| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| CHOICE HEALTHCARE AT ROANOKE | 324 KING GEORGE AVE SW ROANOKE, VA 24016 |

| (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 |
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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 2/8/22 through 2/11/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced COVID-19 Focused Infection Control Survey and complaint survey was conducted on 2/8/2022 through 2/11/2022. Three complaints were investigated during the survey: VA00054175, VA00054265, and VA00054266 were all substantiated. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.<br><br>On 2/8/2022, the census in this 130 certified bed facility was 57. The survey sample consisted of 15 current residents and 1 closed record review.<br><br>Of the 57 current residents, no residents had tested positive for the COVID-19 virus and no test results were pending. | F 000 | | |
| F 567 SS=E | Protection/Management of Personal Funds<br>CFR(s): 483.10(f)(10(i)(ii)<br><br>§483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.<br>(i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, | F 567 | | |

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

Lynne Scott administrator 3-29-22 | 03/21/2022

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

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| F 567 | Continued From page 1<br>and account for the personal funds of the resident deposited with the facility, as specified in this section.<br>(ii) Deposit of Funds.<br>(A) In general: Except as set out in paragraph (f)( l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.<br>(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, resident representative review, and in the course of a complaint investigation, the facility staff failed to allow 4 of 15 residents to manage their personal funds, Resident #11, #3, #2, and #16. For Resident's #11, #3, #2, and #16 the facility staff failed to disperse the requested funds for the residents' pre-arranged funeral expenses.<br><br>The findings included: | F 567 | F567<br>1. Resident # 11, 3, 2, 16 funds released. RP notified.<br>2. Facility audit of residents accounts.<br>3. Business office manager educated on polices regarding resident rights to manage his or her financial affairs to include the right to know, in advance, what charges a facility may impose against a resident's personal funds<br>4. Administrator/ or designee will audit 4 random resident accounting records twice weekly for six weeks. Audits and audit findings will be reported to the facility QAPI Committee to review the need for continued intervention or amendment of the plan.<br>5. Allegation of compliance set for 03.28.22 | |

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1. Resident #11's face sheet listed diagnoses which included but not limited to epilepsy, Down syndrome, respiratory failure, hypothyroidism, adult failure to thrive, and pneumonia.

Section C, cognitive patterns, of Resident #11's most recent comprehensive (significant change) MDS (minimum data set) with an ARD (assessment reference date) of 12/07/21 coded the resident as having both long and short term memory problems and severely impaired cognitive skills for daily decision making. Resident #11's clinical record also contained a "death in facility" MDS, with an ARD of 12/13/21.

Resident #11's RP (responsible party) was interviewed on 02/08/22 at 1:30 pm via telephone. The RP stated they had received a notice in July 2021 from the facility BOM (business office manager) that the resident had too much money in their account and it needed to be spent down. The RP stated they then went and made funeral arrangements to spend the money under the allowed amount. The RP stated that when Resident #11 passed in December 2021, they went to funeral home to finalize the arrangements, and was told the funeral home had never received payment from the facility. The RP stated they spoke with the BOM in person on December 21, and was told the facility was short-staffed, there was no one to sign the check, and that the person who signs the checks was in another state.

The RP stated they called the funeral home on January 24, 2022 and was told the funeral home had invoiced the facility twice, but had still not received payment. The RP stated they called the

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facility to speak with the BOM on January 24, 2022, but BOM never returned their call. The RP stated they also called the facility on January 31, 2022 to speak with the administrator, and was told administrator was in a meeting, and never returned the call.

The funeral home director was interviewed via telephone on 02/08/22 at 4 pm. The funeral director stated Resident #11's RP initially came in July 2021 to make arrangements. The funeral director stated they sent an invoice to the facility in July, but did not receive payment. When Resident #11 passed, the RP came in to finalize arrangements and again advised to send the invoice to the facility. At the time of the interview, the funeral home had still not received payment from the facility.

The BOM was interviewed on 02/09/22 at 2:30 pm. The BOM provided a copy of the invoice from the funeral home dated 07/29/21, in the amount of $2140.28. The BOM was asked why the funeral home invoice had not been paid. The BOM stated, "I had an assistant BOM at the time the invoice came in, and they got it. They only worked about another week or so after that. When I was cleaning out their desk, I found the invoice. I knew Resident #11 was not deceased, so I laid it aside with my files." The BOM was asked if they had the ability to pay the invoice at that time and they stated that they did, but had not had the ability since "around the middle of August" until present.

The concern of not paying for the resident's pre-planned funeral was discussed with the administrative team (administrator, director of nursing, assistant director of nursing, regional

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nurse consultant) on 02/11/22 at 11:55 am.

No further information was provided prior to exit.

This is a complaint deficiency.
2. Resident #3's diagnosis list indicated diagnoses, which included, but not limited to Chronic Obstructive Pulmonary Disease, Acute Combined Congestive Heart Failure, Paranoid Schizophrenia, End Stage Renal Disease, Essential Hypertension, Dependence on Renal Dialysis, and Hypo-osmolality and Hyponatremia.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 2/05/22 assigned the resident a BIMS (brief interview for mental status) summary score of 15 out of 15, indicating the resident was cognitively intact.

On 2/11/22, Resident #3's funds statement provided by the facility BOM (business office manager) was reviewed and indicated the resident's balance on 2/03/22 was $4,497.73.

On 2/11/22 at 9:51 am, Resident #3's parent was interviewed and asked if they were notified of the resident's funds exceeding the limit. Resident #3's parent stated they were notified and made arrangements for pre-burial expenses and the facility was supposed to pay the funeral home. Resident #3's parent stated they had last spoken with the funeral home two (2) weeks ago and they had not received the payment. Resident #3's parent stated this has been going on for three (3) months and they have called the facility four or five times and was told the facility needs a signature on a check before it can be sent to the funeral home.

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On 2/11/22 at 11:02 am, the facility BOM (business office manager) was interviewed and asked if Resident #3's pre-arranged funeral expenses had been paid from their resident funds account and the BOM stated it had not. The BOM further stated the facility has not had signers on the signature card since mid-November 2022 and they have submitted paperwork to RFMS (Resident Funds Management System) yesterday and are now waiting for the okay that everything was updated. The BOM stated they have been working with the new facility owner and they received new billers last week and they were able to assist the BOM.

A copy of the bill provided by the funeral home evidenced the total funeral expenses were $4600.00. This document was signed by Resident #3's parent but not dated.

On 2/11/22 at 11:55 am, a meeting was held with the administrator, director of nursing, assistant director of nursing, and the regional director of clinical services. The concern of Resident #3's funds not being dispersed to pay for pre-arranged funeral services as requested by the resident was disucssed.

No further information regarding this concern was presented prior to the exit conference on 2/11/22.

3. Resident #2's diagnosis list indicated diagnoses, which included, but not limited to Dementia, Type 2 Diabetes Mellitus, Anxiety Disorder, Unsteadiness on Feet, Peripheral Vascular Disease, Muscle Wasting and Atrophy, Normal Pressure Hydrocephalus, and Essential Hypertension.

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The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/13/22 assigned the resident a BIMS (brief interview for mental status) summary score of 14 out of 15 indicating Resident #2 was cognitively intact.

On 2/11/22, Resident #2's resident funds statement provided by the facility BOM (business office manager) was reviewed and documented the resident's balance on 2/03/22 was $4,595.56.

On 2/11/22 at 10:05 am, Resident #2 was interviewed and asked if they had been notified that their resident funds account was over $2,000 and the resident stated "no ma'am". Resident #2's spouse was present and stated they were notified of needing to do a "spend-down" and spent the money on funeral expenses. Resident #2's spouse stated someone from the funeral home came to the facility "back in the fall" and made the arrangements. Resident #2's spouse was asked if the funeral expenses had been paid, and they stated the facility was supposed to have paid it but they still owe the cemetery additional money.

On 2/11/22 at 10:17 am, the BOM was interviewed and asked if Resident #2's prearranged funeral expenses had been paid out to the funeral home. The BOM stated no, they just received the statement at the end of November or first of December. A copy of the bill provided by the funeral home documented the total funeral expense was $3317.00. This document was signed by Resident #2's spouse but not dated. At 11:06 am, the BOM stated the bill would be paid when the new facility signature

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cards for check signing were updated and the okay was received from RFMS (Resident Funds Management System).

On 2/11/22 at 11:55 am, a meeting was held with the administrator, director of nursing, assistant director of nursing, and the regional director of clinical services. The concern of Resident #2's funds not being dispersed to pay for pre-arranged funeral services as requested by the resident was disucssed.

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22.

4. Resident #16's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus with Diabetic Autonomic Polyneuropathy, Chronic Kidney Disease Stage 4, Major Depressive Disorder, Nontraumatic Subarachnoid Hemorrhage, and Chronic Pain.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/14/22 assigned the resident a BIMS (brief interview for mental status) summary score of 14 out of 15 indicating the resident was cognitively intact.

On 2/11/22, Resident #16's resident funds statement provided by the facility BOM (business office manager) was reviewed and documented the resident's balance on 2/03/22 was $4,904.15.

On 2/11/22 at 10:05 am, Resident #16 was interviewed and asked if they had been notified that their resident funds account was over $2,000. Resident #16 stated they were notified of

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needing to do a "spend-down" and spent the money on funeral expenses. Resident #16 stated someone from the funeral home came to the facility "back in the fall" and made the arrangements. Resident #16 was asked if the funeral expenses had been paid and they stated the facility was supposed to have paid it but they still owe the cemetery additional money.

On 2/11/22 at 10:17 am, the BOM was interviewed and asked if Resident #16's prearranged funeral expenses had been paid out to the funeral home. The BOM stated no, they just received the statement at the end of November or first of December. The bill provided by the funeral home documented the total funeral expense was $3317.00. This document was signed by Resident #16 but not dated. At 11:06 am, the BOM stated the bill would be paid when the new facility signature cards for check signing were updated and the okay was received from RFMS (Resident Funds Management System).

The facility policy entitled "Resident Personal Funds" documented in part, "Policy: The resident has a right to manage his or her financial affairs to include the right to know, in advance, what charges a facility may impose against a resident's personal funds. Policy Explanation and Compliance Guidelines: 2. If the resident chooses to deposit their personal funds with the facility, upon written authorization of a resident, the facility must act as fiduciary of the resident's fund and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility."

On 2/11/22 at 11:55 am, a meeting was held with the administrator, director of nursing, assistant

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| F 567 | Continued From page 9<br>director of nursing, and the regional director of clinical services. The concern of Resident #16's funds not being dispersed to pay for pre-arranged funeral services as requested by the resident was disucssed.<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22. | F 567 | F569<br><br>1. Resident # 11, 4, 7, 8 funds released. RP notified.<br><br>2. Facility audit of residents with Medicaid accounts. | 03.28.2022 |
| F 569 SS=E | Notice and Conveyance of Personal Funds<br>CFR(s): 483.10(f)(10)(iv)(v)<br><br>§483.10(f)(10)(iv) Notice of certain balances.<br>The facility must notify each resident that receives Medicaid benefits-<br>(A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and<br>(B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.<br><br>§483.10(f)(10)(v) Conveyance upon discharge, eviction, or death.<br>Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, resident representative interview, and in | F 569 | 3. Business office manager educated on polices regarding notification of each resident that receives Medicaid benefits:When the amount in the resident's account reaches $200 less than the SSI resource limit for one person and; If the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.<br><br>4. Administrator/ or designee will audit twice weekly for six weeks Medicaid residents account balances. Audits and audit findings will be reported to the facility QAPI Committee to review the need for continued intervention or amendment of the plan.<br><br>5. Allegation of compliance set for 03.28.22 | |

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the course of a complaint investigation, the facility staff failed to provide notice and conveyance of residents personal funds of 4 of 15 residents, Resident #11, Resident #4, Resident #7, and Resident #8.

For Resident #11 the facility staff failed to disperse the resident's funds within 30 days of discharge/death. For Resident's #4, #7 and #8 the facility staff failed to notify the resident and/or resident representative when the residents' accounts were within $200 of the SSI (supplemental security income) resource limit of $2000.00.

The findings included:

1. Resident #11's face sheet listed diagnoses which included but not limited to epilepsy, Down syndrome, respiratory failure, hypothyroidism, adult failure to thrive, and pneumonia.

Section C, cognitive patterns, of Resident #11's most recent comprehensive (significant change) MDS (minimum data set) with an ARD (assessment reference date) of 12/07/21 coded the resident as having both long and short term memory problems and severely impaired cognitive skills for daily decision making. Resident #11's clinical record also contained a "death in facility" MDS, with an ARD of 12/13/21.

