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AUTUMN CARE OF NORFOLK	1401 HALSTEAD AVENUE REVISED NORFOLK, VA 23502

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted on 5/25/21 through 5/27/21. Four complaints were investigated: VA00051818 was unsubstantiated; VA00051096 both allegations #1 and #2 were substantiated with deficiency; VA00051002 allegation #1 and #3 were substantiated with no deficiency, allegation #2 was unsubstantiated; VA00050639 allegations #1 through #6 were unsubstantiated. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 120 certified bed facility was 90 at the time of survey. The survey sample consisted of 2 current residents (Resident #1 through Resident #2) and 3 closed record reviews (Resident #3 through #5).	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Heather Abernathy

TITLE
Administrator

(X6) DATE
6/18/2021

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F 580	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to notify the responsible party and physician after a resident had fallen for one of five residents, (Resident #5, a closed record resident), in the survey sample.	F 580	Past noncompliance: no plan of correction required.	

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F 580	Continued From page 2 The findings included: Resident #5 was admitted to the facility on 10/06/2018 and discharged on 04/30/2021 to an acute hospital. Diagnosis for Resident #5 included but not limited to Anxiety Disorder and Unspecified Dementia without Behavior Disturbance. The current Minimum Data Set (MDS), a discharged assessment with an Assessment Reference Date (ARD) of 4/30/2021 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for short term memory problems as well as moderately impaired for daily decision making. In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, locomotion on and off the unit, dressing, eating, toileting use and personal hygiene. Requiring total dependence of one person with bathing. The Care Plan dated 4/14/21 indicated: "Focus: Resident #5 is at risk for falls impaired cognition, weakness and incontinence. Actual fall on 04/07/2021. Goal: Resident #5 will have no injuries related to falls through next review date. Target Date: 04/09/2021. Interventions: encourage out of bed in wheelchair for dinner. 4/7/2021- staff education on current interventions Date Initiated: 04/08/2021. Do not leave unattended while toileting. Apply green tape to call bell to encourage reminder to use. Bed in low position. Encourage the resident to be up in the wheelchair at all meals. Encourage toileting after breakfast Date Initiated: Ensure proper footwear while sitting on side of bed. Ensure proper	F 580		

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footwear/nonskid socks. Implement preventative fall interventions/devices. Maintain call light within reach. Educate resident to use call light. Maintain needed items within reach.

A review of nursing notes dated 4/27/21 through 4/29/21 reveal no resident assessments, documentation of a fall, or notifications given to a Responsible Party, or Medical Doctor.

A review of nurses notes dated 4/29/21 at 6:12 PM reveal that Resident #5 is alert, in her wheel chair. Skin warm, dry and intact, no open areas noted. No complaints voiced.

A review of nursing notes reveal: On 4/30/2021 at 12:16 PM Family/Responsible Party Contact Note Late Entry: Called placed to POA (Power of Attorney) to notify that resident had increased AMS (Altered Mental Status). Notified POA that resident has three reddened areas noted to right hip, right shoulder and left knee. One stage 2 to right knee. Notified POA that it was reported to DON on 4/30/21 that resident obtained a fall on 4/27/21. Informed POA that MD ordered resident to be transported to ER for evaluation. POA verbalized understanding and reported she will meet resident at local hospital.

A review of nursing notes reveal: On 4/30/2021 12:18 PM Staff reports resident is having AMS (Altered Mental Status) post fall. MD notified. Sent to ED (Emergency Department) for evaluation. Transported to hospital on 4/30/21.

A review of nursing notes reveal: According to a staff member resident fell out of the wheelchair to the floor on 4/27/21. The curtain was pulled so the roommate yelled out for the nursing staff,

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F 580	Continued From page 4 because she heard the resident fall out of the wheelchair. A review of nursing notes reveal: On 4/30/2021 at 13:34 (1:34 PM) Contacted Doctor, and RP made of fall on the 4/27/21, noted bruising on the bilateral lower extremities at anterior lateral knee and right hip, right side of head, no open area. Able to move all extremities within her limit. No acute complaint of discomfort. Obtain V.S. Order given to transport resident to ER (Emergency Room) for Eval. (Evaluation). A review of nursing notes reveal: On 4/30/2021 at 14:50 PM., Resident transfer to ER for evaluation. Transfer via ambulance, with face sheet, contacted MD and RP. Paperwork given during transfer, care plan, current medication, bed hold agreement. Explain to resident and RP transfer agreement. A review of progress notes on 5/06/21 at 11:44 AM an IDT (Interdisciplinary Department Meeting) Reveal: According to a staff member resident fall out of the wheelchair to the floor on 4/27/21. The curtain was pulled so the roommate yelled out for the nursing staff, because she heard the resident when she fell out of the wheelchair. Resident was sent to ED when staff was notified on 4/30/21: Contacted Dr., and RP made of fall on the 4/27/21, noted bruising on the bilateral lower extremities at anterior lateral knee and right hip, right side of head no open area. Able to move all extremities within her limit. no acute complain of discomfort. Obtain V.S. Order given to transport resident to ER for evaluation. Fall Intervention= staff education on fall prevention and reporting procedures.	F 580		

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A review of Resident #5's hospital admission note dated 4/30/21 reads: Resident #5 is presented with chief complaint of AMS (Altered Mental Status) according to the ED (Emergency Department) Physician. Presented with local facility, apparently fell off the wheel chair with 101 F (temperature) noted to have agitation. H&P note reads: Anemia, easy bleeding, easy bruising.

The Hospital admissions assessment revealed: Ecchymosis to right shoulder and right upper leg non blanching ecchymosis, right and left knee non blanching ecchymosis and hemotoma to forehead.

Admissions report on 4/30/21 at 6:44 PM reveal: No evidence of acute intracranial pressure.

A review of the hospital discharge note dated 5/04/21 reads: Monitor wound care, discharge back to SNF (skilled nursing facility). Patient will be discharged in stable condition to SNF with instructions and medications as noted which was discussed with the patient at the time of discharge.

On 5/26/21 at approximately 10:26 AM an interview was conducted with the DON (Director of Nursing) concerning abuse allegations associated with resident #5. She stated, "There was no mentioning of anyone abusing the resident. We do standard procedures, interviewing staff. My job is to do education with staff members and conduct the investigation. My interview consisted of interviewing the resident."

On 5/26/21 at approximately 10:52 AM an interview was conducted with CNA (Certified Nurse Assistant) #1, concerning Resident #5. She

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stated, "She would fight when getting showers, ADL (Activities of Daily Living) care. She was not an early morning person. She had one fall the day they sent her to the hospital. I was going past her room when her roommate said she's on the floor. She fell out her chair. Her charge nurse was informed. They put her in the bed. The Charge Nurse does not work here anymore. We didn't see any bruises on her at that time. An agency CNA had her that day. I didn't see any bruises on Resident #5."

On 5/26/21 at approximately 12:23 PM an interview was conducted with the DON concerning Resident #5. She stated, "On 4/30/21 we did notice Resident #5 had a stage 2 pressure area of the right knee. She also had areas to her shoulder, right hip and her left knee. (After the fall) the fall happened on 4/27/21. I notified the RP (Responsible Party). I let her know that resident was being transferred to the hospital, due to altered mental status. The RP (Responsible Party) was upset, wanted to know what happened. I explained to her that we would do an investigation. No staff name was given to her because we were still investigating. We were alerted that she wasn't feeling well. The finding of the investigation was that I found out from a staff member that she did fall on 4/27/21. It was not reported. She was an agency nurse. I didn't allow her to come back to the facility. She did not follow up with me concerning the investigation. She (the assigned Nurse) didn't do neuro (neurological checks). She (the assigned nurse) said that she hadn't called anyone. The resident gets confused. Her roommate was interviewed. She stated that she yelled help when the resident fell."

On 5/26/21 at approximately 8:20 PM an

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interview was conducted with LPN (Licensed Practical Nurse) #3. Concerning Resident #5. She stated, " I remember them discussing about a fall in the morning meeting. I don't recall any bruising. I was on the medication cart when someone said she had some bruising. The DON (Director of Nursing) and ADON (Acting Director of Nursing) went in to look at her and we sent her to the hospital that day. I worked 7:00 AM until 3:00 PM. I didn't notice the bruising. We usually do a fall huddle after they get situated. A team comes together to see them about interventions. We notify the family and the Medical Doctor. For unwitnessed falls we do neuro (neurological) checks or If a fall is witnessed without the residents bumping their head. We do a head to toe assessment on them then follow up for next few hours and days every shift."

