines utilizing the established behavioral care plan, and/or Point Click Care (PCC) documentation as indicated. Any issues identified will be corrected/ modified at the time of discovery. What measures will be put in place to ensure that the deficient practice does not recur: 1. The Director of Nursing or designee will educate RN's and LPN's on the importance, and the expectation of documenting all resident behaviors in plan of care (POC) and/or PCC accurately, and timely, so that the MDS can be coded for behaviors accurately. Additionally, the Director of Nursing will educate the Social Services Director/Designee on the importance of accurately coding behaviors on the MDS section E0200 in accordance with the RAI guidelines.	

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F 641	Continued From page 12 resident) has a behavior of putting herself on the floor to look for items in her drawer. The goal read; Resident will not experience a significant fall related injury through the next review, 8/12/21. The interventions included; staff to assist resident in removing her jewelry from her drawer as and when needed. Staff to constantly remind resident to not put herself on the floor. Staff will put frequently used items within easy reach. Staff will round on the resident frequently. Staff to ensure resident's cushion is properly placed in the wheelchair. Re-educate resident to call for assistance with items needed from the drawer. An interview was conducted with the MDS Coordinator on 5/27/21 at approximately 11:35 a.m. The MDS Coordinator stated she hadn't completed Resident #203's MDS assessment or care plan recently but she knew her to be cognitively intact, have Parkinson's disease and a history of frequent falls and or be found seated on the floor. The MDS Coordinator stated she had never personally witnessed any of the resident incidents and she never interviewed the resident for her account of the incidents but if it was a current behavior of the resident and it occurred within the look back period it should be recorded on the MDS assessment. The above information was addressed with the Administrator, the Director of Nursing and the Regional Director on 5/27/21 at approximately 1:20 p.m. The Director of Nursing stated behaviors should be recorded on the MDS assessment.	F 641	How will the corrective action be monitored: The MDS Coordinator or Director of Nursing will randomly audit 25% of the current facility census to ensure that the residents with behaviors are accurately coded on the MDS in section E0200C weekly x 3, then monthly x 3. Findings of the audits will be shared by the Social Service Director or Director of Nursing at the QAPI Committee monthly x 3. Compliance will be met by 6/21/2021	
F 657 SS=D	COMPLAINT DEFICIENCY Care Plan Timing and Revision	F 657	What corrective action will be accomplished for those residents found to have been affected	

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F 657	Continued From page 13 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and clinical record review the facility's staff failed to review and revise the care plan to reflect the needs of the resident for 1 of 14 residents (Resident #203), in the survey sample. The findings included:	F 657	by the deficient practice: 1. Resident # 203 resides in the facility without any ill effects. On 6/15, 2021, the resident was interviewed. The care plan was revised to reflect the current status of the resident. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be put in place: 1. The Director of Nursing or designee will audit all current residents care plans to assure that the plan of care has been updated and revised timely, and is reflective of the current status of the resident. Any issues will be corrected at the time of discovery. What measures will be put in place to ensure that the deficient practice does not recur: 1. The Director of Nursing or designee will educate RN's and LPN's on the importance, and the expectation of updating the plan of care timely. This will include necessary episodic revisions, quarterly, annually and with significant changes of condition. How will the corrective action be monitored: The Director of Nursing or designee will randomly audit 25% of the facility census to ensure that the residents plan of care has been updated with episodes, quarterly, annually and with significant changes of conditions weekly x 3, then monthly x 3. Findings of the audits will be shared by the Social Service Director or Director of Nursing at the QAPI Committee monthly x 3.	