Resident #11's RP (responsible party) was in terviewed on 02/08/22 at 1:30 pm via telephone. The RP stated they had received a notice in July 2021 from the facility BOM (business office manager) that Resident #11 had too much money in their account and it needed to be spent down. The RP stated they then went and made funeral

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arrangements to spend the money under the allowed amount. The RP stated that when Resident #11 passed in December 2021, they went to funeral home to finalize the arrangements, and was told the funeral home had never received payment from the facility. The RP stated they spoke with the BOM in person in December 2021, and was told the facility was short-staffed, there was no one to sign the check, and that the person who signs the checks was in another state.

The facility BOM was interviewed on 02/09/22 at 2:00 pm. The BOM was asked what was to be done with resident funds upon their death. The BOM stated they are to be paid out within 30 days. The BOM was asked why Resident #11's funds had not been paid. The BOM stated "We have had a lot of turn-over and have had no one to sign the checks. We have to have 2 people to sign checks."

The BOM was interviewed again on 02/09/22 at 2:30 pm. The BOM provided a copy of Resident #11's quarterly "Resident Fund Management Service" statement, which indicated the resident had an account balance of $4576.55 as of 12/31/21. The BOM stated they have not had the ability to pay out funds "since around the middle of August."

A copy of a facility policy entitled "Resident Personal Funds" documented in part, "Conveyance upon Discharge, Eviction, or Death" 1. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility will convey within 30 days the resident's funds and final account of those funds to the resident, or in the case of death, the

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individual or probate jurisdiction administering the resident's estate, in accordance with State law."

The concern of not dispersing the remainder of the resident's funds within 30 days of their passing was discussed with the administrative team (administrator, director of nursing, assistant director of nursing, regional nurse consultant) on 02/11/22 at 11:55 am. No further information was provided prior to exit.

This is a complaint deficiency.

2. Resident #4's face sheet listed diagnoses which included but not limited to metabolic encephalopathy, dementia, congestive heart failure, cerebral infarction, developmental disorders, convulsions, hypertension, and respiratory failure. The resident's face sheet listed the primary payer as HMO-Managed Medicaid VA.

Section C, cognitive patterns, of Resident #4's quarterly MDS (minimum data set) with an ARD (assessment reference date) of 12/28/22 coded the resident as having both long and short term memory problems and severely impaired cognitive skills for daily decision making.

On 02/09/22, Resident #4's "Fund Management Service" statement was reviewed. This statement indicated that the resident had an account balance of $6694.49 as of 12/31/21. The BOM (business office manager) was interviewed on 02/09/22 at 3:30 pm regarding Resident #4's account balance. The BOM was asked if the resident or their RP (responsible party) had been notified of the resident's account exceeding the resource limit. The BOM stated, "There is no one

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to notify, (Resident #4) only has an emergency contact, and they don't want anything to do with it. We need to apply for a guardian for (Resident #4). The BOM was asked what would happen if the resident's account continued to be over the resource limit, and BOM stated, "They will go private pay until the money is gone, then they will go back to Medicaid."

The concern of not notifying the resident/RP when the resident's account was over the resource limit was discussed with the administrative team (administrator, director of nursing, assistant director of nursing, regional nurse consultant) on 02/11/22 at 11:55 am. No further information was provided prior to exit.

This is a complaint deficiency.
3. Resident #7's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease Affecting Left Non-Dominant Side, Dysphagia, Aphasia, Chronic Viral Hepatitis C, Acute on Chronic Systolic Congestive Heart Failure, Essential Hypertension, Paroxysmal Atrial Fibrillation, Dementia, and Bipolar Disorder. Resident #7's demographic admission record listed the resident's primary payer as Medicaid HMO (health maintenance organization).

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/12/22 assigned the resident a BIMS (brief interview for mental status) summary score of 10 out of 15 indicating Resident #7 was moderately cognitively impaired.

The facility BMO (business office manager)

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provided Resident #7's resident account statement for the time period of 7/01/21 through 2/03/22 entitled, "Resident Statement Landscape". According to the resident statement, Resident #7's account balances for the beginning of each month were documented as: 10/01/21 $3,473.08, 11/01/21 $2,000.12, 12/01/21 $2,040.14, 1/03/22 $3,683.14, and 2/01/22 $2,120.18.

On 2/11/22 at 11:00 a.m., the BMO was interviewed and asked if Resident #7 or the resident's representative were notified of the resident's account being over the resource limit. The BMO stated "I don't think (his/her) family has been." When asked why the notification was not made the BOM stated "I didn't do it."

Concerns were discussed with the administrator, director of nursing, assistant director of nursing, and the regional director of clinical services on 2/11/22 at 11:55 a.m. during a meeting with the survey team.

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22.

4. Resident #8 was admitted to the facility with diagnoses including quadriplegia, tracheostomy, gastrostomy, paranoid schizophrenia, hypertension, cardiopulmonary disease, and type 2 diabetes mellitus with foot ulcers. On the annual minimum data set assessment with assessment reference date 12/16/2021, the resident was assessed with moderate long term memory impairment and moderate impairment of cognitive skills for daily life.

On 2/11/2022, Resident #8's guardian was

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interviewed by phone. The guardian reported not being notified that the resident's personal fund balance exceeded the current limit. The guardian stated that Resident #8 had unpaid bills from prior care providers and that Resident #8 needed a hearing aid. The guardian had been unaware the resident had the funds for the copayment.

A copy of a facility policy entitled "Resident Personal Funds" documented in part, "Notice of Certain Balances 1. The facility must notify each resident that receives Medicaid benefits: a. When the amount in the resident's account reaches $200 less than the SSI (supplemental security income) resource limit for one person and; b. If the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resources limit for one person, the resident may lose eligibility for Medicaid or SSI."

The Business Office Manager (BOM) was interviewed by on 2/11/2021. The BOM was unable to state why the resident representative had not been notified of the excess balance in the account. The BOM did report an inability to disburse funds for resident expenses because no one who worked for the facility was authorized to sign checks from resident accounts.

The above concern was discussed with the administrator, director of nursing, assistant director of nursing, and the regional director of clinical services on 2/11/22 at 11:55 a.m. during a meeting with the survey team.

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22.

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| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(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-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(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);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(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.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). | F 580 | F580<br><br>1. Resident #2 MD notified. No further orders on received. RP notified.<br><br>2. Full facility audit of all falls to ensure MD and RP notification.<br><br>3. All licensed nursing staff reeducated regarding assessing falls and their causes and notification of changes policies by Director of Nursing.<br><br>4. Director of Nursing/ or designee will audit twice weekly for six weeks all falls to ensure immediate MD and RP notification. Audits and audit findings will be reported to the facility QAPI Committee to review the need for continued intervention or amendment of the plan.<br><br>5. Allegation of compliance set for 03.28.2022 | 03.28.2022 |

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§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, clinical record review, and facility document review, the facility staff failed to notify the resident's physician following an accident with injury for 1 of 16 residents in the survey sample, Resident #2. For Resident #2, the facility staff failed to notify the physician following a fall resulting in a cut over the resident's left eye.

The findings included:

Resident #2's diagnosis list indicated diagnoses, which included, but not limited to Dementia, Type 2 Diabetes Mellitus, Unsteadiness on Feet, Peripheral Vascular Disease, Muscle Wasting and Atrophy, Normal Pressure Hydrocephalus, Anxiety Disorder, and Essential Hypertension.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/13/22 assigned the resident a BIMS (brief interview for mental status) summary score of 14 out of 15 indicating Resident #2 was cognitively intact. Resident #2 was coded as requiring supervision only with transfers and walking.

A review of Resident #2's clinical record revealed

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a nursing progress note dated 1/18/22 6:53 a.m. stating in part, "This nurse was called into (sic) residents room due to resident fall. Resident stated (he/she) was walking into the room when (he/she) slipped on the plastic sheeting covering the door. Resident has a small cut over left eye. Resident stated (he/she) did not want to go to the hospital and that (he/she) felt fine."

According to Resident #2's clinical record, they also had a fall on the previous day (1/17/22) in which (he/she) was sent at the ER and an abrasion to the forehead was "glued together". There was no evidence of physician notification following the resident's fall on 1/18/22 located in the clinical record.

Concerns were discussed with the administrator, DON (director of nursing), ADON (assistant director of nursing), and the RDCS (regional director of clinical services) during a meeting on 2/09/22 at 4:21 p.m. and evidence of physician notification of the resident's fall with injury occurring on 1/18/22 was requested.

On 2/10/22 at 3:29 p.m., during a meeting with the administrator, DON, ADON, and the RDCS, the staff advised that the facility did not have any additional information to offer related to the identified concern.

The facility policy entitled "Assessing Falls and Their Causes" stated in part, "When a fall results in a significant injury or condition change, nursing staff will notify the practitioner immediately by phone. When a fall does not result in significant injury or a condition change, nursing staff will notify the practitioner routinely (e.g., by fax or by phone the next office day)."

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| F 580 | Continued From page 19<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22. | F 580 | F584<br><br>1. Resident #6 and #7 tube feeding pumps and poles cleaned, floor mopped, debris removed from floor. Resident #8 tube feeding pump and pole cleaned used incontinence brief removed from room, debris removed from floor and window sill. Resident #9 plastic litter removed from floor, personal items placed in bedside dresser and wardrobe, floor mopped.<br><br>2. Full facility audit to ensure a safe, clean, comfortable, homelike environment for all residents.<br><br>3. All staff reeducated on Routine Cleaning and Disinfection policy to ensure safe, clean, comfortable, and homelike environment.<br><br>4. Administrator/ or designee will audit twice weekly for six week to ensure no litter or debris is present outside of designated disposal containers, tube feeding poles are clean. Audits and audit findings will be reported to the facility QAPI Committee to review the need for continued intervention or amendment of the plan.<br><br>5. Allegation of compliance set for 03.28.2022 | 03.28.2022 |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas; | F 584 | | |

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§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation and in the course of a complaint investigation, facility staff failed to maintain a clean, comfortable homelike environment for 4 of 16 residents in the survey sample, Residents #6, 7, 8, and 9.

Findings include:

1. Resident #8 was admitted to the facility with diagnoses including quadriplegia, tracheostomy, gastrostomy, paranoid schizophrenia, hypertension, cardiopulmonary disease, and type 2 diabetes mellitus with foot ulcers. On the annual minimum data set assessment with assessment reference date 12/16/2021, the resident was assessed with moderate long term memory impairment and moderate impairment of cognitive skills for daily life.

During initial tour on 2/8/2022, observed in Resident #8's room was a used incontinence brief on the room's window sill. On the floor near the head of the bed were plastic wrappers, a pad style call bell, and foam cups. There was light brown dried matter on the tube feeding pole.

On 2/9/2022, the room as observed. The brief had been removed, but the rest remained.

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| F 584 | Continued From page 21<br>The administrator, director of nursing, assistant director of nursing, and the regional director of clinical services were notified of the concerns during an end of day meeting with the survey team.<br><br>2. Resident #9 was admitted to the facility with diagnoses including cerebral infarct, respiratory failure, sepsis, tracheostomy, and hypertension. On the minimum data set assessment with assessment reference date 11/24/21, the resident was assessed as non-verbal and with highly impaired vision, hearing, and cognition.<br><br>During initial tour on 2/8/2022, Resident #9's room was observed. On the floor around the bed was a stuffed animal, a package of wipes, plastic spoons, pieces of clear plastic wrapping, and spots of a dried substance. On 2/9/2022, the room was again observed and the spots and clear plastic litter remained.<br><br>The administrator, director of nursing, assistant director of nursing, and the regional director of clinical services were notified of the concerns during an end of day meeting with the survey team.<br>3. Resident #6's face sheet listed diagnoses which included but not limited to respiratory failure, diabetes mellitus type II, chronic respiratory failure, anemia, pneumonia, tracheostomy status, dysphagia, and hypertension.<br><br>The most recent MDS (minimum data set) with an ARD (assessment reference date) of 01/15/22 assigned the resident a BIMS (brief interview for mental status) score of 1 out 15 in section C, cognitive patterns indicating severe cognitive | F 584 | | |

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impairment.

Resident #6 was observed on 02/08/22 at 12:10 pm. Resident #6 was resting in bed, tube feeding running via pump. Tan-colored dried debris was observed on the top and sides of feeding pump, down the sides of the pump pole, around the base of the feeding pump pole, and on the floor surrounding the feeding pump.