On 5/27/21 at approximately 9:10 AM an interview was conducted with the DON (Director of Nursing) concerning Resident #5. She stated, "Resident #5 fell on 4/27/21. I called the nurse that was assigned to Resident #5 and asked her to write a statement but she didn't. She no longer works at facility. She was agency staff. I didn't get rid of anyone. I just stopped using the nurse and CNA (Certified Nursing Assistant) that was assigned to Resident #5 on the day she fell. On 4/30/21 we did a head to toe and noticed bruising. When I spoke with the nurse asking her if resident fell on 4/27/21. She stated yes she fell at 11:00 am. I explained the procedure to her. She said I thought I documented it. We have a sheet and a process. I did call her agency and the Board of Nursing to report what occurred. Moving forward we re-in serviced everyone, discussed the post fall process to be included in the orientation process. LPN #4 (Unit Manager) said

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that she was not alerted to the fall. Walking rounds are done here. The fall was not reported in the twenty-four hour report from each unit manager."

On 5/27/21 at approximately, 9:25 AM an interview was conducted with LPN #4 concerning Resident #5. She stated, "On 4/30/21 I was in a morning meeting when CNA #1 came and got me. She said Resident #5 wasn't responding. She had bruises and discoloration when I turned her over. Her right lateral knee was discolored. It blanched when I pushed on it. I took her off her side. I sent them to get the DON. So she could assess her. The bruises and discoloration were on her right shoulder, hip and ankle. I staged her knee as stage 2. We had already dialed 911."

On 5/27/21 at approximately 9:51 PM an interview was conducted with CNA #2. She stated, " I was her CNA. I worked on 4/28/21 and 4/29/21. I was not assigned to her on those days. I did provide ADL (Activities of Daily Living) care. I was assigned to her on 4/30/21 the day she went to the hospital. I went in to clean her up on 4/30/21. I went to give her water but she wasn't holding her head normal. I noticed marks, on her shoulder, neck, knees and ankle and that's when I reported it. She would talk to you if she liked you and she would make her needs known. I asked her what happened. She didn't respond. I always say something in her ear. The CNA said nothing about the resident when her shift ended. The Red marks were on the resident. She had fallen days prior to. We do neuro checks every few hours. Some nurses do their own neuro checks. (after a resident falls)."

On 5/27/21 at approximately 11:55 AM an

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interview was conducted with CNA #3 concerning Resident #3. She stated, "I was off the day she fell but returned the following day. I had her the 2 days afterward. I never noticed any marks or knots on her. I gave her a bed bath. She appeared sleepy and didn't eat much that day. She would communicate with me. She usually would be tired if she was up mostly the day before. I did incontinent care as well. She's a small and fragile lady. The CNA is responsible for doing skin assessments."

A review of skin assessments dated on 4/12/21 and on 4/21/21 reveal no skin issues.

A review of skin assessments dated on 4/30/21 reveal: red non blanchable areas on resident's right front shoulder, right trochanter (hip), right knee and an open area stage 2 on the right knee.

No other skin assessments were available for review.

A review of the clinical record did not reveal an incident report was completed post fall.

Several documents of staff statements concerning Resident #5's fall were provided to the surveyor.

A review of the FRI (Facility Reported Incident) dated 5/04/21 reveals that Resident #5 had an unwitnessed fall that occurred on 4/27/21. RP (Responsible Party) was made aware on 5/04/21. Resident was admitted to local hospital for change in condition and UTI (Urinary Tract Infection) on 4/30/21. The FRI also states that RP, Physician, APS and Law Enforcement were notified.

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F 580	Continued From page 10 The follow up FRI was reviewed. It reads: Residents were interviewed with no issues noted. On 05/27/21 at approximately 12:45 PM., the above findings were shared with the Administrator, Director of Nursing and Director of Clinical Services. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. The facility's policy titled Fall Management Program. Revised date: July 27, 2017. The Purpose: To provide a systemic review of the resident to determine risk for falls and to develop the appropriate intervention. Definitions: A fall is any sudden, unintentional change in position to cause an individual to land at a lower level on an object, the floor or ground. Falls include: Rolls out of bed or chair onto the floor. Fall risks: Infections, cognitive disorders such as dementia related disorders, and previous falls. Interventions: Individualize service Plans. Follow-up Post Fall: An incident/Accident report must be completed. Investigations: A review and analysis of possible contributing factors to the fall with or without injuries will be completed using the facility report form. All resident falls will be investigated, reported and documented by the healthcare professional, the incident and all follow-up reports should be documented in the residents' record. Notifications: All findings should be reported to the resident's physician, supervisor, and family when the incident occurs once the resident is deemed safe. The individual completing the notification will document in the resident's record, all notifications and responses. All incidents will be reported to the appropriate agencies within the time frame as required by	F 580		

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F 580	Continued From page 11 state. This policy will be included in orientation materials for new employees. Ecchymosis: The medical term for a type of bruise. https://www.webmd.com/skin-problems-and-treatments/ecchymosis Blanchable-Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. https://secure.in.gov/isdh/files/Pressure_Ulcer_Classifications_-_Color_Version.pdf	F 580		
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 staff interview, facility document review, and clinical record review, it was determined that facility staff failed to assess, document and notify the responsible party and physician after a resident had fallen in a timely manner for one of five residents, (Resident #5, a closed record resident), in the survey sample. The findings included:	F 684	Facility staff failed to assess, document, and notify responsible party/MD after resident had fallen in a timely manner. 1. Resident #5 no longer resides at the facility 2. Residents who reside in the facility who experience a fall have the potential to be affected by deficent practice. Interviewable residents with BIMS of 12 or greater were interviewed concerning falls. Non-interviewable residents had skin assessment perfomed to rule out any injury. 3. Licensed nurses have been educated on the post fall process and assessment/documentation/ notification requirements related to fall. 4. The 24 hour report will be reviewed during clinicial meeting by DON or designee to identify residents who have experienced fall and validate assessment/documentation and required notification. Findings of these audits will be submitted to the QAPI committee for 3 months for review and recommendations. 5. Date of compliance 6/24/2021	6/24/2021

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Resident #5 was admitted to the facility on 10/06/2018 and discharged on 04/30/2021 to an acute hospital. Diagnosis for Resident #5 included but not limited to Anxiety Disorder and Unspecified Dementia without Behavior Disturbance. The current Minimum Data Set (MDS), a discharged assessment with an Assessment Reference Date (ARD) of 4/30/2021 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for short term memory problems as well as moderately impaired for daily decision making.

In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, locomotion on and off the unit, dressing, eating, toileting use and personal hygiene. Requiring total dependence of one person with bathing.

The Care Plan dated 4/14/21 indicated: "Focus: Resident #5 is at risk for falls impaired cognition, weakness and incontinence. Actual fall on 04/07/2021. Interventions: Resident #5 will have no injuries related to falls through next review date. Target Date: 04/09/2021. Interventions: encourage out of bed in wheelchair for dinner. 4/7/2021- staff education on current interventions Date Initiated: 04/08/2021. Do not leave unattended while toileting. Apply green tape to call bell to encourage reminder to use. Bed in low position. Encourage the resident to be up in the wheelchair at all meals. Encourage toileting after breakfast Date Initiated: Ensure proper footwear while sitting on side of bed. Ensure proper footwear/nonskid socks. Implement preventative fall interventions/devices. Maintain call light within

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reach. Educate resident to use call light. Maintain needed items within reach.

A review of nursing notes dated 4/27/21 through 4/29/21 reveal no resident assessments, documentation of a fall, or notifications given to a Responsible Party, or Medical Doctor.

A review of nurses notes dated 4/29/21 at 6:12 PM reveal that Resident #5 is alert, in her wheel chair. Skin warm, dry and intact, no open areas noted. No complaints voiced.

A review of nursing notes reveal: On 4/30/2021 at 12:16 PM Family/Responsible Party Contact Note Late Entry: Called placed to POA (Power of Attorney) to notify that resident had increased AMS (Altered Mental Status). Notified POA that resident has three reddened areas noted to right hip, right shoulder and left knee. One stage 2 to right knee. Notified POA that it was reported to DON on 4/30/21 that resident obtained a fall on 4/27/21. Informed POA that MD ordered resident to be transported to ER for evaluation. POA verbalized understanding and reported she will meet resident at local hospital.

A review of nursing notes reveal: On 4/30/2021 12:18 PM Staff reports resident is having AMS (Altered Mental Status) post fall. MD notified. Sent to ED (Emergency Department) for evaluation. Transported to hospital on 4/30/21.