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F 657	Continued From page 14 Resident #203 was originally admitted to the facility 8/18/17, and had never been discharged. Resident #203's diagnoses included; Parkinson's disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/11/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #203's cognitive abilities for daily decision making were intact. In section "E" (Behavior) the resident was coded for no behaviors. In section "G" (Physical functioning) the resident was coded as requiring total care of two people with toileting, total care of one with bathing, extensive assistance of two with bed mobility and transfers, extensive assistance of one person with locomotion, personal hygiene and dressing and supervision of one person after set-up with eating. Review of the current care plan revealed a problem dated 12/27/17 which read; (name of the resident) has a behavior of putting herself on the floor to look for items in her drawer. The goal read; Resident will not experience a significant fall related injury through the next review, 8/12/21. The interventions included; staff to assist resident in removing her jewelry from her drawer as and when needed. Staff to constantly remind resident to not put herself on the floor. Staff will put frequently used items within easy reach. Staff will round on the resident frequently. Staff to ensure resident's cushion is properly placed in the wheelchair. Re-educate resident to call for assistance with items needed from the drawer. An interview was also conducted with Certified	F 657	Compliance will be met by 6/21/2021.	

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F 657	Continued From page 15 Nursing Assistant (CNA) #1 on 5/27/21 at approximately 10:05 p.m. CNA #1 stated Resident #203 has no behaviors and is very sweet but she is sometimes weak and falls. CNA #1 stated because of the falls if the resident is sleepy, weak or starts to lean in the wheelchair she puts her back to bed. CNA #1 stated everyone was aware the resident slides out of the wheelchair but there was never an occasion witnessed in which the cushion came out the chair with the resident. CNA #1 stated many times she witnessed the resident was on the floor and her role was to notify the nurse, the nurse would assess for injuries and she was to follow the nurse instructions to get the resident off the floor with other staff assistance. An interview was also conducted with the Assistant Director of Nursing on 5/27/21 at approximately 11:11 a.m. The ADON stated Resident #203 had a diagnoses of Parkinson's disease, a history of leaning to the side in the wheelchair therefore frequent rounds were conducted on the resident and she had no behaviors. The ADON reviewed Resident #203's care plan and stated she was unable to explain the reason the resident had a care plan for a behavior of putting herself on the floor to look for items in her drawer. The ADON stated in her role as Unit Manager she attended and participated in the Resident's care plan meeting but she didn't know that problems was on the care plan. An interview was conducted with the Social Worker (SW) on 5/27/21 at approximately 1:55 p.m. The SW stated she coded section "E" (Behaviors) of the MDS assessment and she had never coded Resident #203's MDS for a behavior based on review of the nurse's notes, talking with	F 657		

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F 657	Continued From page 16 the nursing staff and the resident. The SW stated she didn't realize there was a behavior care plan therefore she didn't review it to ensure it was still appropriate for the resident's current status. The SW stated after speaking with other staff she was informed today (5/27/21), that the resident continues to be observed on the floor during rounds but she was unaware of until just now. The SW stated they had considered after talking today to declutter the room and obtain a reacher for the resident's use. Further review of the above care plan problem for behavior revealed the last change in the interventions were made 12/13/18. This intervention read; staff to ensure the resident's cushion is properly placed in the wheel chair. The above information was addressed with the Administrator, the Director of Nursing and the Regional Director on 5/27/21 at approximately 2:45 p.m. The Director of Nursing stated during the care plan meeting review and revision of the entire care plan is expected.	F 657		
F 740 SS=D	COMPLAINT DEFICIENCY Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not	F 740	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident # 203 resides in the facility without any ill effects. On 6/15/2021, the behavioral plan was developed and implemented to reflect the current status of the resident. 2. The resident was seen by the psychiatrist on 6/7/2021 and 6/15/2021.	