Resident #6 was observed again on 02/09/22 at 8:30 am. Resident #6 was resting in bed, tube feeding running via feeding pump. Dried tan-colored debris on and around the feeding pump, pole, pole base and surrounding floor was again observed.

The above concern was discussed with the administrative team (administrator, director of nursing, assistant director of nursing, regional nurse consultant) during a meeting on 02/09/22 at 4:20 pm. On 02/11/22 the administrator informed the survey team that corporate members of the housekeeping department were on site to evaluate the facility.

No further information was provided prior to exit.

This is a complaint deficiency.
4. Resident #7's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease Affecting Left Non-Dominant Side, Dysphagia, Aphasia, Chronic Viral Hepatitis C, Acute on Chronic Systolic Congestive Heart Failure, Essential Hypertension, Paroxysmal Atrial Fibrillation, Dementia, and Bipolar Disorder.

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| F 584 | Continued From page 23<br>The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/12/22 assigned the resident a BIMS (brief interview for mental status) summary score of 10 out of 15 indicating Resident #7 was moderately cognitively impaired.<br><br>On 2/08/22 at 11:45 a.m., Resident #7 was observed in bed receiving Jevity 1.5 tube feeding formula via pump at 55 ml per hour. The Jevity 1.5 formula was liquid and light brown in color. A dried, light brown substance was observed on the tube feeding pump, down the tube feeding pole, at the base of the pole, on the cushioned fall mat located on the right side of the bed, and on the floor beside and under the bed.<br><br>On 2/09/22 at 8:00 a.m, Resident #7 was observed again. The tube feeding pump, pole fall mat and floor were in the same condition as the day before.<br><br>The administrator, director of nursing, assistant director of nursing, and the regional director of clinical services were notified of the above observations on 2/09/22 at 4:21 p.m. during an end of day meeting with the survey team.<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22. | F 584 | | |
| F 607 SS=D | Develop/Implement Abuse/Neglect Policies<br>CFR(s): 483.12(b)(1)-(3)<br><br>§483.12(b) The facility must develop and implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, | F 607 | | |

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| | 495156 | A. BUILDING _____ B. WING _____ | C 02/11/2022 |

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| CHOICE HEALTHCARE AT ROANOKE | 324 KING GEORGE AVE SW ROANOKE, VA 24016 |

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| F 607 | Continued From page 24<br>neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, facility document review, and during the course of a complaint investigation, the facility staff failed to implement abuse policies and procedures for an injury of unknown origin for 1 of 16 residents in the survey sample, Resident #1.<br><br>For Resident #1, the facility staff failed to follow policies and procedures to investigate and report an incident where Resident #1 was found face down in the floor with injuries.<br><br>The findings included:<br><br>Resident #1's diagnosis list indicated diagnoses, which included, but not limited to Pneumonia due to MRSA (Methicillin Resistant Staphylococcus Aureus), Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure, Anxiety Disorder, Essential Hypertension, Dementia, Muscle Wasting and Atrophy, Dysphagia, and Dependence on Respirator Status.<br><br>The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 12/23/21 assigned the resident a BIMS (brief interview for mental status) summary score of 14 out of 15 indicating the resident was cognitively intact. Resident #1 was coded as requiring | F 607 | 1. In-service Administrator/Director of Nursing on Reporting abuse to State Agencies and Other Entities/ Individuals policy and Abuse Investigation policy.<br><br>2. Facility to perform 100% audit of any reports of abuse.<br><br>3. Corporate Clinical Consultant in-serviced Administrator/ Director of Nursing on Virginia Department of Health Reporting of Incidences and facility policy on Abuse Prohibition.<br><br>4. Administrator/ or designee will audit progress notes twice weekly for six weeks. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.<br><br>5. Allegation of compliance 3/28/22 | 03.28.2022 |

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| F 607 | Continued From page 25 | F 607 | | |

extensive assistance with bed mobility, dressing, toileting, and personal hygiene and being totally dependent on staff for bathing.

A review of Resident #1's clinical record revealed a nursing progress note dated 1/16/22 at 4:14 am, "0400 (4:00 am) - Resident was found face down by the writer after the writer heard the ventilator making a funny beeping sound. Writer assisted by CNA (certified nursing assistant) and RT (respiratory therapist) to turn the rsd (resident) over. Resident was grunting and had several lacerations that were bleeding from (his/her) left eye and left lateral side of face, along with skin tears to right shoulder, right forearm, one on the front of right knee and one on the right lateral knee. After getting the resident [sp] got turned around and back on ventilator. The writer went and called 911, while RT and CNA were in the room with the resident. 0415 (4:15 am) - EMS arrived and was given report from the RT and the writer. Also, writer gave them a transfer sheet with the demographic information of the resident. 0430 (4:30 am) - The resident was stable and was receiving ventilations by ambu bag via trach by paramedic when (he/she) left the facility to go to the ER at (name)."

On 2/09/22 at 10:56 am the DON (director of nursing) was interviewed and stated the nurse and CNA working at the time Resident #1 fell were agency staff who have not returned to the facility since that day. The investigation into the incident was requested and the DON stated there was "no formal work-up for that" and it was the weekend of a snow storm and they were not in the facility at the time of Resident #1 being found in the floor. DON further stated they "didn't directly know" about the incident as they were

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| F 607 | Continued From page 26 | F 607 | | |

helping with resident care during the snow storm.

The DON stated Resident #1 has had episodes of significant panic in the past and did not normally have the strength to move out of bed but may have increased strength during panic attacks.

The DON if a FRI (facility reported incident) report was submitted to the State Agency and DON stated no. When asked the reason for an FRI not being completed, the DON stated there was "no excuse for it" and they felt an FRI should have been done.

The facility policy entitled "Abuse, Neglect and Exploitation" documented in part:

IV. Identification of Abuse, Neglect and Exploitation
B. Possible indicators of abuse include, but are not limited to:
3. Physical injury of a resident, of unknown source

V. Investigation of Alleged Abuse, Neglect and Exploitation
A. An immediate investigation is warranted when suspicion of abuse or exploitation, or reports of abuse, neglect or exploitation occur.
B. Written procedures for investigation include:
1. Identifying staff responsible for the investigation;
2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence);
3. Investigating different types of alleged violations;
4. Identifying and interviewing all involved

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| F 607 | Continued From page 27<br>persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;<br>5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and<br>6. Providing complete and thorough documentation of the investigation.<br><br>VII. Reporting/Response<br>A. The facility will have written procedures that include:<br>1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:<br>a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or<br>b. Not later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury.<br>B. The administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when the final within 5 working days of the incident, as required by state agencies.<br><br>On 2/09/22 at 4:21 during a meeting with the administrator, DON, ADON (assistant DON), and the RDCS (regional director of clinical services), concerns of the facility not reporting and thoroughly investigating the incident of Resident #1 being found in the floor with injuries was discussed. | F 607 | | |

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| F 607 | Continued From page 28<br>No further information regarding this issue was presented to the survey team prior to the exit conference on 2/11/22. | F 607 | F609<br>1. In-service Administrator/Director of Nursing on Reporting abuse to State Agencies and Other Entities/ Individuals policy and Abuse Investigation policy.<br>2. Facility to perform 100% audit of any reports of abuse.<br>3. Corporate Clinical Consultant in-serviced Administrator/ Director of Nursing on Virginia Department of Health Reporting of Incidences and facility policy on Abuse Prohibition.<br>4. Administrator/ or designee will audit progress notes twice weekly for six weeks. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.<br>5. Allegation of compliance 3/28/22 | 03.28.2022 |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, facility document review, and during the course of | F 609 | | |

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| F 609 | Continued From page 29 | F 609 | | |

a complaint investigation, the facility staff failed to ensure an injury of unknown source was reported for 1 of 16 residents in the survey sample, Resident #1.

For Resident #1, the facility staff failed to report an incident where the resident was found face down in the floor with injuries requiring transport to the hospital.

The findings included:

Resident #1's diagnosis list indicated diagnoses, which included, but not limited to Pneumonia due to MRSA (Methicillin Resistant Staphylococcus Aureus), Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure, Anxiety Disorder, Essential Hypertension, Dementia, Muscle Wasting and Atrophy, Dysphagia, and Dependence on Respirator Status.

The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 12/23/21 assigned the resident a BIMS (brief interview for mental status) summary score of 14 out of 15 indicating the resident was cognitively intact. Resident #1 was coded as requiring extensive assistance with bed mobility, dressing, toileting, and personal hygiene and being totally dependent on staff for bathing.

A review of Resident #1's clinical record revealed the following notes:

A nursing progress note dated 1/16/22 1:55 am, "Resident on vent resting in bed with eyes closed. Evening meds by peg and tube feeding tolerated well by the rsd. Call bell within reach. Will continue to monitor and follow POC (plan of

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| F 609 | Continued From page 30 | F 609 | | |

care)."

A nursing progress note dated 1/16/22 at 4:14 am, "0400 (4:00 am) - Resident was found face down by the writer after the writer heard the ventilator making a funny beeping sound. Writer assisted by CNA (certified nursing assistant) and RT (respiratory therapist) to turn the rsd (resident) over. Resident was grunting and had several lacerations that were bleeding from (his/her) left eye and left lateral side of face, along with skin tears to right shoulder, right forearm, one on the front of right knee and one on the right lateral knee. After getting the resident [sp] got turned around and back on ventilator. The writer went and called 911, while RT and CNA were in the room with the resident. 0415 (4:15 am) - EMS arrived and was given report from the RT and the writer. Also, writer gave them a transfer sheet with the demographic information of the resident. 0430 (4:30 am) - The resident was stable and was receiving ventilations by ambu bag via trach by paramedic when (he/she) left the facility to go to the ER at (name)."

On 2/09/22 at 10:56 am the DON (director of nursing) was interviewed and stated the nurse and CNA working at the time Resident #1 fell were agency staff who have not returned to the facility since that day. The investigation into the incident was requested and the DON stated there was "no formal work-up for that" and it was the weekend of a snow storm and they were not in the facility at the time of Resident #1 being found in the floor. DON further stated they "didn't directly know" about the incident as they were helping with resident care during the snow storm.

The DON stated Resident #1 has had episodes

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| F 609 | Continued From page 31 | F 609 | | |

of significant panic in the past and did not normally have the strength to move out of bed but may have increased strength during panic attacks.

The DON if a FRI (facility reported incident) report was submitted to the State Agency and DON stated no. When asked the reason for an FRI not being completed, the DON stated there was "no excuse for it" and they felt an FRI should have been done.

On 2/09/22 at 2:15 pm, RT #1 was interviewed. RT #1 was present when Resident #1 was found in the floor. RT #1 stated they left Resident #1's room following rounds and went up the hall way and then heard the vent disconnection alarm sounding for Resident #1. RT #1 stated they entered Resident #1's room and found (him/her) face down on the floor between the bed and the heater bleeding "pretty bad" from the head. RT #1 stated they held the resident's head still, maintained C-spine precautions, secured the airway and the nurse checked the resident. RT #1 stated the resident had already started swelling. RT #1 stated Resident #1 liked to lean to the side of the bed when laying on their side and would squirm some in the bed. RT #1 stated that when they last saw Resident #1 prior to the incident, the resident was laying "a little" on their side but not teetering on the edge of the bed. RT #1 stated the resident's bed was "pretty low" as they remember stooping over to do trach care.