A review of nursing notes reveal: According to a staff member resident fell out of the wheelchair to the floor on 4/27/21. The curtain was pulled so the roommate yelled out for the nursing staff, because she heard the resident fall out of the wheelchair.

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A review of nursing notes reveal: On 4/30/2021 at 13:34 (1:34 PM) Contacted Doctor, and RP made of fall on the 4/27/21, noted bruising on the bilateral lower extremities at anterior lateral knee and right hip, right side of head, no open area. Able to move all extremities within her limit. No acute complaint of discomfort. Obtain V.S. Order given to transport resident to ER (Emergency Room) for Eval. (Evaluation).

A review of nursing notes reveal: On 4/30/2021 at 14:50 PM., Resident transfer to ER for evaluation. Transfer via ambulance, with face sheet, contacted MD and RP. Paperwork given during transfer, care plan, current medication, bed hold agreement. Explain to resident and RP transfer agreement.

A review of progress notes on 5/06/21 at 11:44 AM an IDT (Interdisciplinary Department Meeting) Reveal: According to a staff member resident fall out of the wheelchair to the floor on 4/27/21. The curtain was pulled so the roommate yelled out for the nursing staff, because she hear the resident when she fell out of the wheelchair. Resident was sent to ED when staff was notified on 4/30/21: Contacted Dr., and RP made of fall on the 4/27/21, noted bruising on the bilateral lower extremities at anterior lateral knee and right hip, right side of head no open area. Able to move all extremities within her limit. no acute complain of discomfort. Obtain V.S. Order given to transport resident to ER for evaluation. Fall Intervention= staff education on fall prevention and reporting procedures.

A review of Resident #5's hospital admission note dated 4/30/21 reads: Resident #5 is presented

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with chief complaint of AMS (Altered Mental Status) according to the ED (Emergency Department) Physician. Presented with local facility, apparently fell off the wheel chair with 101 F (temperature) noted to have agitation. H&P note reads: Anemia, easy bleeding, easy bruising.

The Hospital admissions assessment revealed: Ecchymosis to right shoulder and right upper leg non blanching ecchymosis, right and left knee non blanching ecchymosis and hemotoma to forehead.

Admissions report on 4/30/21 at 6:44 PM reveal: No evidence of acute intracranial pressure.

A review of the hospital discharge note dated 5/04/21 reads: Monitor wound care, discharge back to SNF (skilled nursing facility). Patient will be discharged in stable condition to SNF with instructions and medications as noted which was discussed with the patient at the time of discharge.

***On 5/26/21 at approximately 10:26 AM an interview was conducted with the DON (Director of Nursing) concerning Resident resident #5. She stated, "We do standard procedures, interviewing staff. My job is to do education with staff members and conduct the investigation. My interview consisted of interviewing the resident concerning Residents' fall."

On 5/26/21 at approximately 10:52 AM an interview was conducted with CNA (Certified Nurse Assistant) #1, concerning Resident #5. She stated, "She had one fall the day they sent her to the hospital. I was going past her room when her roommate said she's on the floor. She fell out her

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chair. Her charge nurse was informed. They put her in the bed. The Charge Nurse does not work here anymore. We didn't see any bruises on her at that time. An agency CNA had her that day. I didn't see any bruises on Resident #5."

On 5/26/21 at approximately 12:23 PM an interview was conducted with the DON concerning Resident #5. She stated, "On 4/30/21 we did notice Resident #5 had a stage 2 pressure area of the right knee. She also had areas to her shoulder, right hip and her left knee. (After the fall) the fall happened on 4/27/21. I notified the RP (Responsible Party). I let her know that resident was being transferred to the hospital, due to altered mental status. The RP (Responsible Party) was upset, wanted to know what happened. I explained to her that we would do an investigation. No staff name was given to her because we were still investigating. We were alerted that she wasn't feeling well. The finding of the investigation was that I found out from a staff member that she did fall on 4/27/21. It was not reported. She was an agency nurse. I didn't allow her to come back to the facility. She did not follow up with me concerning the investigation. She (the assigned Nurse) didn't do neuro (neurological checks). She (the assigned nurse) said that she hadn't called anyone. The resident gets confused. Her roommate was interviewed. She stated that she yelled helped when the resident fell.

On 5/26/21 at approximately 8:20 PM an interview was conducted with LPN (Licensed Practical Nurse) #3. Concerning Resident #5. She stated, " I remember them discussing about a fall in the morning meeting. I don't recall any bruising. I was on the medication cart when someone said she had some bruising. The DON

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(Director of Nursing) and ADON (Acting Director of Nursing) went in to look at her and we sent her to the hospital that day. I worked 7:00 AM until 3:00 PM. I didn't notice the bruising. We usually do a fall huddle after they get situated. A team comes together to see them about interventions. We notify the family and the Medical Doctor. For unwitnessed falls we do neuro (neurological) checks or If a fall is witnessed without the residents bumping their head. We do a head to toe assessment on them then follow up for next few hours and days every shift."

On 5/27/21 at approximately 9:10 AM an interview was conducted with the DON (Director of Nursing) concerning Resident #5. She stated, "Resident #5 fell on 4/27/21. I called the nurse that was assigned to Resident #5 and asked her to write a statement but she didn't. She no longer works at facility. She was agency staff. I didn't get rid of anyone. I just stopped using the nurse and CNA (Certified Nursing Assistant) that was assigned to Resident #5 on the day she fell. On 4/30/21 we did a head to toe and noticed bruising. When I spoke with the nurse asking her if resident fell on 4/27/21. She stated yes she fell at 11:00 am. I explained the procedure to her. She said I thought I documented it. We have a sheet and a process. I did call her agency and the Board of Nursing to report what occurred. Moving forward we re-in serviced everyone, discussed the post fall process to be included in the orientation process. LPN #4 (Unit Manager) said that she was not alerted to the fall. Walking rounds are done here. The fall was not reported in the twenty-four hour report from each unit manager."

On 5/27/21 at approximately, 9:25 AM an

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interview was conducted with LPN #4 concerning Resident #5. She stated, "On 4/30/21 I was in a morning meeting when CNA #1 came and got me. She said Resident #5 wasn't responding. She had bruises and discoloration when I turned her over. Her right lateral knee was discolored. It blanched when I pushed on it. I took her off her side. I sent them to get the DON. So she could assess her. The bruises and discoloration were on her right shoulder, hip and ankle. I staged her knee as stage 2. We had already dialed 911."

On 5/27/21 at approximately 9:51 PM an interview was conducted with CNA #2. She stated, " I was her CNA. I worked on 4/28/21 and 4/29/21. I was not assigned to her on those days. I did provide ADL (Activities of Daily Living) care. I was assigned to her on 4/30/21 the day she went to the hospital. I went in to clean her up on 4/30/21. I went to give her water but she wasn't holding her head normal. I noticed marks, on her shoulder, neck, knees and ankle and that's when I reported it. She would talk to you if she liked you and she would make her needs known. I asked her what happened. She didn't respond. I always say something in her ear. The CNA said nothing about the resident when her shift ended. The Red marks were on the resident. She had fallen days prior to. We do neuro checks every few hours. Some nurses do their own neuro checks. (after a resident falls)."

On 5/27/21 at approximately 11:55 AM an interview was conducted with CNA #3 concerning Resident #3. She stated, "I was off the day she fell but returned the following day. I had her the 2 days afterward. I never noticed any marks or knots on her. I gave her a bed bath. She appeared sleepy and didn't eat much that day. She would communicate with me. She usually

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would be tired if she was up mostly the day before. I did incontinent care as well. She's a small and fragile lady. The CNA is responsible for doing skin assessments."

A review of skin assessments dated on 4/12/21 and on 4/21/21 reveal no skin issues.

A review of skin assessments dated on 4/30/21 reveal: red non blanchable areas on resident's right front shoulder, right trochanter (hip), right knee and an open area stage 2 on the right knee.

No other skin assessments were available for review.

A review of the Resident #5's clinical record reveal no incident report was completed post fall.

Several documents of staff statements concerning Resident #5's fall were provided to the surveyor.

A review of the FRI (Facility Reported Incident) dated 5/04/21 reveals that Resident #5 had an unwitnessed fall that occurred on 4/27/21. RP (Responsible Party) was made aware on 5/04/21. Resident was admitted to local hospital for change in condition and UTI (Urinary Tract Infection) on 4/30/21. The FRI also states that RP, Physician, APS and Law Enforcement were notified.