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F 740	Continued From page 17 limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and clinical record review the facility's staff failed to develop, monitor and implement a behavioral plan to support a resident to attain the highest practicable well-being for 1 of 14 residents (Resident #203), in the survey sample. The findings included: Resident #203 was originally admitted to the facility 8/18/17, and had never been discharged. Resident #203's diagnoses included; Parkinson's disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/11/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #203's cognitive abilities for daily decision making were intact. In section "E" (Behavior) the resident was coded for no behaviors. In section "G" (Physical functioning) the resident was coded as requiring total care of two people with toileting, total care of one with bathing, extensive assistance of two with bed mobility and transfers, extensive assistance of one person with locomotion, personal hygiene and dressing and supervision of one person after set-up with eating. Review of the current care plan revealed a problem dated 12/27/17 which read; (name of the resident) has a behavior of putting herself on the floor to look for items in her drawer. The goal	F 740	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be put in place: 1. The Director of Nursing or designee will audit all current residents care plans to assure that the behavior plan of care has been developed, monitored, and implemented, according to the current status of the resident. What measures will be put in place to ensure that the deficient practice does not recur: 1. The Regional Director of Nursing, and/or Regional Director of Clinical Operations or designee will educate RN's and LPN's, and social work staff on the importance, and the expectation of developing, monitoring and implementing a behavioral plan of care that reflects the current status of the resident. How will the corrective action be monitored: The Director of Nursing will randomly audit 25% of the facility census to ensure that the residents with behaviors have a behavioral plan of care that has been developed, monitored, implemented, and is reflective of the current status of the resident weekly x 3, then monthly x 3. Findings of the audits will be shared by the Director of Nursing at the QAPI Committee monthly x 3. Compliance will be met by 6/21/2021.	

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F 740	Continued From page 18	F 740		

read; Resident will not experience a significant fall related injury through the next review, 8/12/21. The interventions included; staff to assist resident in removing her jewelry from her drawer as and when needed. Staff to constantly remind resident to not put herself on the floor. Staff will put frequently used items within easy reach. Staff will round on the resident frequently. Staff to ensure resident's cushion is properly placed in the wheelchair. Re-educate resident to call for assistance with items needed from the drawer.

Review of the clinical record revealed no documented behaviors of observations or assisting Resident #203 from the floor but during interviews with staff the resident has a known history by all of slipping from the wheel chair to the floor or sitting on the floor. Also review of the clinical record failed to reveal a behavioral tool to document the targeted behavior (intentionally placing self on the floor) to aid staff in determining the frequency or what interventions were effective to decrease the behavior. The facility's staff also failed to ensure all staff including the direct care nursing staff were informed of the resident's behavior. Neither were Social Services, or Psychological Services consulted to behavioral health care and services with the resident to determine the underlying factors related to the behavior which could result in injury.

An interview was also conducted with Certified Nursing Assistant (CNA) #1 on 5/27/21 at approximately 10:05 p.m. CNA #1 stated Resident #203 has no behaviors and is very sweet but she is sometimes weak and falls. CNA #1 stated because of the falls if the resident is sleepy, weak or starts to lean in the wheelchair she puts her back to bed. CNA #1 stated

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F 740	Continued From page 19 everyone was aware the resident slides out of the wheelchair but there was never an occasion witnessed in which the cushion came out the chair with the resident. CNA #1 stated many times she witnessed the resident was on the floor and her role was to notify the nurse, the nurse would assess for injuries and she was to follow the nurse instructions to get the resident off the floor with other staff assistance. An interview was also conducted with Licensed Practical Nurse (LPN) #1 on 5/27/21 at approximately 10:46 a.m. LPN #1 stated she never witnessed a fall or saw the resident on the floor but did witness near fall incidents from wheelchair. LPN #1 stated she didn't participate in the resident's care plan meetings and no one informed her that the resident intentionally placed herself on the floor therefore she was unaware the resident having a behavior care plan. An interview was also conducted with the Assistant Director of Nursing on 5/27/21 at approximately 11:11 a.m. The ADON stated Resident #203 had a diagnoses of Parkinson's disease, a history of leaning to the side in the wheelchair therefore frequent rounds were conducted on the resident and she had no behaviors. The ADON reviewed Resident #203's care plan and stated she was unable to explain the reason the resident had a care plan for a behavior of putting herself on the floor to look for items in her drawer. The ADON stated in her role as Unit Manager she attended and participated in the Resident's care plan meeting but she didn't know that problems was on the care plan. An interview was conducted with the Social Worker (SW) on 5/27/21 at approximately 1:55	F 740		