The facility policy entitled "Abuse, Neglect and Exploitation" documented in part:
IV. Identification of Abuse, Neglect and Exploitation
B. Possible indicators of abuse include, but are

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| F 609 | Continued From page 32<br>not limited to:<br>3. Physical injury of a resident, of unknown source<br>VII. Reporting/Response<br>A. The facility will have written procedures that include:<br>1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:<br>a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or<br>b. Not later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury.<br>B. The administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when the final within 5 working days of the incident, as required by state agencies.<br><br>On 2/09/22 at 4:21 during a meeting with the administrator, DON, ADON (assistant DON), and the RDCS (regional director of clinical services), concerns of the facility not reporting the incident of Resident #1 being found in the floor with injuries was discussed.<br><br>No further information regarding this issue was presented to the survey team prior to the exit conference on 2/11/22. | F 609 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation<br>CFR(s): 483.12(c)(2)-(4) | F 610 | | |

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| F 610 | Continued From page 33<br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, facility document review, and during the course of a complaint investigation, the facility staff failed to ensure an injury of unknown source was investigated for 1 of 16 residents in the survey sample, Resident #1.<br><br>The findings included:<br><br>Resident #1's diagnosis list indicated diagnoses, which included, but not limited to Pneumonia due to MRSA (Methicillin Resistant Staphylococcus Aureus), Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure, Anxiety Disorder, Essential Hypertension, Dementia, Muscle Wasting and Atrophy, Dysphagia, and Dependence on Respirator Status.<br><br>The most recent admission MDS (minimum data | F 610 | F610<br>1. In-service Administrator/Director of Nursing on Reporting abuse to State Agencies and Other Entities/ Individuals policy and Abuse Investigation policy.<br><br>2. Facility to perform 100% audit of any reports of abuse.<br><br>3. Corporate Clinical Consultant in-serviced Administrator/ Director of Nursing on Virginia Department of Health Reporting of Incidences and facility policy on Abuse Prohibition.<br><br>4. Administrator/ or designee will audit progress notes twice weekly for six weeks. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.<br><br>5. Allegation of compliance 3/28/22 | 03.28.2022 |

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| F 610 | Continued From page 34 | F 610 | | |

set) with an ARD (assessment reference date) of 12/23/21 assigned the resident a BIMS (brief interview for mental status) summary score of 14 out of 15 indicating the resident was cognitively intact. Resident #1 was coded as requiring extensive assistance with bed mobility, dressing, toileting, and personal hygiene and being totally dependent on staff for bathing.

A review of Resident #1's clinical record revealed a nursing progress note dated 1/16/22 at 4:14 am, "0400 (4:00 am) - Resident was found face down by the writer after the writer heard the ventilator making a funny beeping sound. Writer assisted by CNA (certified nursing assistant) and RT (respiratory therapist) to turn the rsd (resident) over. Resident was grunting and had several lacerations that were bleeding from (his/her) left eye and left lateral side of face, along with skin tears to right shoulder, right forearm, one on the front of right knee and one on the right lateral knee. After getting the resident [sp] got turned around and back on ventilator. The writer went and called 911, while RT and CNA were in the room with the resident. 0415 (4:15 am) - EMS arrived and was given report from the RT and the writer. Also, writer gave them a transfer sheet with the demographic information of the resident. 0430 (4:30 am) - The resident was stable and was receiving ventilations by ambu bag via trach by paramedic when (he/she) left the facility to go to the ER at (name)."

On 2/09/22 at 10:56 am the DON (director of nursing) was interviewed and stated the nurse and CNA working at the time Resident #1 fell were agency staff who have not returned to the facility since that day. The investigation into the incident was requested and the DON stated

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there was "no formal work-up for that" and it was the weekend of a snow storm and they were not in the facility at the time of Resident #1 being found in the floor. DON further stated they "didn't directly know" about the incident as they were helping with resident care during the snow storm.

The DON stated Resident #1 has had episodes of significant panic in the past and did not normally have the strength to move out of bed but may have increased strength during panic attacks.

On 2/09/22 at 2:15 pm, RT #1 was interviewed. RT #1 was present when Resident #1 was found in the floor. RT #1 stated they left Resident #1's room following rounds and went up the hall way and then heard the vent disconnection alarm sounding for Resident #1. RT #1 stated they entered Resident #1's room and found (him/her) face down on the floor between the bed and the heater bleeding "pretty bad" from the head. RT #1 stated they held the resident's head still, maintained C-spine precautions, secured the airway and the nurse checked the resident. RT #1 stated the resident had already started swelling. RT #1 stated Resident #1 liked to lean to the side of the bed when laying on their side and would squirm some in the bed. RT #1 stated that when they last saw Resident #1 prior to the incident, the resident was laying "a little" on their side but not teetering on the edge of the bed. RT #1 stated the resident's bed was "pretty low" as they remember stooping over to do trach care.

The facility policy entitled "Abuse, Neglect and Exploitation" documented in part:
IV. Identification of Abuse, Neglect and Exploitation

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| F 610 | Continued From page 36<br>B. Possible indicators of abuse include, but are not limited to:<br>3. Physical injury of a resident, of unknown source<br>V. Investigation of Alleged Abuse, Neglect and Exploitation<br>A. An immediate investigation is warranted when suspicion of abuse or exploitation, or reports of abuse, neglect or exploitation occur.<br>B. Written procedures for investigation include:<br>1. Identifying staff responsible for the investigation;<br>2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence);<br>3. Investigating different types of alleged violations;<br>4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;<br>5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and<br>6. Providing complete and thorough documentation of the investigation.<br><br>On 2/09/22 at 4:21 pm during a meeting with the administrator, DON, ADON (assistant DON), and the RDCS (regional director of clinical services), the concern of the facility not completing an investigation into the cause of the incident resulting in Resident #1 being found in the floor with injuries was discussed.<br><br>No further information regarding this issue was presented to the survey team prior to the exit conference on 2/11/22. | F 610 | | |

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| F 684 | Continued From page 37<br>Quality of Care<br>SS=E CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review, facility document review, and during a medication pass and pour observation, the facility staff failed to follow physician's orders for 5 of 16 residents, Resident #13, #2, #3, #7, and #9.<br><br>The findings included:<br><br>1. a. Resident #13's face sheet listed diagnoses which included but not limited to congestive heart failure, chronic kidney disease, atrial fibrillation, anemia, dementia, glaucoma, polyneuropathy, dysphagia and other feeding difficulties.<br><br>The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/07/21 coded the resident as having both long and short term memory problems and moderately impaired cognitive skills for daily decision making.<br><br>LPN (licensed practical nurse) #2 was observed administering medications to Resident #13 during a medication pass and pour on 02/09/22 at 8:15 am. LPN #2 prepared Resident #13's | F 684<br>F 684 | 1. Resident medications/supplements obtained for residents #13,resident #2 order completed, resident #3 medication obtained, resident #7 no longer in facility, MD notified. No further orders on received. RP notified.<br><br>2. Full facility audit to ensure medication availability for all residents.<br><br>3. All licensed nursing staff reeducated regarding medication administration and unavailable medication policies by Director of Nursing.<br><br>4. Director of Nursing/ or designee will audit twice weekly for six weeks the availability of four randomly selected resident's medications to ensure proper administration and documentation of resident medications. Audits and audit findings will be reported to the facility QAPI Committee to review the need for continued intervention or amendment of the plan.<br><br>5. Allegation of compliance set for 03.28.2022 | 03.28.2022 |

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medications, then stated that resident's Ensure was unavailable. LPN #2 asked another staff member if they could get the Ensure for them. LPN #2 then poured the supplement Med Pass into a cup, took it and the resident's prepared medications and administered to the resident.

Resident #13's medications were reconciled on 02/09/22 at 9:30 am. The supplement Med Pass was not listed on the resident's physician's orders.

On 02/09/22 at 9:45 am LPN #2 was asked about the Med Pass, and LPN #2 stated, "You know they're all the same, just the name's different."

b. Resident #13's physician's order summary for the month of February 2022 contained an order, which read in part "gabapentin capsule 300 mg. Give 1 capsule by mouth at bedtime for neuropathy".

Resident #13's eMAR (electronic medication record) was reviewed on 02/11/22. It contained an entry which read in part, "gabapentin capsule 300 mg. Give 1 capsule by mouth at bedtime for neuropathy." This entry was coded as "9" on 02/09/22 and 02/10/22. Chart code "9" was defined as "other/see Nurse Notes".

Resident #13's nurse's notes for these dates were reviewed and contained notes, "02/09/2022 ...gabapentin capsule 300 mg. Give 1 capsule by mouth at bedtime for neuropathy. med not available," and "02/10/2022 ...gabapentin capsule 300 mg. Give 1 capsule by mouth at bedtime for neuropathy. awaiting pharmacy."

A list of medications available in the facility stat

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medication supply was reviewed and Gabapentin 300 mg was listed as being available.

Resident #13's comprehensive care plan was reviewed and contained a care plan for "At risk for alteration in comfort r/t (related to) OA (osteoarthritis) and polyneuropathy". Interventions for this care plan included "medicate as ordered". The comprehensive care plan also contained a care plan for "... is at nutritional risk r/t (related to) dementia, and dysphagia". Interventions for this care plan included "Provide supplements as ordered".

The facility policy entitled "Unavailable Medications" documented in part, "2. A STAT supply of commonly used medication is maintained in-house for timely initiation medications."

The concern of substituting the supplement Med Pass for Ensure and not administering the resident's gabapentin per the physician's order was discussed with the administrative team (administrator, director of nursing, assistant director of nursing, regional nurse consultant) on 02/11/22 at 11:55 am. The DON stated this is not an acceptable substitution without a physician's order.

No further information was provided prior to exit.
2. Resident #2's diagnosis list indicated diagnoses, which included, but not limited to Dementia, Type 2 Diabetes Mellitus, Anxiety Disorder, Unsteadiness on Feet, Peripheral Vascular Disease, Muscle Wasting and Atrophy, Normal Pressure Hydrocephalus, and Essential Hypertension.

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The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/13/22 assigned the resident a BIMS (brief interview for mental status) summary score of 14 out of 15 indicating Resident #2 was cognitively intact.

Resident #2's clinical record included a physician's order for Clonazepam 1 mg by mouth every eight (8) hours for anxiety for one week, to start on 1/09/22.

A review of the resident's January 2022 MAR (medication administration record) revealed Resident #2 received the first administration of Clonazepam on 1/10/22 at 2:00 pm.

According to the nursing progress notes, Clonazepam was not administered as ordered on 1/09/22 at 10:00 p.m. for the documented reason of "awaiting arrival from pharmacy" and 1/10/22 at 6:00 a.m. for the documented reason of "on order".

On 2/08/22 at 4:52 p.m. the DON (director of nursing) stated Clonazepam was available in the Cubex in the dose of 0.5 mg.

The list of medications available in the facility Cubex onsite medication supply listed Clonazepam 0.5 mg tablets with a maximum on hand supply of one (1) and minimum on hand supply of zero (0).

On 2/09/22 at 1:39 p.m. the DON verified Clonazepam was not administered as ordered on 1/09/22 and 1/10/22.

On 2/09/22 at 4:21 p.m., the management team

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consisting of the administrator, DON, assistant DON, and the regional director of clinical services were made aware of the concern of Resident #2 not receiving Clonazepam as ordered.

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22.

3. Resident #3's diagnosis list indicated diagnoses, which included, but not limited to Chronic Obstructive Pulmonary Disease, Acute Combined Congestive Heart Failure, Paranoid Schizophrenia, End Stage Renal Disease, Essential Hypertension, Dependence on Renal Dialysis, and Hypo-osmolality and Hyponatremia.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 2/05/22 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15, indicating the resident was cognitively intact.

Resident #3's active physician's orders included an order dated 5/19/21 for Isosorbide Mononitrate ER Extended Release 24 hour 30 mg by mouth one time a day, and an order dated 2/08/22 (with a previous order date of 5/19/21) for Hydralazine HCL 25 mg two (2) tablets by mouth three (3) times a day every Monday, Wednesday, Friday, Sunday.

A review of Resident #3's January 2022 MAR (medication administration record), February 2022 MAR, and nursing progress notes, revealed Isosorbide Mononitrate was not administered on 1/19/22 at 8:00 a.m. for the documented reason of awaiting medication from pharmacy.

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Hydralazine was not administered on 1/31/22 at 10:00 p.m. and 2/02/22 at 6:00 a.m. for the documented reason of being on order, and also was not administered on 2/02/22 at 2:00 p.m. for the documented reason of pending pharmacy.

The list of medications available in the facility Cubex onsite medication supply included Isosorbide Mononitrate ER 30 mg tablets with a maximum supply of ten (10) and a minimum supply of four (4), and hydralazine 25 mg tablets with a maximum supply of ten (10) and a minimum supply of four (4).

On 2/09/22 at 4:21 p.m., the administrator, DON (director of nursing), assistant DON, and the regional director of clinical services were notified of the concern of Resident #3 not receiving Isosorbide Mononitrate and Hydralazine as ordered: however, each medication was available in the facility onsite supply.

On 2/10/22 at 3:29 p.m., the management team denied having any additional information related to this concern.

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22.

4. Resident #7's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease Affecting Left Non-Dominant Side, Dysphagia, Aphasia, Chronic Viral Hepatitis C, Acute on Chronic Systolic Congestive Heart Failure, Essential Hypertension, Paroxysmal Atrial Fibrillation, Dementia, Anxiety Disorder, and Bipolar

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Disorder.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/12/22 assigned the resident a BIMS (brief interview for mental status) summary score of 10 out of 15 indicating Resident #7 was moderately cognitively impaired.