The follow up FRI was reviewed. It reads: Residents were interviewed with no issues noted.

On 05/27/21 at approximately 12:45 PM., the above findings were shared with the Administrator, Director of Nursing and Director of

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Clinical Services. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.

The facility's policy titled Fall Management Program. Revised date: July 27, 2017. The Purpose: To provide a systemic review of the resident to determine risk for falls and to develop the appropriate intervention. Definitions: A fall is any sudden, unintentional change in position to cause an individual to land at a lower level on an object, the floor or ground. Falls include: Rolls out of bed or chair onto the floor. Fall risks: Infections, cognitive disorders such as dementia related disorders, and previous falls. Interventions: Individualize service Plans. Follow-up Post Fall: An incident/Accident report must be completed. Investigations: A review and analysis of possible contributing factors to the fall with or without injuries will be completed using the facility report form. All resident falls will be investigated, reported and documented by the healthcare professional, the incident and all follow-up reports should be documented in the residents' record. Notifications: All findings should be reported to the resident's physician, supervisor, and family when the incident occurs once the resident is deemed safe. The individual completing the notification will document in the resident's record, all notifications and responses. All incidents will be reported to the appropriate agencies within the time frame as required by state. This policy will be included in orientation materials for new employees.

Ecchymosis: The medical term for a type of bruise.
https://www.webmd.com/skin-problems-and-treatments/ecchymosis

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F 684	Continued From page 21 Blanchable-Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. https://secure.in.gov/isdh/files/Pressure_Ulcer_Classifications_-_Color_Version.pdf	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to identify a sacral pressure ulcer* to prior to an advanced stage for one of five sampled residents, Resident #1. The findings included: Resident #1 was admitted to the facility on 3/2/16	F 686	F686 treatment/services to prevent/heal pressure ulcers. Faclity failed to identify a sacral pressure ulcer prior to an advanced stage for 1 resident. 1. Resident #1 continues to reside at center and is reciving wound care per order. 2. Reisdents who reside at the facility to have the potential to be affected by deficient practice. A house wide skin sweep was performed to validate no other resident had een affected. 3. Licensed nurses have been educated on wound and skin policy, prevention of pressure ulcers and basic skin care. C.N.A.s have been educated on pressure ulcer prevention, shower skin sheets and use of stop and watch tool for skin changes. 4. The facility DON or designee will visually inspect the skin of 10 high risk residents per week to validate the absence of acquired ulcer at advanced stage x 90 days. Findings of these audits will be submitted to the QAPI committee for 3 months for review and recommendations. 5. Date of compliance 6/24/2021	6/24/2021

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F 686	Continued From page 22 and readmitted on 1/15/21 with diagnoses that included but were not limited to COVID-19, muscle weakness, and type two diabetes mellitus. Resident #1's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/11/21. Resident #1 was coded as being severely impaired in cognitive function scoring 03 on the Staff Interview for Mental Status exam. Resident #1 was coded as requiring extensive assistance from one staff member with bed mobility. Resident #1 was coded as having both upper and lower extremity impairments. Review of Resident #1's "Braden Scale Pressure Ulcer Risk Assessment" dated 12/25/20, documented the following: Braden Category: High Risk...Sensory Perception: Very Limited: Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of the body...Moisture: Skin is often, but not always moist,. Linen must be changed at least once a shift... Activity: chairfast: ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. Mobility: Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changed independently. Nutrition: Adequate: Eats over half of most meals...Friction or Shear: Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible..." Review of Resident #1's skin care plan dated 7/12/16 and revised on 2/19/21 documented in part, the following: "(Name of Resident #1) is at	F 686		

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F 686	Continued From page 23 risk for altered skin impairment r/t (related to) history of impairment, poor nutritional intake, anemia, low albumin, and decreased mobility...observe skin during cares (sic) and report any skin redness or skin breakdown to charge nurse (7/12/16)...Provide incontinent care as needed (7/12/16)...skin assessments notify physician of any changes (8/28/18), speciality mattress to bed (2/8/19)..." Review of a biweekly skin assessment dated 12/30/20 documented the following: "Does the resident have current skin issues" A "No" was documented, indicating Resident #1 did not have any skin areas on 12/30/20. Review of Resident #1's medical record revealed that she had developed an unstageable pressure ulcer on 1/8/21. This wound was identified and documented initially at an unstageable on 1/8/21 by the 7a to 7 p shift nurse. The following note was documented at 2:25 a.m., "Open area to sacrum noted with odor, new order dakins wet to dry q (every) shift to sacrum area- to be re-eval (re-evaluated) by wound nurse/MD (Medical Doctor)." Review of the 1/8/21 initial wound assessment documented the following: " (7:24 a.m.) Wound Overview: Pressure, Stage: unstageable (1), Wound Location: sacrum, Length (cm (centimeters)) 6.5 x 16.0 Width (cm) x Depth (cm) 0.0...Location Where wound was Acquired? In House Acquired...Was the skin impairment present on admission: No...Date Wound Identified: 1/7/21. Drainage Type: Serosangious...Drainage Amount: Moderate...Wound Bed Appearance: Necrotic/Slough/Black...Odor: Faint...Periwound	F 686		

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F 686	Continued From page 24 Appearance: N/A (not applicable)...Wound Status: New Wound...Most recent Pain Level: 0 (zero) Comments: Family Notified. Physician Notified...Date and Time: 1/8/2021...Treatments: dakins (2) wet to dry q (every) shift." Review of Resident #1's January 2021 TAR (treatment administration record) revealed Staff were implementing the following order: "Santyl Ointment (3) 250 Unit /GM (grams); Apply to sacrum topically every day shift for wound care. Cleanse sacral wound with 1/4 dakins, Apply santyl, Cover with foam dressing QD (every day) and PRN (as needed)" This order was being implemented until 1/11/21 when Resident #1 was sent out to the hospital. On 1/11/21 per a nursing note; it was revealed that an order was given to send Resident #1 to the hospital. The following was documented in part, "Spoke with resident's RP (responsible party) regarding resident's condition. Resident continues to refuse to eat, drink, and accept PO medications. IV (Intravenous) fluids continue to infuse per MD (Medical Doctor) order. Area to sacrum has deteriorated in appearance...order received to send resident to ED (emergency department) for evaluation and treatment." Further review of Resident #1's clinical record, failed to evidence any physician orders for IV fluids. Review of the January 2020 MAR (Medication Administration Records) failed to reflect orders for IV fluids. Review of Resident #1's nursing notes failed to reflect a poor po (by mouth) intake requiring IV fluids prior to the nurses note on 1/11/21. Review of Resident #1's December and January	F 686		

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Meal Intake Reports dated 12/30/20 through 1/11/21 revealed multiple holes or blanks documenting meal percentages consumed. There was no documentation or evidence that Breakfast and Lunch were given to Resident #1 from 1/2/21 through 1/11/21.

Review of Resident #1's last documented weight before obtaining the wound was on 12/22/20 that documented a weight of "119 pounds." Resident #1's weight on 1/26/21 was documented as "115.2." (3.2 percent weight loss x 1 month which does not indicate significant weight loss).

Further review of Resident #1's weights revealed she had a gradual decline in weight in the year of 2020 with no skin issues present.

Further review of Resident #1's December 2020 meal intake reports revealed that Resident #1's intake varied from 75-100 percent to 0-25 percent.

Review of a note from the NP (Nurse Practitioner) dated 1/11/21 documented in part, the following: "...seen today for an acute visit via telemedicine after staff noted new wound to sacral area...Staff does note poor appetite and po intake...she was given intravenous fluids without much improvement...Staff also noted what appears to be possible Kennedy ulcer (4) to sacral area. The resident's family is requesting be sent out to hospital for further evaluation."

