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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/08/2022 through 03/10/2022. One complaint (VA00054446-substantiated) was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 109 at the time of the survey. The survey sample consisted of 42 current Resident reviews and four closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to place a call bell within reach for one of 46 residents in the survey sample, Resident #103. The findings include: The facility staff failed to place Resident #103's call bell within reach. Resident #103 was admitted to the facility on	F 558	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged	4/19/22

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

Electronically Signed | 03/23/2022

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F 558	Continued From page 1 2/18/22 with diagnoses that include pneumonia and neuropathy. Resident #103's most recent MDS (minimum data set) assessment, a five day Medicare assessment, with an assessment reference date of 2/24/22, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. MDS Section G coded the resident as requiring extensive staff assistance with bed mobility, transfers, dressing, hygiene; total dependence for bathing. Section H coded the resident as frequently incontinent for bowel and for bladder. A review of the comprehensive care plan dated 2/18/22 revealed, in part, "FOCUS: At risk for falls related to recent history of falls at home ...Orient patient to room, call bell, lighting and bathroom. Encourage to use call bell for assistance with needs." On 3/8/22 at 8:05 AM, Resident #103's call bell was noted to be on the floor in between her bed her roommate's bed. Breakfast was observed being delivered to Resident #103 at approximately 8:15 AM. On 3/8/22 at 10:05 AM, Resident #103's call bell was in the same location, on the floor between the two beds. An interview was conducted on 3/8/22 at 10:05 AM with Resident #103. When asked if she had her call bell, Resident #103 stated, "It's probably on the floor. It is on the floor frequently because it slides off of the bed, I guess." An interview was conducted on 3/8/22 at 10:07 AM with OSM (other staff member) #2, a physical	F 558	deficiencies cited have been or will be corrected by the date or dates indicated. 1. Resident□s call light (#103) was placed within reach and secured at bedside immediately after finding was reported. Resident #103 no longer resides in facility. 2. Any resident is at risk of not having call light secured and placed within reach. A 100% audit of all residents call light will be conducted to ensure call lights are secured and within reach. 3. The Director of Nursing or designee will re-educate all staff on the importance of accessibility to call light by resident. 4. Director of Nursing or designee will audit 10 residents per unit for call light accessibility and securement to bed 5x a week for 4 weeks and weekly for 8 weeks; report findings to QAPI committee with any variances addressed. 5. Date of compliance is 4/19/2022	

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therapist. OSM #2 entered Resident #103's room, and was asked about the location of Resident #103's call bell. OSM #2 stated, "Yes, it is on the floor." When asked where the call bell should be located, OSM #2 stated, "It should be within the resident's reach. I'm just going to wipe it and give it back to her, it should not be on the floor." OSM #2 was observed wiping the call bell and cord with an antibacterial wipe, and giving it back to the resident.

On 3/8/22 at 10:15 AM, an interview was conducted with LPN (licensed practical nurse) #2. When asked if she had administered Resident #103's morning medications, LPN #2 stated, "Yes, I gave her the morning meds but did not see the call bell on the floor. I'm sorry about that. It should not be on the floor."

On 3/9/22 at 4:58 PM, ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing were informed of the above findings.

On 3/10/22 at 8:42 AM, ASM #1 stated, "With regards to the call light, I wanted to talk about the accommodation of needs. The resident was able to make her needs known at the time. She asked the social worker if she had washcloths." When asked how the social worker was contacted, ASM #1 stated, "The social worker was going by the room in the hall and the resident called out." When asked if calling out was an accommodation of needs, ASM #1 stated, "No, I don't expect them to call out. We were able to accommodate her needs. We round each shift, the leadership. From a regulatory standpoint there is the requirement that the call bell should be in reach within all times. I do not deny that it happened I

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F 558	Continued From page 3 just do not think it is widespread." A review of the facility's "Call Lights: Accessibility and Timely Response" policy dated 6/1/2021, which revealed, "The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet and bathing facility to allow residents to call for assistance. With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of the resident and secured, as needed." No further information was provided prior to exit.	F 558		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		4/19/22

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F 656	Continued From page 4 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement the comprehensive care plan for five of 46 residents in the survey sample, Residents #45, #24, # 64, #56 and # 103. The findings include: 1. The facility staff failed implement Resident # 45's comprehensive care plan to administer oxygen at two liters per minute. Resident # 45 was admitted to the facility with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (COPD). On the most recent MDS (minimum data set), a	F 656	1. Resident #45□s comprehensive care plan was implemented to ensure that oxygen is administered at the physician prescribed rate. Resident #24 and #56□s comprehensive care plans were implemented to ensure regular communication and coordination with the dialysis center. Resident #64 and #103 no longer resides in the center. 2. All residents have the potential to be affected by this deficient practice. A 100% audit of care plan implementation will be conducted to ensure that oxygen, dialysis communication and call light accessibility are carried out in accordance with comprehensive person-centered care plan. 3. The DON or designee will re-educate	