Resident #7's active physician's orders included an order dated 9/10/21, "Lorazepam Tablet 1 mg give 0.5 tablet via PEG-Tube two times a day related to Anxiety Disorder".

A review of Resident #7's January 2022 and February 2022 MARs (medication administration records) revealed Lorazepam was not administered on the following dates with the reason documented in the clinical record as follows:
1/03/22 5:00 p.m. - "awaiting medication from pharmacy"
1/04/22 9:00 a.m. - "awaiting pharmacy"
1/04/22 5:00 p.m. - "awaiting pharmaxy (sic)"
1/05/22 9:00 a.m. - "awaiting medication from pharmacy"
2/06/22 9:00 a.m. - "awaiting pharmacy"
2/06/22 5:00 p.m. - "awaitin (sic) pharm"

Resident #7's current comprehensive plan of care included a focus area initiated 8/12/20, "(Resident #7) uses anti-anxiety medication r/t (related to) anxiety associated with CVA (cerebrovascular accident), becomes anxious if immediate needs are not met, agitation, screaming, grabbing and is not easily redirected." Interventions included in part, "administer anti-anxiety medications as ordered by the physician."

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The list of medications available in the facility Cubex onsite medication supply included Lorazepam 0.5 mg tablets with a maximum supply of two (2) and a minimum supply of one (1) to be available.

On 2/08/22 at 4:52 p.m. the DON (director of nursing) stated Lorazepam was available in the Cubex in the dose of 0.5 mg.

On 2/09/22 at 1:39 p.m. the DON verified the ordered Lorazepam was not administered on the aforementioned dates/times.

On 2/09/22 at 4:21 p.m., the administrator, DON, assistant DON, and the regional director of clinical services, were notified of the concern of Resident #7 not receiving Lorazepam as ordered on six (6) separate occasions despite being available in the facility onsite supply.

No further information regarding this issue was presented to the survey team prior to the exit conference on 2/11/22.

5. Resident #9 was admitted to the facility with diagnoses including cerebral infarct, respiratory failure, sepsis, tracheostomy, and hypertension. On the minimum data set assessment with assessment reference date 11/24/21, the resident was assessed as non-verbal and with highly impaired vision, hearing, and cognition.

During clinical record review the medication administration record (MAR) was observed blank on 2/5/2022 for all medications scheduled for 6:00 AM.

Those medications were:
Amlodipine besylate tablet 5 mg Give 1 tablet via

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| F 684 | Continued From page 45<br>PEG Tube one time a day hold for sbp<100 or dbp<60 Tube three times a day for secretions<br>Enoxaparin Sodium Solution 40 mg/.4 ml inject 0.4 ml subcutaneously one time a day for blood clots<br>Famotidine Tablet 40 mg Give 1 tablet via PEG Tube one time a day for GERD<br>Ferrous Sulfate liquid Give 5 ml via Peg-tube one time a day for iron<br>Glycopyrrolate Tablet 2 mg Give 1 tablet via PEG Tube 3 times a day for secretions<br><br>An order for Check vital signs (temp and O2 sat) every 4 hours for monitoring was blank on 2/5/2022 at 4:00 AM.<br><br>No nursing note addressed failure to administer the medications on that date.<br><br>On 2/11/2022, the blanks on the MAR were discussed with the director of nursing, who acknowledged there was no evidence the medications had been administered.<br><br>The facility policy entitled, "Unavailable Medications" documented in part:<br>2. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications.<br>3. The facility shall follow established procedures for ensuring residents have a sufficient supply of medications.<br>4. Medications may be unavailable for a number of reason. Staff shall take immediate action when it is known that the medication is unavailable:<br>a. Determine reason for unavailability, length of time medication is unavailable, and what efforts have been | F 684 | | |

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| F 684 | Continued From page 46<br>attempted by the facility or pharmacy provider to obtain the medication.<br>b. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternate treatment orders and/or specific orders for monitoring resident while medication is on hold.<br><br>No further information regarding this issue was presented to the survey team prior to the exit conference on 2/11/22. | F 684 | F690<br>1. Resident #4 catheter bag was removed from the floor, placed in a privacy bag, and then secured to an immovable part of the resident's bed frame immediately. No adverse effect noted.<br><br>2. Full facility audit to ensure all foley catheters secured and not on the floor.<br><br>3. All nursing staff will be educated on the foley catheter care policy.<br><br>4. Director of Nursing/ or designee will audit twice weekly for six weeks all residents with a foley catheter to ensure foleys are secure and not on the floor. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.<br><br>5. Allegation of compliance set for 03.28.2022. | 03.28.2022 |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to | F 690 | | |

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| F 690 | Continued From page 47 | F 690 | | |

prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, the facility staff failed to provide Foley catheter care to prevent urinary tract infections for 1 of 16 residents, Resident #4. Resident #4's Foley catheter bag was observed lying in the floor on two (2) separate occasions during the survey.

The findings included:

Resident #4's face sheet listed diagnoses which included but not limited to metabolic encephalopathy, obstructive and reflux uropathy, urinary tract infection, dementia, congestive heart failure, cerebral infarction, developmental disorders, convulsions, hypertension, and respiratory failure.

Section C, cognitive patterns, of Resident #4's quarterly MDS (minimum data set) with an ARD (assessment reference date) of 12/28/22 coded the resident as having both long and short term memory problems and severely impaired cognitive skills for daily decision making.

Resident #4's comprehensive care plan was reviewed and contained a care plan for "... has a

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| F 690 | Continued From page 48<br>long hx (history) of bladder and kidney related issues, including kidney stones, infections requiring Foley catheter to be replaced. Recent hospitalization due to scrotal abscess. Has urogenital stents."<br><br>Resident #4 was observed on 02/08/22 at 11:45 am. Resident #4 was resting in bed. A Foley catheter drainage bag was observed lying on the floor beside Resident #4's bed.<br><br>Resident #4 was observed again on 02/08/22 at 3:30 pm. Resident #4 was resting in bed. A Foley catheter drainage bag was observed lying in floor bedside Resident #4's bed, in same area as previously observed.<br><br>The facility policy entitled "Catheter Care, Urinary" documented in part, "Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Infection Control: 2. b. Be sure the catheter tubing and drainage bag are kept off the floor."<br><br>The concern as discussed with the administrative team (administrator, director of nursing, assistant director of nursing, regional nurse consultant) during a meeting on 02/11/22 at 11:55 am. The director of nursing stated this was a breach of infection control.<br><br>No further information was provided prior to exit. | F 690 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and | F 692 | | |

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| F 692 | Continued From page 49<br>percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review, and facility document review, facility staff failed to ensure acceptable parameters of nutriton and hydration for 2 of 16 residents in the survey sample, Residents #1 and #6.<br><br>For Resident #1, the facility staff failed to provide tube feeding formula as ordered, and administered water flushes via enteral tube without a current physician's order.<br><br>For Resident #6 the facility staff failed to follow the physician's orders for tube feeding and water flushes.<br><br>The findings included:<br><br>1. Resident #1's diagnosis list indicated | F 692 | F692<br><br>1. Resident #1 No longer at facility, resident #6 rate corrected, md notified, no further orders,<br><br>2. Full facility audit to ensure accurate tube feeding orders.<br><br>3. All licensed nursing staff regarding re-educated by Director of Nursing on .<br><br>4. Director of Nursing/ or designee will audit tube feeding orders and pump for accuracy twice weekly for six weeks. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.<br><br>5. Allegation of compliance set for 03.28.2022 | 03.28.2022 |

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| F 692 | Continued From page 50 | F 692 | | |

diagnoses, which included, but not limited to Pneumonia due to MRSA (Methicillin Resistant Staphylococcus Aureus), Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure, Anxiety Disorder, Essential Hypertension, Dementia, Muscle Wasting and Atrophy, Dysphagia, and Dependence on Respirator Status.

The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 12/23/21 assigned the resident a BIMS (brief interview for mental status) summary score of 14 out of 15 indicating the resident was cognitively intact. Resident #1 was coded for the presence of a feeding tube in which they were receiving 51% or more of total calories and 501 cc/day or more of average fluid intake per tube feeding.

Resident #1's current physician's orders included an order dated 2/07/22, "Enteral Feed Order every shift for nutrition Osmolite 1.5 continuous 50 ml (milliliters)/hr (hour)." There was no current physician's order for water flushes.

Since Resident #1's readmission to the facility on 2/7/22, there was no nutrition assessment for hydration needs. Prior to Resident #1 going out to the hospital, the resident had a physician's order for 125 ml of water every four hours.

On 2/08/22 at 2:00 pm, Resident #1 was observed in bed receiving Jevity 1.5 TF (tube feeding) formula via pump at 50 ml/hour. A fillable TF bag with approximately 1,000 ml of water was also attached to the TF pump with the pump set to deliver 100 ml water flushes every four hours.

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| F 692 | Continued From page 51 | F 692 | | |

A review of Resident #1's February MAR (medication administration record) revealed Osmolite 1.5 was signed on the MAR as being administered on 2/08/22 for day and night shift.

On 2/09/22 at 8:05 am, Resident #1 was observed in bed receiving Osmolite 1.5 TF formula via pump at 50 ml/hr. Resident #1 was also receiving water flushes via pump set to deliver 100 ml every four (4) hours.

On 2/09/22 at 11:54 am, the DON (director of nursing) was notified of Resident #1 receiving water flushes via feeding tube without a physician's order.

On 2/09/22 at 4:21 pm, the administrator, DON, assistant DON, and the regional director of clinical services were advised of the concern of Resident #1 receiving water flushes via tube without a current physician's order.

No further information regarding this issue was presented to the survey team prior to the exit conference on 2/11/22.

2. Resident #6's face sheet listed diagnoses which included but not limited to respiratory failure, diabetes mellitus type II, chronic respiratory failure, anemia, pneumonia, tracheostomy status, dysphagia, and hypertension.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 01/15/22 assigned the resident a BIMS (brief interview for mental status) score of 1 out 15 in section C, cognitive patterns, indicating the resident was severely cognitively impaired.

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| F 692 | Continued From page 52 | F 692 | | |

Resident #6's clinical record was reviewed on 02/09/22 and contained a physician's order summary for the month of February 2022, which included, "Enteral Feed Order every shift for nutrition. Enteral 1- Feeding: Administer Promote RTH (ready to hang) per JT (jejunostomy tube) via pump. Rate: 50 ml/hour, for 24 hours/day; Free H20 75 ml every 2 hours."

Resident #6's eMAR (electronic medication administration record) for the month of February was reviewed and contained an entry which read in part, "Enteral Feed Order every shift for nutrition. Enteral 1- Feeding: Administer Promote RTH per JT via pump. Rate: 50 ml/hour, for 24 hours/day; Free H20 75 ml every 2 hours." This entry was initialed as being completed for each shift.

Resident #6 was observed on 02/08/22 at 12:10 pm. Resident #6 was lying in bed with tube feeding of Promote running at 70 ml/hour, with free water flushes of 60 ml every 2 hours.

Resident #6 was observed again on 02/09/22 at 1:50 pm. Resident #6 was in bed with tube feeding of Promote running at 70 ml/hour, with free water flushes of 60 ml every 2 hours.