Review of the hospital records dated 1/11/21 documented the following: "Large Infected sacral coccyx unstageable ulcer...History of COVID infection: detected on January 11...being admitted for an infected stage IV (5) sacral decubitis

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F 686	Continued From page 26 ulcer...No osteomyelitis (bone infection)...12 x 8: 4 inch deep down to the bone. No drainage at this time. Santyl, then dakins 1/4 strength overtop with kerlex (dry dressing)... -rec (recommendation): Diverting colostomy (6) for fecal diversion...Await wound care nursing team...Infectious Disease has recommended Bactrim (antibiotic) 160/800 mg (milligrams) twice daily to complete a 10 days course upon discharge...Wound Care Recommendations: Large US (unstageable) Sacral/Coccyx PI (Pressure Injury) - approx (approximately) 10 x 15 x 4 cm deep with 100 percent adherent slough covering wound bed. Suspect to be to level of bone once evolved...Recommend serial follow up by wound care specialist as this wound and treatment plan will change over time and she may need debridement in the future...Recommend discussion with pt(patient)/family to discuss fecal diversion- pt incontinent of stool contaminating wound bed. Recommend surgical consult...Remains quite bedridden with poor functional status leading to her decubitis ulcer...Needs assistance with feedings and supervision... " Review of her albumin (protein) (7) levels in the hospital were recorded at "2.4 (Low)" on 1/14/21. Resident #1's albumin level prior to 1/14/21 was drawn on 1/16/2020. Resident #1's albumin level was documented as 3.1, also low. Resident #1 did not have any documented skin concerns or ulcers back in January of 2020. Further review of Resident #1's hospital discharge orders dated 1/15/21 revealed that Resident #1 was put on "Zinc Sulfate (supplement) 220 mg (milligrams) daily for 8 administrations, Vitamin C (supplement) 500 mg	F 686		

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two times a day and Bactrim DS 800-160 mg -one tablet every 12 hours for infection x 20 administrations" to promote wound healing.

Review of Resident #1's physician orders dated 1/20/21, revealed that a 16 Fr (french) Foley Catheter was also put into place to assist with wound healing.

Review of Resident #1's wound care notes revealed that the wound physician had evaluated Resident #1 sacral ulcer on 1/20/21 (5 days after re-admission). This consult did not classify Resident #1's wound as "Kennedy Ulcer." The following was documented: "Stage 4 pressure wound...Wound Size: 12.0 x 17.0 x not measurable...Exudate: Moderate Purulent (infected)...Thick adherent black necrotic (dead) tissue...20 percent...Granulation tissue...10 percent...other viable tissues 20 percent (Bone)..."

Review of Resident #1's most recent wound care visit dated 5/25/21 revealed that her wound had significantly improved despite her downward trend in weight. Resident #1 last documented weight on 5/21/21 was "89.9" pounds. Resident #1's 5/25/21 wound visit documented in part, the following: Wound size: 5 x 6.5 x 1 cm...Moderate Sero-sangious exudate (drainage)...will have Peg (feeding tube) placed on 6/9 (6/9/21)...Single use NPWT (Negative Pressure Wound Therapy) (Wound VAC) (8) Once weekly for 7 days..."

Review of the facility FRIs (Facility Reported Incidents) revealed that the facility had submitted a FRI on 1/15/21 to the appropriate state agencies regarding Resident #1's sacral wound. The following was documented: "Received

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message from (Name of LTC (long term care) Ombudsman that (Name of Resident #1)'s family reported that she has a Stage 4 pressure area. Investigation initiated and ongoing. Investigation will be completed within 5 working days."

A witness statement dated 1/19/21 from CNA (Certified Nursing Assistant) #4, a CNA who worked on the COVID hall on 1/4/21, 1/5/21,1/6/21 1/7/21, and 1/8/21 7 a to 7 p shift documented the following: "Yes, I took care of (Name of Resident #1), yes I seen (sic) wound yes I told a nurse I'm not sure her name but she is a heavy set Caucasian lady who was from agency, she told me to apply cream on it then (Name of DON) came a few days later and asked me had I seen it I told her yes and I told her the nurse I told and what she told me. Told me it was far past cream and needed to have a wound bandage on it. and I'm only a Cna (sic) so there is not much I can do in that area. But she did put a bandage on it- (Name of DON) I mean."

A witness statement (no date) from CNA #5, an aide who worked on the COVID hall on 1/1/21, 1/4/21, 1/5/21, 1/6/21, and 1/7/21 documented the following: I (Name of CNA #5) charted on (Name of Resident #1) that she had something on her buttocks."

Review of a "Timeline for (Name of Resident #1's) Wound," documented in part, the following: "

January 8th 2021 Administrator notified DON (Director of Nursing) that the Ombudsman had notified her that the sister of (Name of Resident #1) stated she had a wound.
January 8th, 2021, Wound Care Nurse and DON

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F 686	Continued From page 29 went to assess resident's skin. Unstageable noted to resident's sacrum. Wound Care nurse measured and put in a treatment. Spoke with agency CNA that she stated she did indeed take care of the resident for the past few days and noticed that resident had an area and notified charge nurse. She stated that charge nurse did not do anything about it. Charge nurse at the time was (Name of RN (Registered Nurse #5) an Agency RN. January 8th, 2021 Administrator was notified of findings as well as MD. RP was notified of area 7 p-7a nurse previous night (1/7/21) she was the nurse who put in the skin/wound assessment after the night CNA bought (sic) to her attention. Monday, January 11, 2021 administrator informed DON that family member needed a return call to answer questions that the Administrator was unable to answer. After morning meeting on January 11, 2021 UM (unit manager) 2 showed DON a picture of resident's wound, wound had greatly deteriorated over the weekend. DON and wound care nurse contacted provider (Name of NP) informing her of the wounds deterioration and appearance. NP agreed that this wound if most likely a Kennedy Ulcer. DON and Wound Care nurse contacted resident's sister to answer any questions...Don informed RP that wound was large and had deteriorated from the weekend due to resident not eating or drinking. Overall condition was reviewed with RP. RP wished resident to remain a Full Code so the decision was made to send resident to the ED for evaluation and treatment." There was no evidence that RN #5, the nurse in	F 686		

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question in the above timeline was interviewed regarding when Resident #1's wound was reported to her.

Review of the follow up to the FRI dated 1/20/21, documented in part, the following: "Findings: Facility identified a sacral ulcer on 1.8.21 and notified the responsible party and the health care provider. Treatment orders were initiated. Wound declined over a weekend. Upon notification of responsible party and medical; provider of the decline, a decision was made to transfer the resident to the hospital for further evaluation."

On 5/26/21 at 11:00 a.m., an interview was conducted with OSM (Other Staff Member) #5, the Regional Dietician. When asked if a weight loss of 3.2 percent in one month would trigger her to add more dietary interventions to prevent the development of a pressure ulcer, OSM #5 stated that a weight loss of 3.2 percent would not be considered significant or proactive and that she would just have staff continue with the current plan of care. OSM #5 stated that at the most, she would have staff maybe go over food preferences or get foods that the resident would be more willing to eat. OSM #5 stated that Resident #1 always had a varied po intake. OSM #5 confirmed that from 12/22/21 through 1/26/21, Resident #1 had lost 3.2 percent. OSM #5 confirmed that this weight loss was not significant or even enough for her to do any proactive interventions at that time.

On 5/26/21 at 11:07 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, the former wound care nurse back in January of 2021. When asked what she could remember about Resident #1's wound, LPN #1 stated, "I came into work on the 8th and was told to look at

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her." When asked who found the wound before her, LPN #1 stated, "I am not exactly sure. A 7 p.m. to 7 a.m. shift nurse." LPN #1 stated that the 7 a to 7 p.m. shift nurse called and obtained a treatment and that the treatment was slightly changed to santyl ointment after she and the DON (Director of Nursing) had looked at the wound. When asked what she saw upon her assessment, LPN #1 stated that she she observed a large unstageable sacral ulcer with necrotic blackish tissue. LPN #1 stated that there was quite a bit of drainage coming from it. When asked if it was likely that Resident #1's wound would have been first identified as a large unstageable ulcer, LPN #1 stated , "I would have thought something, some skin area would have been there previously." LPN #1 confirmed that she would expect to see a less advanced wound present first. LPN #1 stated that there was no odorous drainage at that time and that the physician didn't feel like an antibiotic was warranted at that time. When asked about Resident #1's appetite, LPN #1 stated that Resident #1 always had issues with eating, that she would go through periods of not opening her mouth for staff. LPN #1 stated that it would take Resident #1 some time to eat and that at times, she would get pulled to the floor to assist Resident #1 with eating.

On 5/26/21 at 11:21 a.m., an interview was attempted with the 7 p to 7 a nurse who documented the initial note on Resident #1's wound. She could not be reached for an interview.

On 5/26/21 at 11:37 a.m., 12:30 p.m. and on 5/27/21 at 11:00 a.m. several attempts were made to get in touch with the nursing aide (CNA

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#4) the aide who had saw an area to Resident #1's bottom prior to 1/8/21. She could not be reached for an interview.