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F 740	Continued From page 20 p.m. The SW stated she coded section "E" (Behaviors) of the MDS assessment and she had never coded Resident #203's MDS for a behavior based on review of the nurse's notes, talking with the nursing staff and the resident. The SW stated she didn't realize there was a behavior care plan therefore she didn't review it to ensure it was still appropriate for the resident's current status. The SW stated after speaking with other staff she was informed today (5/27/21), that the resident continues to be observed on the floor during rounds but she was unaware of until just now. The above information was addressed with the Administrator, the Director of Nursing and the Regional Director on 5/27/21 at approximately 2:45 p.m. The Director of Nursing presented Weekly Risk Meeting minutes for 8/21/19 which stated Resident #203 has a behavior of placing herself on the floor, staff to continue to assist her with getting her beads and all frequently used items. No more recent documentaion was presented.	F 740		
F 838 SS=F	COMPLAINT DEFICIENCY Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a	F 838	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. The East unit crash cart was immediately replenished with oxygen extension tubing and nasal cannulas, and the cart was inspected to assure that all required emergency equipment was readily available and functioning on that cart. Additionally, LPN #8 was educated on the proper process for assuring that the emergency cart inventory sheet is accurate and that the cart is stocked with all necessary equipment.	

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F 838	Continued From page 21 substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide	F 838	2. The North unit crash cart oxygen was replaced with an oxygen tank that was full and validated as appropriately functioning. Also, LPN #9 was educated with a competency check to assure that proper validation of the oxygen tank delivery system could be accomplished. Specifically, this competency was to assure the nurse was competent in assuring oxygen is flowing from the tank, and competent in the oxygen administration procedure. Additionally, the 11-7 nurse was educated on the proper process for assuring that the emergency cart inventory sheet is accurate and that the cart is stocked with all necessary equipment. 3. The Emerald Court suction canister was replenished, and the cart was inspected to assure that all required emergency equipment was readily available, and functioning on that cart. Also, the 11-7 nurse was educated on the proper process for assuring that the emergency cart inventory sheet is accurate and that the cart is stocked with all necessary equipment. 4. The West unit LPN was educated using a competency check to assure understanding of the proper way to validate the oxygen tank delivery system is functioning, how to read an oxygen gauge, and the oxygen administration procedure. Additionally, the 11-7 nurse was educated on the proper process for assuring that the emergency cart inventory sheet is accurate, and that the cart is stocked with all necessary equipment. 5. The West (11) unit nurse # 10 was educated with a competency check to validate understanding on how to assemble, and operate a suction machine.	

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F 838	Continued From page 22 services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of facility documentation, the facility failed to ensure emergency medical equipment was in place and operational, and that staff were able to demonstrate they were able to provide the required emergency care to residents on 6 of the facility's 6 units. The findings include: According to the review of the facility's assessment dated 12/2019 through 11/2020, it indicated the following: "The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day to day operations and emergencies." The assessment also indicated that another purpose of the assessment was to to ensure the capabilities to provide care and services to the residents in the facility, using a competency based approach that focused on the provision of care to each resident in order to attain and maintain their highest physical well-being. The competencies required and demonstrated proficiency included specialized care-oxygen administration, suctioning, and trach care/suctioning. It must be determined that the	F 838	6. The South Unit Nurse #11 was educated with a competency check to validate understanding on how to assemble, and operatea suction machine, and the proper procedure for retrieving the back board for CPR and/or lower a person to the floor for CPR. Also, RN #3 and RN #6 were educated with a competency check to validate understanding on how to assemble, and operate a suction machine and how to retrieve a back board for CPR and/or lower a person to the floor for CPR. 7. Nurse # 5 and RN # 6 were educated with a competency check to validate understanding on how to assemble, and operate a suction machine. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be put in place: 1. The Unit Manager will assure that the each emergency carts inventory sheet is accurate, and that the cart is stocked with all necessary emergency equipment. What measures will be put in place to ensure that the deficient practice does not recur: 1. RN's and LPN's will be educated by the Regional DON and/or Regional Director of Clinical Operations or designee on the proper process for assuring that the emergency cart inventory sheet is accurate, and that the cart is stocked with all necessary equipment. Also, the unit manager and/or supervisor will verify that the cart is replenished and equipment is functioning daily by co-signing the emergency inventory sheet daily (check the checker).	