Resident #6's comprehensive care plan was reviewed and contained a care plan for "... is at nutrition and/or hydration risk aeb (as evidenced by) dx (diagnosis) T2DM (type 2 diabetes mellitus), HTN (hypertension), anemia, alcohol dependence; overweight per BMI (body mass index); NPO (nothing by mouth)/requires enteral feed via PEJ (percutaneous endoscopic jejunostomy); antipsychotic medication; abnormal

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| F 692 | Continued From page 53<br>labs". Intervention for this care plan included "Provide, serve diet as ordered..."<br><br>Resident #6 was observed with the DON present on 02/09/22 at 3:25 pm. The DON stated that the resident's tube feeding was not running at correct rate. The DON stated, "The nurse did not verify the order when they set it up and signed off on eMAR. I will correct it now."<br><br>The facility policy entitled "Enteral Nutrition" documented in part, "Policy Statement: Adequate nutritional support through enteral feeding will be provided to residents as ordered."<br><br>The concern of not following the resident's tube feeding order was discussed with the administrative team (administrator, director of nursing, assistant director of nursing, regional nurse consultant) during a meeting on 02/11/21 at 11:55 am.<br><br>No further information was provided prior to exit. | F 692 | | |
| F 697 SS=G | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, resident interview, clinical record review, facility document review, and during a medication pass and pour observation, the facility staff failed to provide | F 697 | | |

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| F 697 | Continued From page 54<br>adequate pain management for 1 of 16 residents, Resident #12, resulting in harm. Resident #12's pain medications oxycodone 10 mg and gabapentin 300 mg were not available for administration.<br><br>The findings included:<br><br>Resident #12's face sheet listed diagnoses which included but not limited to ventilator associated pneumonia, chronic respiratory failure, anxiety, motor and sensory neuropathy, dysphagia, scoliosis and precordial pain.<br><br>Resident #12's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 12/31/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns, indicating the resident was cognitively intact.<br><br>LPN (licensed practical nurse) #1 was observed during a medication pass and pour on 02/09/22 at 7:50 am. LPN #1 was preparing Resident #12's medications. While preparing the resident's medications, LPN #1 stated that they did not have the resident's oxycodone or gabapentin available to administer due to the resident having been in the hospital, and had only returned "early this morning". LPN #1 stated they could not pull Resident #12's pain medications from the stat supply due to the pharmacy needing a new hard script prior to giving an authorization code to pull medications. Upon exiting Resident #12's room, LPN #1 asked another staff member when the resident had returned from the hospital, and this staff person stated "... came back early Monday morning (02/07/22)." | F 697 | F697<br><br>1. Resident # 12 no longer at facility.<br><br>2. As all residents could potentially be affected by this deficiency in practice, a full facility audit was performed to ensure ordered pain medication availability for all residents.<br><br>3. All licensed nursing staff reeducated regarding pain policy, medication administration, and unavailable medication policies by Director of Nursing.<br><br>4. Director of Nursing/ or designee will audit new admissions for ordered analgesics to ensure medication is available, twice weekly for six weeks. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.<br><br>5. Allegation of compliance set for 03.28.2022 | 03.28.2022 |

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| F 697 | Continued From page 55 | F 697 | | |

Resident #12's medications were reconciled on 02/09/21. Resident #12's physician's order summary for the month of February contained the following, "Gabapentin Capsule 300 mg. Give 2 capsule by mouth three times a day for restless leg" and "oxyCODONE HCl Tablet 10 mg. Give 1 tablet by mouth two times a day for r/t (related to) pain."

Resident #12's eMAR (electronic medication administration record) for the month of February was reviewed and documented, "Gabapentin Capsule 300 mg. Give 2 capsule by mouth three times a day for restless leg" and "oxyCODONE HCl Tablet 10 mg. Give 1 tablet by mouth two times a day for r/t (related to) pain." The start date for these medications was listed as 02/07/22.

The entry for oxycodone was initialed as administered on 02/07/22 and 02/08/22 at 9:00 pm. On 02/08/22 at 9:00 am, the entry was coded "9". The entry for gabapentin was initialed as administered on 02/07/22 and 02/08/22 at 9:00 pm. On 02/08/22 at 9:00 am, the entry was coded "9". The chart code "9" was defined as, "Other/See Nurse Notes."

Resident #12's nurse's notes were reviewed and no documentation was located regarding Resident #12's medications.

Resident #12's comprehensive care plan was reviewed and contained care plans for "Alteration in comfort related to pain... has an alteration in musculoskeletal r/t (related to) severe scoliosis, MD (muscular dystrophy) with bilateral upper and lower contractures... is at risk for alteration in comfort r/t self care deficit bein (sic) bedfast,

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| F 697 | Continued From page 56 | F 697 | | |

contractures, Dx (diagnosis): of Muscular Dystrophy, Chronic resp. failure with vent dependency... has intermittent pain due to MD with noted deformities to joints, especially back". Interventions for these care plans included medications per MD (medical doctor) orders, give analgesics as ordered by the physician, notify the physician if pain control is ineffective, and observe for nonverbal indications of pain.

The DON (director of nursing) was interviewed on 02/09/22 at 10:55 am regarding Resident #12's medications. The DON stated they had faxed the hard script to the pharmacy and confirmed that they were received. The DON stated they had obtained an authorization code to pull the medications from the stat supply this morning. The DON was asked about the medications that were signed as administered on 02/07 and 02/08, and the DON stated, "I believe it was a falsification of a record. I do not believe (Resident #12) received them at all. I destroyed the previous meds when (Resident #12) went in the hospital so there were none here to administer." The DON provided a copy of the hard scripts for the medications, dated 01/19/22. The DON also provided a copy of the resident's narcotics control record for each medication indicating that the medications had been destroyed on 02/07/22 by the DON and ADON (assistant director of nursing).

Resident #12 was interviewed on 02/09/22 at 1:15 pm. Resident #12 was asked about their pain medications and Resident #12 stated, "I just got back from the hospital and they had to get my pain meds straightened out." Resident #12 was asked if they were in pain without receiving their medications. Resident #12 stated, "My legs and

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| F 697 | Continued From page 57<br>back hurt. The first night was bad in my legs and feet." Resident #12 was asked to rate their pain on a scale of 1-10 and the resident stated, "I have nerve pain in my legs and feet and it was over a 10, probably 5-6 in my back, it comes and goes. I have scoliosis in my back." Resident #12 was asked if they had received anything else for pain and the resident stated, "Only Tylenol, but it doesn't help much."<br><br>Resident #12's physician's order summary contained an order for, "Tylenol Tablet 325 mg (Acetaminophen) Give 650 mg by mouth every 8 hours as needed for pain or fever."<br><br>Resident #12's eMAR included an entry for Tylenol 325 mg tablet, give 650 mg by mouth every 8 hours as needed for pain or fever. This entry listed a pain level of "7" on 02/08/22 at 8:20 am. This administration was documented as ineffective.<br><br>The facility document "Pain Assessment and Management" included, "Implementing Pain Management Strategies: 6. Implement the medication regimen as ordered, carefully documenting the results of the interventions."<br><br>The concern of not providing adequate pain control for Resident #12 was discussed with the administrative team (administrator, DON, ADON, regional nurse consultant) on 02/11/22 at 11:55 am.<br><br>No further information was provided prior to exit. | F 697 | | |
| F 755 SS=E | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) | F 755 | | |

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| F 755 | Continued From page 58<br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, facility document review, and a medication pass and pour observation, the facility staff failed to ensure medications were available for administration for 4 of 16 residents, Resident #12, #13, #3 and #15. | F 755 | F755<br><br>1. Resident medications/supplements obtained for residents #12, no longer at facility, resident #13 medication obtained resident #3 medication obtained, resident #15 , MD notified. No further orders on received. RP notified.<br><br>2. Full facility audit to ensure medication availability for all residents.<br><br>3. All licensed nursing staff reeducated regarding medication administration and unavailable medication policies by Director of Nursing.<br><br>4. Director of Nursing/ or designee will audit twice weekly for six weeks the availability of four randomly selected resident's medications to ensure proper administration and documentation of resident medications. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.<br><br>5. Allegation of compliance set for 03.28.2022 | |

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For Resident #12, the facility staff failed to ensure oxycodone (pain medication) and gabapentin (nerve pain medication) were available.

For Resident #13, the facility staff failed to ensure Cosopt PF (used to lower eye pressure and treat Glaucoma) eye drops were available.

For Resident #3, the facility staff failed to ensure Diltiazem (calcium channel blocker used to treat high blood pressure and control angina), Nephro-Vite, and Bacitracin ointment were available for administration.

For Resident #15, the facility staff failed to ensure Ciprofloxacin eye ointment was available for administration.

The findings included:

1. Resident #12's face sheet listed diagnoses which included but not limited to ventilator associated pneumonia, chronic respiratory failure, anxiety, motor and sensory neuropathy, dysphagia, scoliosis and precordial pain.

Resident #12's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 12/31/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns, indicating the resident was cognitively intact.

LPN (licensed practical nurse) #1 was observed during a medication pass and pour on 02/09/22 at 7:50 am. LPN #1 was preparing Resident #12's medications. While preparing the resident's medications, LPN #1 stated that they did not have

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the resident's oxycodone or gabapentin available to administer due to the resident having been in the hospital, and had only returned "early this morning". LPN #1 stated they could not pull Resident #12's pain medications from the stat supply due to the pharmacy needing a new hard script prior to giving an authorization code to pull medications. Upon exiting Resident #12's room, LPN #1 asked another staff member when the resident had returned from the hospital, and this staff person stated "... came back early Monday morning (02/07/22)."

Resident #12's eMAR (electronic medication administration record) for the month of February was reviewed and documented, "Gabapentin Capsule 300 mg. Give 2 capsule by mouth three times a day for restless leg" and "oxyCODONE HCl Tablet 10 mg. Give 1 tablet by mouth two times a day for r/t (related to) pain." The start date for these medications was listed as 02/07/22.

The entry for oxycodone was initialed as administered on 02/07/22 and 02/08/22 at 9:00 pm. On 02/08/22 at 9:00 am, the entry was coded "9". The entry for gabapentin was initialed as administered on 02/07/22 and 02/08/22 at 9:00 pm. On 02/08/22 at 9:00 am, the entry was coded "9". The chart code "9" was defined as, "Other/See Nurse Notes."

Resident #12's nurse's notes were reviewed and no documentation was located regarding Resident #12's medications.

The DON (director of nursing) was interviewed on 02/09/22 at 10:55 am regarding Resident #12's medications. The DON stated they had faxed the

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hard script to the pharmacy and confirmed that they were received. The DON stated they had obtained an authorization code to pull the medications from the stat supply this morning.

The concern of medication not being available for administration for Resident #12 was discussed with administrative team (administrator, DON, ADON, regional nurse consultant) on 02/11/22 at 11:55 am.

No further information was provided prior to exit.

2. Resident #13's face sheet listed diagnoses which included but not limited to congestive heart failure, chronic kidney disease, atrial fibrillation, anemia, dementia, glaucoma, polyneuropathy, dysphagia and other feeding difficulties.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/07/21 coded the resident as having both long and short term memory problems and moderately impaired cognitive skills for daily decision making.

LPN (licensed practical nurse) #2 was observed administering medications to Resident #13 during a medication pass and pour on 02/09/22 at 8:15 am. LPN #2 prepared Resident #13's medications, then stated that resident's eye drops were not available.

Resident #13's medications were reconciled on 02/09/22 at 9:30 am. The physician's order summary for the month of February 2022 contained an order for, "Cosopt PF Solution 2-0.5% (Dorzolamide HCl-Timolol Mal PF) Instill 1 drop in both eyes two times a day for Glaucoma."

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A list of medications available in the facility stat medication supply was reviewed. Cosopt eye drops was not listed as available in the stat supply.

The concern of the resident's eye drops not being available for administration was discussed with the administrative staff (administrator, director of nursing, assistant director of nursing, regional nurse consultant) on 02/11/22 at 11:55 am.

No further information was provided prior to exit.
3. Resident #3's diagnosis list indicated diagnoses, which included, but not limited to Chronic Obstructive Pulmonary Disease, Acute Combined Congestive Heart Failure, Paranoid Schizophrenia, End Stage Renal Disease, Essential Hypertension, Dependence on Renal Dialysis, and Hypo-osmolality and Hyponatremia.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 2/05/22 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15, indicating the resident was cognitively intact.

Resident #3's current physician's orders included active orders dated 5/18/21 for Dilt-XR (Diltiazem HCL ER) Extended Release 24 Hour 180 mg give one capsule by mouth one time a day for HTN (hypertension); and Nephro-Vite Tablet 0.8 mg give 1 tablet by mouth one time a day for Renal Failure/Dialysis. Resident #3 also had an active order dated 2/07/22 for Bacitracin Ointment 500 unit/gm apply to bilateral lower extremity topically two times a day for wound care.

A review of Resident #3's January 2022 MAR (medication administration record) revealed

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Diltiazem was not administered on 1/04/22 at 8:00 am. According to the resident's nursing progress notes, Diltiazem was not administered due to awaiting medication from the pharmacy. The January MAR also indicated Nephro-Vite was not administered on 1/11/22 at 8:00 am due to being on order.

A review of Resident #3's February 2022 MAR revealed Bacitracin ointment was not administered on 2/08/22 at 8:00 am and 2/09/22 at 8:00 am. According to the resident's nursing progress notes, Bacitracin was not administered on each occasion due to awaiting pharmacy delivery.

On 2/09/22 at 4:21 p.m., the administrator, DON (director of nursing), assistant DON, and the regional director of clinical services were made aware of the concern of Resident #3 not receiving Diltiazem, Nephro-Vite, and Bacitracin ointment as ordered.

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22.