On 5/26/21 at 11:42 a.m., further interview was conducted with OSM #5, the Regional Dietician. OSM #5 stated that the resident being incontinent of bowel as well as having a low albumin and prealbumin could have also contributed to Resident #1's pressure. When asked if she had all those risk factors last year in 2020 with no skin areas, OSM #5 confirmed that she did not have any skin issues last year. OSM #5 then stated that she heard the wound was a Kennedy Ulcer. When asked OSM #5 the definition of a Kennedy Ulcer, OSM #5 stated that to her understanding its a wound with a very rapid onset, usually towards the end of life, but not always.

On 5/26/21 at 12:12 p.m., an interview was conducted with RN (Registered Nurse) #5, the RN identified in the above FRI. RN #5 stated that she could not give any information because she could not recall Resident #1 or any resident with a large wound. When asked the process if a nursing aides reports a wound, RN #5 stated that she would go assess the wound, clean it, dress it and call the MD (Medical doctor) immediately.

On 5/26/21 at 1:00 p.m., an interview was conducted with ASM (Administrative Staff Member) #5, the wound care physician. When asked what she could recall about Resident #1's wound, ASM #5 stated, "After it was found, it was apparently bad." When asked if it was possible for a resident to develop an unstageable wound within a few hours at a size of 6.5 x 16 cm; ASM #5 stated , 'I'll I can tell you is look at her documentation and hopefully there was an area

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prior to. And the state that it was in upon admission into the hospital, it didn't just appear one day." ASM #5 stated that there is an ulcer that can appear like that if a Resident is terminal or has been receiving end of life care but that "right now she is 90 pounds and her wound is clean and healing." ASM #5 stated that Kennedy Ulcers were ulcers that occurred in residents nearing end of life. ASM #5 stated that Kennedy ulcers do not occur in any other circumstance. ASM #5 stated that in her career as a wound care nurse, she has only seen one true Kennedy Ulcer and the resident had passed a few days later. ASM #5 stated that pressure wounds can look like Kennedy Ulcers and take on the "Butterfly shape" similar to a Kennedy Ulcer. ASM #5 stated that even if a resident is elderly and frail, most wounds can be turned around. When asked if a COVID prognosis could cause a rapid onset of a wound, ASM #5 stated that she really can't say that COVID causes skin breakdown. ASM #5 that however during pandemic times, it maybe hard to have enough staff to turn and reposition a resident like they should be etc. ASM #5 stated that when she first saw Resident #5's wound back in January of 2021, Resident #5 was not emaciated and cachetic like she is now, and her wound is still healing regardless of her nutritional status. ASM #5 stated that Resident #5 was scheduled to have a peg tube placed soon.

On 5/26/21 at 2:09 p.m., an interview was conducted with CNA (Certified Nursing Assistant) #5, an aide who had worked with Resident #1 frequently during the first week of January. CNA #5 stated that she had seen Resident #1's wound when it was reddened skin and prior to it opening up. CNA #5 stated that when she first saw the wound, there was no dressing to the area. CNA

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F 686	Continued From page 34 #5 stated that she was working the day shift but could not recall the date she first saw this wound or what nurse she had told. CNA #5 stated that there was a lot of agency staff on the COVID hall. CNA #5 stated that when she first saw the wound, it looked like it "was about to open up." This writer read CNA #5's witness statement about how she documented on Resident #1's wound. When asked where this documentation could be located, CNA #5 stated that she had charted on the wound after the resident had returned from the hospital. CNA #5 stated that in the first week of January; the COVID hall was limited to the 600 hall only. CNA #5 stated that she did not have access to a Kiosk or the computers at the nurses station. CNA #5 stated that she was not given any options on alternative ways to chart care rendered. CNA #5 stated that they did not have paper back on the 600 hall either. CNA #5 stated the only computer available was the nurses laptop on her medication cart. CNA #5 stated that the nurse was always so busy passing medications that the aides could not access her computer. When asked about Resident #1's appetite, CNA #5 stated that it was not good, that Resident #1 mostly consumed about 25 percent each meal. CNA #5 stated that on a good day, Resident #1 would consume approximately 75 percent but that some days, she would not open her mouth at all. CNA #5 stated that she had received in report that Resident #1 would go through periods of not eating and varied po intake. When asked if there was enough staff to assist Resident #1 with her meals, CNA #5 stated that there was. When asked why almost the entire month of January was blank for meal intake, CNA #5 stated that again, was due to not having access to computers to chart, but that the resident was always assisted with her meals.	F 686		

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F 686	Continued From page 35 On 5/26/21 at 3:07 p.m., an interview was conducted with OSM #7, the former DON (Director of Nursing). When asked how she determined RN #5 was the nurse who failed to follow up on the CNAs report about Resident #1's scaral ulcer per above timeline, OSM #7 stated that that the CNA (CNA #4) specifically said it was RN #5. When asked if RN #5 was asked to provide a statement at the time of the investigation, as this writer did not see one, RN #5 stated that she could not recall. When asked how she was made aware about Resident #1's wound, RN #5 stated that the nurse on the previous shift had alerted her and the wound care nurse. When asked how the wound appeared during her observation, RN #5 stated that the wound was an unstageable at the time. RN #5 denied infection. When asked if the investigation ever determined that the nurse did in fact failed to follow up on a skin area prior to it becoming an advanced stage, RN #5 stated that she couldn't determine. RN #5 then stated, "I left shortly after, in the middle of the investigation. I don't recall the details." RN #5 clarified and stated that she resigned from her position as DON at the facility in the middle of the investigation. When asked if she expected staff to alert the nurse on duty of a new skin alteration, RN #5 stated that she expected staff to alert the assigned nurse. RN #5 then stated that she would expect the nurse to assess the area, notify the medical doctor and then put a treatment into place. RN #5 stated if the assigned nurse was not a Registered Nurse, she would expect the LPN to make a clear description of what was found so that her and the wound care nurse could go behind stage the wound. When asked about Resident #1's appetite, RN #5 stated that her appetite had been	F 686		

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poor and been poor for awhile; even prior to COVID. RN #5 stated that she always had varied by mouth intake. RN #5 recalled Resident #1 having IV fluids in place prior to hospitalization but could not recall for how long or when the fluids started. RN #5 stated that the physician was well aware of her poor appetite. When asked if she expected staff to document after assisting Resident #1 with her meals, RN #5 stated that she did. When asked if in the beginning of January, when the COVID unit was limited to the 600 hall only, how CNAs were able to document, RN #5 stated that there was kiosk on the 600 hallway for staff to document.

On 5/27/21 at approximately 10:00 a.m., ASM#1, the facility Administrator, ASM #2, the DON (Director of Nursing), and ASM #3 the Regional Director of Clinical Services were made aware of the concern for harm related to finding Resident #1's wound at an advanced stage.

Facility policy titled, "Wound Documentation Policy" documents, in part, the following: "Timely Reporting and Documentation: New Wounds/Skin areas identified by the C.N.A are to be reported immediately to charge nurse/wound or treatment nurse/floor nurse/or nurse supervisor."

Review of a QAPI (Quality Assurance and Performance Improvement)Action Plan dated 1/15/21 documented the following: "Issue/Concern: Increase in the number of facility acquired wounds, Questionable accuracy of staging and etiology. Goals/Objectives/Expected Outcomes- Decrease in occurrence of avoidable wounds, Early Identification, and increase in compliance with wound process once identified.

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F 686	Continued From page 37 1/15/21 Root Cause- education, compliance with weekly skin checks and wound process, inconsistent staffing. All residents are at risk...complete house wide skin sweep...Projected Completion Date: 1/15/21. Validation sweep to be performed by support team...Projected completion Date: 1/16/21. Staff education covering prevention and treatment of pressure ulcer, Interact stop and watch, resident bath/showering/scheduling policy, bath and shower sheets and wound documentation policy. Projected Completion Date: 1/18/21 and ongoing. 1/18/21 complete. Develop wound tracking log for use by Wound Care nurse or designee. Projected Completion Date: 1/15/20 (sic) Rehab to evaluate/screen residents with current wounds for positioning or support surface recommendations. POC will be updated as needed. Projected Completion Date: 1/20/21. Completed. RD (Registered Dietician) will re-assess residents with current wounds for evaluation of nutritional needs/status. Update plan of care as needed...RD assessed residents with pressure ulcers on 1/18/21 and recommendations updated as needed. Audit/Validate preventative ointments and cleanser available in resident rooms for incontinent residents. 1/18/21 completed. Discuss with medical doctor or (Name) wound doctor initiating weekly wound rounds...Spoke to (Name of physician) on 1/16 and 1/18 regarding treatment order changes. (Name) wound MD to assess residents with wounds on 1/19/21 and then weekly. Rehab audit all w/c (wheelchairs) to validate w/c cushions in place and in use. Projected completion date: 1/18/21 Completed.	F 686		