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F 838	Continued From page 23 training is effective for all new and existing staff and appropriate knowledge and supervision for caring for the assessed resident population Physical equipment and medical supplies in place and operational included oxygen tanks and tubing and suctioning equipment. The following observations were made on each of the facility's 6 units that either the equipment not available or operational on the unit's crash cart or that the staff was not able to demonstrate and verbalize proficiency in the usage of the crash cart's equipment: 1. On 5/25/21 at 3:20 p.m., on the East Unit, inspection of the unit's crash cart was missing nasal cannulas to administer emergency oxygen (O2) and O2 extension tubing. These items were marked off and signed by the 11-7 p.m. shift licensed nurse on the Emergency Cart Inventory as in place on 5/24/21. Licensed Practical Nurse (LPN) #8 stated she was not aware of any medical emergencies, but that no one should take anything off the crash cart. She stated if there was an emergency, the crash cart should be replenished with all necessary equipment. She stated she hoped that O2 equipment would be available if another nurse responded to an emergency with their unit's crash cart. 2. On 5/25/21 at 3:50 p.m., on the North Unit, LPN #9 stated that he was the only nurse on the unit. The O2 tank appeared to be half full, but when the LPN turned on the tank, there was no sound that would have demonstrated flowing oxygen. The LPN stated, "This is a silent O2 tank and if I have to respond to a code, I would take this tank and hook it up. It is just silent, but you can see it is half full of oxygen." By this time, the	F 838	2. RN's and LPN's will be educated by the Regional Director of Nursing and/or Regional Director of Clinical Operations or designee with a competency check to assure understanding of how to validate that the oxygen tank delivery system is functioning, and that oxygen is flowing from the tank, and the entire oxygen administration procedure. Additionally, RN's and LPN's will be educated on the proper process for assuring that the emergency cart inventory sheet is accurate, and that the cart is stocked with all necessary equipment. Additionally, the unit manager and/or supervisor will verify (check the checker) that all emergency carts are replenished daily, and equipment is functioning by co-signing all emergency inventory sheets daily. 3. The Regional Director of Nursing and/or Regional Director of Clinical Operations or designee will educate RN's and LPN's on their responsibility to assure that the emergency cart is inspected to assure that all required emergency equipment is readily available, and functioning on that cart. Also, RN's and LPN's will be educated on the proper process for assuring that the emergency cart inventory sheet is accurate and that the cart is stocked with all necessary equipment. This will be validated daily by the unit manager or supervisor by co-signing the emergency inventory sheet for each emergency cart. 4. The Regional Director of Nursing and/or Regional Director of Clinical Operationsor designee will educate RN's and LPN's using a competency check to assure understanding of the proper way to validate the oxygen tank delivery system is functioning, how to read an oxygen gauge, and the oxygen administration procedure. Additionally, the Regional Director	