4. Resident #15's diagnosis list indicated diagnoses, which included, but not limited to Paranoid Schizophrenia, Alzheimer's Disease, Generalized Anxiety Disorder, Bilateral Vitreous Degeneration, and Essential Hypertension.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/04/22 coded the resident as being severely cognitively impaired with short-term and long-term memory problems.

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A review of Resident #15's clinical record revealed a scanned document dated (sic) 2/02/21 titled "Nursing Communication Form" which documented, "milky drainage from both eyes." Also included at the bottom of this document was a signed physician's telephone order dated 2/03/22 for, "Ciprofloxacin 0.3% apply 1 gtt (drop) into both eyes Q (every) 4 (hours) x (for) 14 days bacterial conjunctivitis."

A nursing progress note dated 2/03/22 9:46 am documented, "new order to start Ciprofloxacin 0.3 Q 4 hours x 14 days r/t (related to) bacterial conjunctivitis."

Resident #15's February MAR (medication administration record) indicated Ciprofloxacin ointment was not administered as ordered on 2/04/22, 2/05/22, 2/07/22, and 2/08/22.

According to the resident's progress notes, the medication was not administered for the following documented reasons:
2/04/22 12:00 pm - "pending pharmacy"
2/04/22 4:00 pm - "pending pharmacy"
2/04/22 8:00 pm - "awaiting delivery"
2/05/22 8:00 am - "pending arrival from pharmacy"
2/05/22 12:00 pm - "pending arrival from pharmacy"
2/05/22 4:00 pm - "pending arrival from pharmacy"
2/07/22 12:00 pm - "waiting for pharmacy refill"
2/08/22 8:00 am - "waiting to be received from pharmacy"
2/08/22 4:00 pm - "waiting to be received from pharmacy"

On 2/10/22 at 1:52 pm, the pharmacy tech #1

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was interviewed concerning Resident #15's Ciprofloxacin eye ointment unavailability. Pharmacy tech #1 stated the medication was delivered to the facility on 2/07/22 but was unable to provide the exact time of delivery. Pharmacy tech #1 stated there were no notes in the system of the facility contacting the pharmacy concerning delivery of the medication.

On 2/10/22 at 3:08 pm, the DON provided a copy of the medication label from Resident #15's Ciloxan Oin 0.3% OP (Ciprofloxacin eye ointment) with a dispense date of 2/03/22 and next available refill date of 2/09/22.

The DON also provided a copy of a form entitled, "Pharmacy Memo" dated 2/03/22 regarding Resident #15's "Ciloxan oin 0.3% OP" documenting, "Medicine is on order and will be sent (sic) on ASAP (as soon as possible)."

The DON stated they believe the medication was delivered to the facility on 2/04/22.

The facility policy entitled, "Unavailable Medications" documented in part:
3. The facility shall follow established procedures for ensuring residents have a sufficient supply of medications.
4. Medications may be unavailable for a number of reason. Staff shall take immediate action when it is known that the medication is unavailable:
a. Determine reason for unavailability, length of time medication is unavailable, and what efforts have been
attempted by the facility or pharmacy provider to obtain the medication.
b. Notify physician of inability to obtain

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| F 755 | Continued From page 66<br>medication upon notification or awareness that medication is not available. Obtain alternate treatment orders and/or specific orders for monitoring resident while medication is on hold.<br><br>On 2/10/22 at 3:29 pm, the administrator, DON, ADON, and the regional director of clinical services, were advised of the concern of Resident #15 not receiving Ciprofloxacin eye ointment as ordered.<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22. | F 755 | | |
| F 759 SS=E | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, and during a medication pass and pour observation, the facility staff failed to ensure a medication error rate of less than 5 %. There were 6 errors in 25 opportunities for a medication error rate of 24 %.<br><br>The findings included:<br><br>1. Resident #12's face sheet listed diagnoses which included but not limited to ventilator associated pneumonia, chronic respiratory failure, anxiety, motor and sensory neuropathy, dysphagia, scoliosis and precordial pain. | F 759 | | |

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| F 759 | Continued From page 67<br><br>Resident #12's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 12/31/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns, indicating the resident was cognitively intact.<br><br>LPN (licensed practical nurse) #1 was observed during a medication pass and pour on 02/09/22 at 7:50 am. LPN #1 was preparing Resident #12's medications. While preparing the resident's medications, LPN #1 stated that they did not have the resident's oxycodone or gabapentin available to administer due to the resident having been in the hospital, and had only returned "early this morning". LPN #1 stated they could not pull Resident #12's pain medications from the stat supply due to the pharmacy needing a new hard script prior to giving an authorization code to pull medications. Upon exiting Resident #12's room, LPN #1 asked another staff member when the resident had returned from the hospital, and this staff person stated "... came back early Monday morning (02/07/22)."<br><br>Resident #12's medications were reconciled on 02/09/21. Resident #12's physician's order summary for the month of February contained the following, "Gabapentin Capsule 300 mg. Give 2 capsule by mouth three times a day for restless leg" and "oxyCODONE HCl Tablet 10 mg. Give 1 tablet by mouth two times a day for r/t (related to) pain."<br><br>The facility staff was notified of the issues regarding Resident #12's medications during an end of day meeting on 02/09/22 at 4:20 pm. | F 759 | F759<br><br>1. Resident medications/supplements obtained for residents #12, no longer at facility, resident #13 medication obtained resident #3 medication obtained, resident #14 orders reconciled , MD notified. No further orders on received. RP notified.<br><br>2. Full facility audit to ensure availability of supplements for all residents.<br><br>3. All licensed nursing staff reeducated regarding medication administration and unavailable medication policies by Director of Nursing.<br><br>4. Director of Nursing/ or designee will audit twice weekly for six weeks the availability of four randomly selected resident's supplements to ensure proper administration and documentation of resident supplements. Audits and audit findings will be reported to the facility QAPI Committee to review the need for continued intervention or amendment of the plan.<br><br>5. Allegation of compliance set for 03.28.2022 | 03.28.2022 |

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2. Resident #13's face sheet listed diagnoses which included but not limited to congestive heart failure, chronic kidney disease, atrial fibrillation, anemia, dementia, glaucoma, polyneuropathy, dysphagia and other feeding difficulties.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/07/21 coded the resident as having both long and short term memory problems and moderately impaired cognitive skills for daily decision making.

LPN (licensed practical nurse) #2 was observed administering medications to Resident #13 during a medication pass and pour on 02/09/22 at 8:15 am. LPN #2 prepared Resident #13's medications, then stated that the resident's eye drops were unavailable.

Resident #13's medications were reconciled on 02/09/22 at 9:30 am. The physician's order summary for the month of February 2022 included, "Cosopt PF Solution 2-0.5% (Dorzolamide HCl-Timolol Mal PF) Instill 1 drop in both eyes two times a day for Glaucoma."

The facility staff was notified of the issues regarding Resident #13's medications during an end of day meeting on 02/09/22 at 4:20 pm.

3. Resident #14's face sheet listed diagnoses which included but not limited to type 2 diabetes, hypothyroidism, hypertension, disorders of magnesium metabolism, and constipation.

Resident #14's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 01/26/22 assigned the resident a BIMS (brief interview for mental status) score of

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| F 759 | Continued From page 69 | F 759 | | |

6 out of 15 in section C, cognitive patterns, indicating the resident was moderately cognitively impaired.

LPN (licensed practical nurse) #3 was observed on 02/09/22 at 8:30 am during a medication pass and pour. LPN #3 prepared and administered Resident #14's medications, which included Magnesium 500 mg, Colace 100 mg ii capsules. Resident #14 was in the room, with a partially consumed breakfast tray sitting on the overbed table. LPN #3 prepared and administered 10 units of Lantus insulin. LPN #3 did not prepare or administer the resident's insulin aspart.

Resident #14's medications were reconciled on 02/09/22 at 9:40 am. Resident #14's physician's summary contained orders which included:
"Magnesium oxide 400 mg. Give 1 tablet by mouth one time a day for supplement"
"Senna-Docusate Sodium Tablet 8.6-50 mg (Sennosides-Docusate Sodium). Give 2 tablet by mouth two times a day for bowel movement"
"Insulin Aspart Solution Pen-Injector 100 unit/ml. Inject 10 unit subcutaneously before meals related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65) hold if <150."

LPN #3 was interviewed on 02/09/22 at 9:50 am regarding Resident #14's medications. LPN #3 was asked to confirm the medications magnesium and colace. LPN #3 checked the medications and confirmed that they had administered the wrong medications. LPN #3 was then asked about Resident #14's insulin aspart, and LPN #3 stated, "I gave it after you walked off."

A facility policy entitled "Administering

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| F 759 | Continued From page 70<br>Medications" documented in part, "Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication."<br><br>The facility staff was notified of the issues regarding Resident #14's medications during an end of day meeting on 02/09/22 at 4:20 pm.<br><br>The concern of the facility having a medication error rate of greater than 5% was discussed with the administrative staff (administrator, director of nursing, assistant director of nursing, regional nurse consultant) on 02/11/22 at 11:55 am.<br><br>No further information was provided prior to exit. | F 759 | | |
| F 760 SS=D | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical record review, facility staff failed to ensure residents were free of significant errors as evidenced by failure to follow insulin | F 760 | | |

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| F 760 | Continued From page 71<br>administration parameters for 2 of 16 residents in the survey sample, Residents #5 and 14.<br><br>Findings included:<br><br>1. Resident #5 was admitted to the facility with diagnoses including dominant side hemiplegia/hemiparesis, cardiopulmonary disease, type II diabetes mellitus, hypertension, anxiety, pain, and dysphagia. On the minimum data set assessment with assessment reference date 8/12/2021, the resident scored 14/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.<br><br>Clinical record review revealed a physician order for Novolog FlexPen Solution Pen Injector 100 unit/ml Inject 17 units subcutaneously before meals related to Type 2 diabetes mellitus without complications, hold if <150.<br><br>The January 2022 medication administration record (MAR) documented the insulin was held on the following dates:<br>1/6/22 - blood sugar of 186 (coded 11= held per parameters)<br>1/11/22 - blood sugar of 234 (coded 11= held per parameters)<br>1/20/22 - blood sugar of 192 (coded 12= insulin not required)<br><br>The concern of holding the resident's insulin outside the physician ordered parameters was discussed with the administrative staff (administrator, director of nursing, assistant director of nursing, regional nurse consultant) on 02/11/22.<br>2. Resident #14's face sheet listed diagnoses | F 760 | 1. Resident #5, #14<br>Orders verified. MD notified. No adverse effects noted. No new orders. RP notified.<br><br>2. Full facility audit to ensure no further significant medications errors occurred.<br><br>3. All licensed nursing staff reeducated regarding medication administration policy and medication error policy by Director of Nursing.<br><br>4. Director of Nursing/ or designee will randomly audit medication errors twice weekly for six weeks to ensure no significant medication errors occur. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.<br><br>5. Allegation of compliance set for 03.28.2022 | |

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which included but not limited to type 2 diabetes, hypothyroidism, hypertension, disorders of magnesium metabolism, and constipation.

Resident #14's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 01/26/22 assigned the resident a BIMS (brief interview for mental status) score of 6 out of 15 in section C, cognitive patterns, indicating the resident was moderately cognitively impaired.

Resident #14's clinical record included a physician's order summary for the month of February 2022 which documented, "Insulin Aspart Solution Pen-Injector 100 UNIT/ML. Inject 10 unit subcutaneously before meals related to TYPE 2 DIABETES MELLITUS WITH HYPOGLYCEMIA (E11.65) hold if <150."

Resident #14's eMAR (electronic medication record) for the month of February 2022 documented, "Insulin Aspart Solution Pen-Injector 100 UNIT/ML. Inject 10 unit subcutaneously before meals related to TYPE 2 DIABETES MELLITUS WITH HYPOGLYCEMIA (E11.65) hold if <150".

On 02/01/22 at 6:30 am, the resident's blood sugar was recorded as 157, and the entry for insulin was coded "12". On 02/02/22 at 6:30 am, the resident's blood sugar was recorded as 194 and the entry for insulin was coded "12". Chart code "12" was defined as "insulin not required."