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F 686	Continued From page 38 Skin sheets will be reviewed during the clinical meeting to ensure timely completion...Projected Completion Date: 1/18/21 and ongoing. Treatment nurse will validate 10 skin checks per week for 4 weeks then random validation weekly...1/18/21 and ongoing. Administration was able to provide evidence on 1/16/21 and 1/18/21 that nursing staff, including CNAs were educated on Prevention of Pressure Ulcers, wound documentation, resident bathing, showering, scheduling, stop and watch, and skin checks. Administration also provided evidence that the wound care nurse was provided education on 1/22/21 regarding monitoring of UDA's, completing /monitoring of missed assessments, wound tools completed timely, weekly wound log, skin sheets will be reviewed during clinical meeting to ensure timely completion, and that the treatment nurse will validate ID skin checks per week x 4 weeks, then random weekly. The facility staff could not provide anything additional related to the 1/15/21 QAPI plan. Further review of the QAPI plan revealed further concerns related to pressure ulcers on 4/23/21. The following was documented: 4/23/21- Failure to obtain treatment orders for patients admitted with wounds. Root Cause- Lack of adequate backup plan when wound nurse was removed from position; failure to transcribe measurements on paper to EMR (electronic medical record). Initiate appropriate treatment and ancillary orders. Projected completion date: 4.23.21 Complete house wide skin sweep. Projected completion date: 4/26/21. Validation skin sweep to be performed by support team. Braden scale completed on residents with	F 686		

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F 686	Continued From page 39 pressure ulcer and care plans reviewed. 4/22/21 RDCS (Regional Director of Clinical Services) validated 60 percent of residents with wounds for proper staging and treatment order in place. 4/23/21 Initiate Skin Sweep, completion date: 4.26.21. 3/4/21 reeducation on prevention, accuracy of skin checks, positioning devices and reporting. Wound assessments that are on paper documents will be entered into EMR system and paper documents will be maintained in binder as reference. Projected Completion Date: 4/30/21. Develop wound tracking log for use by wound nurse or designee...updated 4/23/21. RD will re-assess residents with current wounds for evaluation of nutritional needs/status/ Update care plan as needed. 4/23/21 Send wound logs to RD weekly. Rehab audit all w/c (wheelchairs) to validate w/c cushions in place and in use- 4/23/21 new w/c cushion audit. 4/23/21 APM (Alternating Pressure Mattress) completed 4/28/21. The facility was able to provide evidence of all rehab aduits conducted on 4/27/21 as well as APM mattress audits dated 4/27/21. The facility also provided skin checks dated 4/26/21 through 4/27/21. Further review of the QAPI revealed that on 5/3/21 5 (five) new skin areas were identified on one current resident in the facility. Some of these areas were first identified at an advanced stage. The following was documented: "Concern/issue/focus area/problem: 5 new skin areas observed on 5.3.21 (Left heel X 2 unstageable, stage 2 right knee X 2 and stage 2 right buttock. Root cause Analysis: Resident has had a decline	F 686		

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F 686	Continued From page 40 in ADL (Activities of daily living) function since fall with hip fracture on 4/9/21. Poor communication regarding more assistance with turning and positioning and ADLS. Goals and Objectives Nurses will give a brief report to CNAs at start of shift. Daily communication/capturing of any new skin areas at any early stage utilizing bathing sheets and STOP and WATCHES. Action Items: Skin sweep on current residents. Start date: 5/4/21. Estimated Completion Date: 5/5/21. Braden Scores reviewed and residents with moderate to high risk reviewed to ensure preventative interventions in place. Start Date: 5/5/21. Estimated Completion Date: 5/5/21. Actual Completion Date: 5/5/21. Licensed nurses educated on completion of skin assessments per UDA schedule, reviewing completed bath sheets daily and on the process of completing incident sheets. (No date) was documented for completion date. When a skin concern is identified, notification of MD and RP and obtaining treatment order. Education to give a brief report to CNAs at the start of shift. (No date) was documented for a completion date. UDAs will be reviewed during the clinical meeting for completion. UM (Unit manager/designee) will assigned 5 X weekly audit of skin checks, shower sheets and review of any new skin concerns. (No Date) was documented for a completion or projected completion date. Wound nurse /designee and back up will complete VOHRA Wound CEUS (continuing education credits). Projected Completion Date: 6/22/21. New admissions will be audited for wound and skin care needs and validation of proper	F 686		

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F 686	Continued From page 41 documentation and treatment and orders discussed daily in stand down meetings x 8 weeks. Results will be reviewed by QAPI monthly. Projected Completion date: 6/18/21. Will audit 5 residents per week to validate weekly wound assessments are accurate and documented on EMR. Projected Completion date: 6/18/21. No further information was presented prior to exit. COMPLAINT DEFICIENCY *Pressure Injury (ulcer): A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. https://npuap.org/page/PressureInjuryStages. (1) Unstageable Pressure Ulcer- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description:Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry,	F 686		

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adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed. This information was obtainted from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

(2) Dakin's Solution® Quarter Strength is a broad-spectrum antimicrobial cleanser that is gentle to the skin. Effective against MRSA, VRE, other bacteria, viruses, molds, fungi and yeast. Also used for odor control. For external use only. This information was obtained from https://www.woundsource.com/product/dakins-solution-quarter-strength.

(3) *SANTYL® Ointment is an FDA-approved active enzymatic therapy that continuously removes necrotic tissue from wounds at the microscopic level. This works to free the wound bed of microscopic cellular debris, allowing granulation to proceed and epithelialization to occur. (<http://www.santyl.com/about>)

(4) The Kennedy Terminal Ulcer (KTU) is an unavoidable skin breakdown or skin failure that occurs as part of the dying process. Research is limited but the literature suggests that KTUs are typically pear-shaped, red/yellow/black, similar in appearance to an abrasion, and tend to occur suddenly in the sacral/coccygeal region not long before death. This information was obtained from The National Institutes of Health. https://pubmed.ncbi.nlm.nih.gov/19797802/.

(5) Stage IV Pressure Ulcer-Stage: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and

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F 686	Continued From page 43 tunneling. Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. This information was obtainted from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. (6) Diverting Colostomy-A colostomy is a surgical procedure that brings one end of the large intestine out through the abdominal wall. During this procedure, one end of the colon is diverted through an incision in the abdominal wall to create a stoma. A stoma is the opening in the skin where a pouch for collecting feces is attached. This information was obtained from https://www.healthline.com/health/colostomy#:~:text=A%20colostomy%20is%20a%20surgical,for%20collecting%20feces%20is%20attached. (7) Albumin is the most abundant circulating protein found in (blood) plasma. It represents half of the total protein content (3.5 g (grams)/dL (deciliter) to 5 g/dL) of plasma in healthy human patients. This information was obtained from The National Institutes of Health. https://pubmed.ncbi.nlm.nih.gov/29083605/. (8) A wound vacuum (Wound Vacuum Assisted Closure) is a device that assists in wound closure by applying localized negative pressure to draw the edges of the wound together....accelerates wound healing...."This information was obtained from Fundamentals of Nursing 6th Edition, Potter	F 686		

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F 686	Continued From page 44 & Perry, 2005. Page 1536.	F 686		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842	F842 Resident Records Faclity staff failed to maintain a complete and accurate clinical record for 2 residents 1. Resident #1 continues to reside at the facility. Resident #4 no longer resides at the facility. Facility staff are documenting complete and accurate intake in the medical record. 2. Residents who reside at the facility have the potential to be affected. D.O.N. has reviewed the last 72 hours of intake documentation to determine if others have been affected by by deficient practice. 3. Staff have been educated on ADL documentation policy. Licensed nurses have been educated on validating ADL documentation completion prior to end of shift. 4. The facility D.O.N. or designee will audit 10 records per week to validate completed and accurate intake documentation in medical record. Findings of these will be submitted to the QAPI committee for 3 months for review and recommendations. 5. Date of compliance 6/24/2021	6/24/2021

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F 842	Continued From page 45 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation, it was determined that facility staff failed to maintain a complete and accurate clinical record for two of four sampled residents, Resident #1 and #4. The findings included:	F 842		

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Resident #1 was admitted to the facility on 3/2/16 and readmitted on 1/15/21 with diagnoses that included but were not limited to COVID-19, muscle weakness, and type two diabetes mellitus. Resident #1's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/11/21. Resident #1 was coded as being severely impaired in cognitive function scoring 03 on the Staff Interview for Mental Status exam. Resident #1 was coded as requiring extensive assistance from one staff member with eating.