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F 838	Continued From page 24 Regional Director of Operations was present and overheard the LPN. He stated, "No, you should hear a hissing sound." An nasal cannula was removed from the crash cart and hooked to the O2 tank. The prongs of the cannula was placed under water in a plastic cup with no emanating bubbles noted. The Central Supply employee arrived and stated after the last problem with inadequately stocked crash carts, he was checking all of the unit's crash cart. He validated that the O2 tank was defective and that they had the type of O2 tanks that did not require the gauges to be replaced. It was determined that the Emergency Cart Inventory check list was signed by the 11-7 licenced nurse on 5/24/21 that the O2 tank was operational. 3. On 5/25/21 at 4:00 p.m., there was no suction canister on the top of the Emerald Court unit's crash cart. It was determined that the Emergency Cart Inventory check list was signed by the 11-7 licenced nurse on 5/24/21 that the suction canister was on the carsh cart. 4. On 5/25/21 at 4:24 p.m., charge nurse LPN #5 on West I stated that she could not read the gauge on the O2 tank to determine how much oxygen remained in the tank. She stated, "It is probably in the red, which really means there is probably 8 in there, but I don't really know." It was determined that the Emergency Cart Inventory check list was signed by the 11-7 licenced nurse on 5/24/21 that the O2 tank was full. 5. On 5/25/21 at 5:00 p.m., charge nurse LPN #10 on the West II unit was not able to demonstrate how to assemble and operate the suction machine. He stated, "I guess I need to check a manual or ask someone." He tried	F 838	of Nursing and/or Regional Director of Clinical Operations or designee will educate RN's and LPN's on the proper process for assuring that the emergency cart inventory sheet is accurate, and that the cart is stocked with all necessary equipment. This will be validated daily by the unit manager or supervisor by co-signing the emergency inventory sheet for each emergency cart. 5. The Regional Director of Nursing and/or Regional Director of Clinical Operations or designee will educate RN's and LPN's with a competency check to validate understanding on how to assemble, and operate a suction machine. 6. The Regional Director of Nursing and/or Regional Director of Clinical Operations or designee will educate RN's and LPN's with a competency check to validate understanding on how to assemble, and operate a suction machine, and the proper procedure for retrieving the back board for CPR and/or how to lower a person to the floor for CPR administration. Also, RN's and LPN's were educated with a competency check to validate understanding on how to assemble, and operate a suction machine and how to retrieve a back board for CPR and/or lower a person to the floor for CPR. 7. The Regional Director of Nursing and/or Regional Director of Clinical Operations educated RN's and LPN's with a competency check to validate understanding on how to assemble, and operate a suction machine. Every 6 months competency checks will be completed on RN's and LPN's on oxygen	

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F 838	Continued From page 25 repeatedly without success. 6. On 5/26/21 at 2:50 p.m., charge nurse LPN #11 on the South Unit was not able to demonstrate how to assemble and operate the suction machine, she was not able to open the cabinet to the crash cart that held the back board needed to place under residents in need of Cardio Pulmonary Resuscitation (CPR). She stated, "When someone needs suctioning another nurse will know what to do or if a code is called someone else will bring a backboard. The 911 people will have a backboard." She was not sure if head/foot board could come off and be used as a backboard. The South/Emerald Court Registered Nurse (RN) #3 and RN #6 Supervisor entered the nurse's station, and they were not able to demonstrate proficiency at assembling the suction canisters or able to retrieve the crash carts backboard. Based on all of the licensed nurse's inadequacies, the Administrator who was an RN was called to the unit. She observed that none of the licensed nurses present were able to assemble the suction canisters in order to quickly use the suction machine in the event of an emergency. She gave them on an site inservice. No one present was able to unlock the cabinet that housed the backboard either. She was able to instruct them that the resident could be lowered to the floor if necessary to perform CPR. It was determined that the Emergency Cart Inventory check list was signed by the 5/25/21 11-7 licenced nurse that all equipment was observed accounted and in place. 7. On 5/26/21 at 4:20 p.m., a return observation to the Emerald Court was made to determine if a suction canister was replaced on the top of the crash cart. In addition, RN#5 charge nurse as	F 838	administration, suction machine use, and backboard retrieval to assure that the nurses remain competent x 1 year. All new licensed nurses will be competency checked upon hire for on oxygen administration, suction machine use, and backboard retrieval to assure that the nurses remain competent x 1 year. How will the corrective action be monitored: The Director of Nursing or designee will randomly audit 25% of the facility emergency carts, validate 25 % of nurses competencies on oxygen administration, suction machine use and CPR back board retrieval weekly x 3, then monthly x 3. Findings of the audits will be shared by the Social Service Director or Director of Nursing at the QAPI Committee monthly x 3. Compliance will be met by 6/21/2021.	

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F 838	Continued From page 26 well as the RN #6 supervisor was not able to demonstrate proficiency at assembling the suction canister or tubing required to use suction residents in the event of an emergency. The Administrator was present and conducted another inservice for the both RNs. On 5/27/21 at 1:30 p.m., during debriefing with the Administrator, Director of Nursing and Regional Director of Operations, the aforementioned issues were re-reviewed. The Administrator stated she knew what she would start addressing that included ensuring the nursing staff had a complete working knowledge of all emergency equipment and that the crash carts were sufficiently stocked on a daily basis. She also stated she needed to implement a "Check the checker system." No further information was provided prior to survey exit.	F 838		