The concern of holding the resident's insulin outside the physician ordered parameters was discussed with the administrative staff (administrator, director of nursing, assistant

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| F 760 | Continued From page 73<br>director of nursing, regional nurse consultant) on 02/11/22 at 11:55 am.<br><br>No further information was provided prior to exit. | F 760 | F842<br><br>1. Resident #12, no longer at facility, resident #7 no longer at facility, resident #15 medication received, MD notified. No further orders on received<br><br>2. Full facility audit to ensure medication availability for all residents.<br><br>3. All licensed nursing staff reeducated regarding medication administration and unavailable medication policies by Director of Nursing.<br><br>4. Director of Nursing/ or designee will audit twice weekly for six weeks the resident's medications to ensure proper administration and documentation of resident medications. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.<br><br>5. Allegation of compliance set for 03.28.2022 | 03.28.2022 |
| F 842 SS=E | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(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.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§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-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, | F 842 | | |

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neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or 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 clinical record review and staff interview, the facility staff failed to ensure a complete and accurate clinical record for 3 of 16 residents, Resident #12, #15, and #7.

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For Resident #12, the facility staff documented administration of medications when they were not available.

For Resident #15, the facility staff documented administration of Ciprofloxacin antibiotic eye ointment on nine (9) separate occasions prior to the medication being received from the pharmacy.

For Resident #7, the facility staff failed to accurately document administration of tube feeding and water flushes.

The findings included:

1. Resident #12's face sheet listed diagnoses which included but not limited to ventilator associated pneumonia, chronic respiratory failure, anxiety, motor and sensory neuropathy, dysphagia, scoliosis and precordial pain.

Resident #12's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 12/31/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns, indicating the resident was cognitively intact.

LPN (licensed practical nurse) #1 was observed during a medication pass and pour on 02/09/22 at 7:50 am. LPN #1 was preparing Resident #12's medications. While preparing the resident's medications, LPN #1 stated that they did not have the resident's oxycodone or gabapentin available to administer due to the resident having been in the hospital, and had only returned "early this morning". LPN #1 stated they could not pull Resident #12's pain medications from the stat

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supply due to the pharmacy needing a new hard script prior to giving an authorization code to pull medications. Upon exiting Resident #12's room, LPN #1 asked another staff member when the resident had returned from the hospital, and this staff person stated "... came back early Monday morning (02/07/22)."

Resident #12's medications were reconciled on 02/09/21. Resident #12's physician's order summary for the month of February contained the following, "Gabapentin Capsule 300 mg. Give 2 capsule by mouth three times a day for restless leg" and "oxyCODONE HCl Tablet 10 mg. Give 1 tablet by mouth two times a day for r/t (related to) pain."

Resident #12's eMAR (electronic medication administration record) for the month of February was reviewed and documented, "Gabapentin Capsule 300 mg. Give 2 capsule by mouth three times a day for restless leg" and "oxyCODONE HCl Tablet 10 mg. Give 1 tablet by mouth two times a day for r/t (related to) pain." The start date for these medications was listed as 02/07/22.

The entry for oxycodone was initialed as administered on 02/07/22 and 02/08/22 at 9:00 pm. On 02/08/22 at 9:00 am, the entry was coded "9". The entry for gabapentin was initialed as administered on 02/07/22 and 02/08/22 at 9:00 pm. On 02/08/22 at 9:00 am, the entry was coded "9". The chart code "9" was defined as, "Other/See Nurse Notes."

The DON (director of nursing) was interviewed on 02/09/22 at 10:55 am regarding Resident #12's medications. The DON stated they had faxed the

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hard script to the pharmacy and confirmed that they were received. The DON stated they had obtained an authorization code to pull the medications from the stat supply this morning. The DON was asked about the medications that were signed as administered on 02/07 and 02/08, and the DON stated, "I believe it was a falsification of a record. I do not believe (Resident #12) received them at all. I destroyed the previous meds when (Resident #12) went in the hospital so there were none here to administer." The DON provided a copy of the hard scripts for the medications, dated 01/19/22. The DON also provided a copy of the resident's narcotics control record for each medication indicating that the medications had been destroyed on 02/07/22 by the DON and ADON (assistant director of nursing).

The concern of documenting the resident's medications as administered when they were not available for administration was discussed with the administrative team (administrator, DON, ADON, regional nurse consultant) on 02/11/22 at 11:55 am.

No further information was provided prior to exit.
2. Resident #15's diagnosis list indicated diagnoses, which included, but not limited to Paranoid Schizophrenia, Alzheimer's Disease, Generalized Anxiety Disorder, Bilateral Vitreous Degeneration, and Essential Hypertension.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/04/22 coded the resident as being severely cognitively impaired with short-term and long-term memory problems.

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A review of Resident #15's clinical record revealed a physician's order dated 2/03/22 to start on 2/04/22 at 12:00 pm for Ciprofloxacin HCL Ointment 0.3% instill 1 ribbon in both eyes every 4 hours for bacterial infection for 14 days.

Resident #15's February 2022 MAR (medication administration record) revealed Ciprofloxacin was not administered on multiple occasions between 2/04/22 and 2/08/22 due to awaiting delivery from the pharmacy.

However, Ciprofloxacin was signed on the MAR as being administered on 2/05/22 12:00 am, 2/05/22 4:00 am, 2/05/22 8:00 pm, 2/06/22 12:00 am, 2/06/22 4:00 am, 2/06/22 8:00 am, 2/06/22 12:00 pm, 2/06/22 4:00 pm, and 2/06/22 8:00 pm.

On 2/10/22 at 1:52 pm, the pharmacy tech #1 was interviewed concerning Resident #15's Ciprofloxacin eye ointment. Pharmacy tech #1 stated the medication was delivered to the facility on 2/07/22 but was unable to provide the exact time of delivery.

The facility listing of onsite medications available in the Cubex system and Ciprofloxacin eye ointment was not listed as being available onsite.

On 2/10/22 at 3:08 pm, the DON provided a copy of the medication label from Resident #15's Ciloxan Oin 0.3% OP (Ciprofloxacin eye ointment) with a dispense date of 2/03/22 and next available refill date of 2/09/22.

The DON also provided a copy of a form entitled, "Pharmacy Memo" dated 2/03/22 regarding Resident #15's "Ciloxan oin 0.3% OP" documenting, "Medicine is on order and will be

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sent (sic) on ASAP (as soon as possible)."

The DON stated they believed the medication was delivered to the facility on 2/04/22.

The three nurses who signed the MAR as administering Ciprofloxacin on 2/05/22 and 2/06/22 were not available for interview.

On 2/10/22 at 3:29 pm, the administrator, DON, ADON, and the regional director of clinical services, were informed of the concern of Resident #15's MAR indicating the resident received Ciprofloxacin prior to delivery from the pharmacy.

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22.

3. Resident #7's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease Affecting Left Non-Dominant Side, Dysphagia, Aphasia, Chronic Viral Hepatitis C, Acute on Chronic Systolic Congestive Heart Failure, Essential Hypertension, Paroxysmal Atrial Fibrillation, Dementia, Anxiety Disorder, and Bipolar Disorder.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/12/22 assigned the resident a BIMS (brief interview for mental status) summary score of 10 out of 15 indicating Resident #7 was moderately cognitively impaired.

On 2/08/22 at 11:45 am, Resident #7 was

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| F 842 | Continued From page 80<br>observed in bed with Jevity 1.5 tube feeding formula running at 55 ml/hour via pump and a fillable water bag in place with the pump set to run water flushes at 175 ml/hour every 4 hours.<br><br>Resident #7's current physician's orders included an order, "Every shift continuous tube feeding: Administer Jevity 1.5 per pediatric 'button' via pump. Rate 55 ml/hr for 24 hours. Administer 175 ml water flush q. (every) 4 hrs. (hours) for adequate nutritional needs."<br><br>A review of Resident #7's February 2022 MAR (medication administration record) revealed the order for Jevity 1.5 at 55 ml/hour continuous via pump and water flushes of 175 ml every 4 hours were only being signed on the MAR as being administered once daily at 12:00 pm.<br><br>On 2/09/22 at 4:21 pm, surveyor met with the administrator, director of nursing, assistant director of nursing, and the regional director of clinical services and discussed the concern of Resident #7's continuous tube feeding administration and every 4 hour water flushes only being documented once daily on the resident's MAR.<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22. | F 842 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and | F 880 | | |

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| F 880 | Continued From page 81<br>comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the | F 880 | 1. Housekeeper #1, LPN #2 educated on proper infection control/isolation/contact precautions<br><br>2. Full facility audit to ensure all staff following infection control/isolation/contact precautions.<br><br>3. All staff will reeducated regarding isolation/ Infection Control Policy and PPE policy.<br><br>4. Director of Nursing/ or designee will audit twice weekly for six weeks on isolation/ contact precautions. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.<br><br>5. Allegation of compliance set for 03.28.2022 | 03.28.2022 |

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| F 880 | Continued From page 82<br>circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review, facility document review, and during the course of a medication pass and pour observation, the facility staff failed to maintain an infection control measures to prevent the transmission of infections for 2 of 16 residents in the survey sample, Resident #15 and #13.<br><br>For Resident #15, the facility staff failed to don an isolation gown prior to entering a resident's room requiring contact precautions and failed to remove gloves and perform hand hygiene prior to exiting the room. Staff then entered another resident's room while carrying a used garbage bag from the contact precautions room into the other resident's room. | F 880 | | |

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For Resident #13, the facility staff failed to follow infection control procedures during medication administration.

The findings included:

1. Resident #15's diagnosis list indicated diagnoses, which included, but not limited to Paranoid Schizophrenia, Alzheimer's Disease, Generalized Anxiety Disorder, Bilateral Vitreous Degeneration, and Essential Hypertension.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/04/22 coded the resident as being severely cognitively impaired with short-term and long-term memory problems.

On 2/10/22 at 11:20 am, HSM (Housekeeping Staff Member) #1 was observed in Resident #15's room wearing gloves and collecting the trash from the resident's waste container. HSM #1 was not wearing an isolation gown. HSM #1 exited Resident #15's room carrying the used garbage bag, did not remove gloves or perform hand hygiene. HSM #1 then entered an adjacent resident room wearing the same gloves and carrying the same used garbage bag.

Resident #15's room had a white sign taped to the door documenting, "Contact Precautions ...Hand Hygiene ...Gown ...Gloves ...On all room entries, regardless of anticipated patient contact." A three-drawer caddy was located to the right of Resident #15's door containing gloves, hand sanitizer, and disposable isolation gowns.

HSM #1 was interviewed after they exited the

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adjacent resident room and asked if they were aware Resident #15 required contact precautions. HSM #1 stated "I didn't know," and that they usually worked the back hall and was "just getting trash." The IP (infection preventionist) was notified of the observation of HSM #1.

A review of Resident #15's clinical record revealed a current physician's order dated 2/08/22 stating in part, "Contact Precautions for Conjunctivitis."

On 2/10/22 at 3:29 pm, the administrator, director of nursing, assistant director of nursing, and the regional director of clinical services were notified of the observations of HSM #1.

On 2/11/22 at 8:50 am, the IP was interviewed concerning the observations of HSM #1. The IP stated they should have been wearing gloves and a gown while in the resident's room and removed their gloves and washed hands prior to exiting the room. IP further stated that staff cannot wear the same gloves from room to room, and should not have carried the used garbage bag into another room as that is cross contamination. The IP stated staff have been re-educated on infection control and hand washing.

The facility policy entitled "Isolation Precautions" documented, "'Contact precautions' are measures that are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the resident or the resident's environment." An attached table, "Recommendations for Personal Protective Equipment (PPE)" indicated for contact precautions gowns are indicated "whenever

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anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle."

No further information regarding this issue was presented to the survey team prior to the exit conference on 2/11/22.

2. Resident #13's face sheet listed diagnoses which included but not limited to congestive heart failure, chronic kidney disease, atrial fibrillation, anemia, dementia, glaucoma, polyneuropathy, dysphagia and other feeding difficulties.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/07/21 coded the resident as having both long and short term memory problems and moderately impaired cognitive skills for daily decision making.

LPN (licensed practical nurse) #2 was observed administering medications to Resident #13 during a medication pass and pour on 02/09/22 at 8:15 am. LPN #2 prepared Resident #13's medications, and during preparation, LPN #2 dropped a medication tablet onto the medication cart, picked it up with a bare hand, and placed it in the medication cup with other medications.

The DON (director of nursing) was interviewed on 02/09/22 at 10:55 am regarding the observation. The DON stated it was not acceptable to touch medications such as tablets with bare hands.

The concern of LPN #3 picking up the tablet with their bare hand was discussed with the administrative team (administrator, director of nursing, assistant director of nursing, regional

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| F 880 | Continued From page 86<br>nurse consultant) on 02/11/22 at 11:55 am.<br><br>No further information was provided prior to exit. | F 880 | | |