Review of Resident #1's December and January Meal Intake Reports dated 12/30/20 through 1/11/21 revealed multiple holes or blanks documenting meal percentages consumed. There was no documentation or evidence that Breakfast and Lunch were given to Resident #1 from 1/2/21 through 1/11/21.

Review of Resident #1's last documented weight before obtaining the wound was on 12/22/20 that documented a weight of "119 pounds." Resident #1's weight on 1/26/21 was documented as "115.2." (3.2 percent weight loss x 1 month which does not indicate significant weight loss).

On 5/26/21 at 2:09 p.m., an interview was conducted with CNA (Certified Nursing Assistant) #5, an aide who had worked with Resident #1 frequently during the first week of January. When asked why almost the entire month of January was blank for meal intake, CNA #5 stated CNA #5 stated that in the first week of January; the COVID hall was limited to the 600 hall only. CNA #5 stated that she did not have access to a Kiosk or the computers at the nurses station. CNA #5

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stated that she was not given any options on alternative ways to chart care rendered. CNA #5 stated that they did not have paper back on the 600 hall either. CNA #5 stated the only computer available was the nurses laptop on her medication cart. CNA #5 stated that the nurse was always so busy passing medications that the aides could not access her computer. When asked about Resident #1's appetite, CNA #5 stated that it was not good, that Resident #1 mostly consumed about 25 percent each meal. CNA #5 stated that on a good day, Resident #1 would consume approximately 75 percent but that some days, she would not open her mouth at all. CNA #5 stated that she had received in report that Resident #1 would go through periods of not eating and varied po intake but that the resident was always assisted with her meals.

On 5/26/21 at 12:30 p.m., an interview was conducted with CNA #6, another nursing aide who worked on the COVID hall back in January of 2021. CNA #6 stated that she did not have Resident #1 until after the resident had been admitted back to the facility from the hospital. CNA #6 stated that she knew Resident #1 was not eating much when she arrived back from the hospital and that she was total assist with meals. When asked if staff should document after they assist a resident with eating; CNA #6 stated that intakes should be documented as well as refusals. CNA #6 stated that she usually alerts the nurse if a resident only consumes about 25 percent or refuses. When asked what blanks meant on the intake report, CNA #6 stated that blanks meant that the nursing aides "Neglected to document." CNA #6 stated that sometimes however, it was hard to chart because being agency, she did not always receive log in

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information to access the computer system. CNA #6 stated that nurses or other aides would offer for her to chart under their username and that she did not feel comfortable with that. CNA #6 stated that on the COVID hall during the beginning of January, a lot of agency nurses worked the floor. CNA #6 stated that she was always told to back chart another day. CNA #6 stated, "I did what I could do."

On 5/26/21 at 3:07 p.m., an interview was conducted with OSM (Other Staff Member) #7, the former DON (Director of Nursing). When asked if she expected staff to document after assisting Resident #1 with her meals, RN #5 stated that she did. When asked if in the beginning of January, when the COVID unit was limited to the 600 hall only, how CNAs were able to document, RN #5 stated that there was kiosk on the 600 hallway for staff to document.

On 5/26/21 at 4:09 p.m., an interview was conducted with OSM #3, the Director of Maintenance. OSM #3 stated that end of December and early January the COVID wall was indeed the 600 hallway only. OSM #3 stated that the staff should have had access to a Kiosk on the hallway as well as the nurse had her own lap top on her medication cart.

On 5/27/21 at approximately 10:00 a.m., ASM#1, the facility Administrator, ASM #2, the DON (Director of Nursing), and ASM #3 the Regional Director of Clinical Services were made aware of the above concerns. ASM #1 had stated that staff had access to a Kiosk on the hallway to document. When asked if she expected staff to document care rendered, ASM #2 stated, "Yes."

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	495253	A. BUILDING _____ B. WING _____	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NORFOLK	1401 HALSTEAD AVENUE REVISED NORFOLK, VA 23502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 49 Facility policy titled, "ADL (Activities of Daily Living) documentation Policy" documented in part, the following: "In facilities where an electronic health record is utilized, ADLs (Activities of Daily Living) will be documented with the POC (Point of Care) module of the record. In facilities still using paper records, ADLs will be documented in the ADL flow record: ...Actual meal consumption will be documented." COMPLAINT DEFICIENCY 2. Resident #4 was admitted to the facility on 05/21/2019. Resident #4 was discharged to the hospital on 01/01/2021. Diagnosis included but were not limited to, Unspecified Hydronephrosis and Diabetes Mellitus. Resident #4's Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 01/01/2021 coded Resident #4 with no short-term memory problems, no long-term memory problems and with modified independent cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #4 as activity occurred only once or twice with assistance of 1 for eating, activity occurred only once or twice with assistance of 2 with personal hygiene and walking in room, limited assistance of 1 with bed mobility, transfer and toilet use and physical help in part of bathing of 1. On 05/26/2021 at approximately 4:00 p.m., requested Resident #4's ADL (Activities of Daily	F 842		

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F 842	Continued From page 50 Living) Log with meal consumption percentages for the month of December 2021 and received. Review of ADL Log revealed no documentation of meal consumption percentages after 12/24/2020 except for 12/25/2020 and 12/26/2020 at Dinner time. On 05/26/2021 at approximately 4:45 p.m., an interview was conducted with Certified Nursing Assistant (CNA) #7. When asked do you document resident meal consumption percentages, CNA #7 stated, "Yes." When asked where do you document, CNA #7 stated, "Use the computer at the nurse's station." When asked do you have access to kiosk on the wall, CNA #7 stated, "Yes suppose to use computer on the wall but usually use computer at the nurse's station." When asked have you always had access to document resident meal consumption percentages, CNA #7 stated, "Yes." Reviewed Resident #4's CNA ADL Log with CNA #7 regarding meal percentages and the blank spaces on the log. Reviewed with CNA #7 that Administrative Staff Member (ASM) #2 stated that she was assigned to provide care for Resident #4 on 12/27/2020 on the 3-11 shift. When asked why is the space on 12/27/2020 blank, CNA #7 stated, "I guess I didn't document." CNA #7 stated, "I don't know why I didn't document." CNA #7 asked, "Can I ask my lead CNA and try to find out why?" Surveyor stated, "Yes." Accompanied CNA #7 to 600 Hall. Surveyor observed one kiosk on the 600 Hall located between the double doors leading into the 600 Hall and the plastic barrier drape. The kiosk is located outside the plastic barrier drape. CNA #7 stated, "When the 600 Hall had positive COVID residents the staff entered and exited through the Exit Door at the end of the 600 Hall	F 842		

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F 842	Continued From page 51	F 842		

and could not go past the plastic barrier drape that divided the COVID section from the rest of the unit and the staff could not use the kiosk because it was outside of the plastic barrier." When asked where did you document the care provided to residents and the meal percentages, CNA #7 stated, "I don't know." 12/27/2020, the 600 Hall was the COVID Unit and Resident #4 was positive for COVID.

An interview was conducted with CNA # 5 on 05/26/2021 at 5:10 p.m. When asked how was Resident #4's appetitte when he was on the COVID Unit, CNA #5 stated, "When he was first admitted to the COVID Unit he was ok then he started to decline rapidly. I use to ask him can you drink this water or tea. He became dehydrated." When asked did he eat for you, CNA #5 stated, "At first he did and then it got less and less." Review of schedule revealed that CNA #5 was Resident #4's CNA on 12/26, 12/27 and 12/30/2020 on the 7-3 shift. Review of CNA ADL Log revealed that spaces on 12/26, 12/27 and 12/30 were blank. When asked did you document how much he ate, CNA #5 stated, "No did not document but informed the nurses what was going on with him." When asked why didn't you document the percentages of the meals eaten, CNA #5 stated, "Computer wasn't available to you on that side on the COVID Unit."

On 05/27/2021 at 1:45 p.m., during briefing the above was reviewed with the Administrator, Director of Nursing and Regional Nurse. The Administrator stated, "They had access to the kiosk, laptop computer and the 2 computers the nurse's had access to." Surveyor responded, "Yes but the staff did not document." When asked what are your expectations of nursing,

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F 842	Continued From page 52 Administrator stated, "My expectations are to follow the policy." The Administrator, Director of Nursing and Regional Nurse was informed of the finding at the pre-exit meeting on 05/27/2021 at 4:15 p.m. The facility did not present any further information about the finding.	F 842		