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F 656	Continued From page 5 quarterly assessment with an ARD (assessment reference date) of 01/17/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 45 for "Oxygen Therapy" while a resident. On 03/08/22 at approximately 1:36 p.m., an observation of Resident # 45 revealed they were lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of three liters per minute. On 03/09/22 at approximately 8:35 a.m., an observation of Resident # 45 revealed they were lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of three liters per minute. On 03/09/22 at approximately 12:50 p.m., an observation of Resident # 45 revealed they were lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of three liters per minute. The physician order for Resident #45 documented, "O2 (oxygen) at 2 (two) L/min (liters per minute) via (by) nasal cannula every 4 (four) hours as needed for SOB (shortness of breath). Order Date: 02/19/2022. Start Date 02/19/2022." The comprehensive care plan for Resident # 45 dated 09/04/2021 documented in part, "Focus: [Resident # 45] has respiratory problem (s)	F 656	the nursing staff on implementing the resident□s comprehensive person-centered care plan. 4. Director of Nursing or designee(s) will conduct an audit of 10 resident care plans to ensure implementation of oxygen, communication with dialysis center and placing call light within resident□s reach as per resident care plan and standards of practice weekly for 12 weeks and report findings to QAPI committee. 5. Date of compliance is 4/19/2022	

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related to acute illness or chronic condition r/t (related to) COPD, Asthma. Date Initiated: 09/04/2021 ...Provide oxygen as ordered. Date Initiated: 09/04/2021."

On 03/09/2022 at approximately 12:55 p.m., an observation of Resident # 45's flow meter on their oxygen concentrator and interview was conducted with LPN (licensed practical nurse) # 4. When asked how they read the oxygen flow rate on an oxygen concentrator LPN # 4 stated, "The liter line goes through the middle of the ball." When asked to read the oxygen flow rate on Resident # 45's oxygen concentrator, LPN # 4 read the flow meter and stated, "Three liters per minute." After reviewing the physician's order for Resident # 45's oxygen administration, LPN # 4 stated, "It should be two liter per minute." When asked to describe the purpose of a resident's care plan, LPN # 4 stated, "How we go about taking care of the resident." After reviewing the comprehensive care plan for Resident # 45's respiratory care LPN # 4 was asked if the care plan was being followed. LPN # 4 stated, "Right now, no."

On 03/09/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, interim administrator and ASM # 2, director of clinical services, were made aware of the above findings.

A review of the facility document "Comprehensive Care Planning Process" was conducted. This policy did not specifically direct that the care plan must be followed / implemented.

No further information was provided prior to exit.

2. The facility staff failed implement Resident #

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24's comprehensive care plan to maintain regular communication with the dialysis center. Resident # 24 was admitted to the facility with diagnoses included but were not limited to: end stage renal disease [2]. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/23/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 24 for "Dialysis" while a resident.

The physician's order sheet for Resident # 24 documented in part, Resident receives Dialysis as follows: 1) [Name, Address and Phone Number of Dialysis Center]. Dialysis Days: Tues-Thurs-Sat 4) Dialysis Medical DX: ESRD 5) Dialysis Transport (company): [Name of Company]. 6) Chair time: 10:55am (a.m.). Start Date 08/10/2021."

The comprehensive care plan for Resident # 24 dated 08/10/2021 documented in part, "Focus: [Resident # 24] has Renal Disease requiring dialysis Date Initiated: 08/10/2021 ...Coordinate with dialysis center for dialysis treatments as ordered. Communicate with dialysis provider regularly via pre/post treatment notes ...Date Initiated: 08/10/2021."

Review of the facility's "Transfer and Treatment Forms" for Resident # 24's dialysis failed to evidence documentation of the following: all vital signs on 01/03/0221 and 01/08/2021; respiration and temperature on 01/11/2021 and the nurse's signature on 01/03/0221, 01/08/2021, 01/11/2021, 01/13/0221, 01/18/2021, 01/25/2021, 01/27/2021,

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02/05/2021, 03/01/2021 and 03/05/2021.

On 03/09/2022 at approximately 4:05 p.m. an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked what portions of the dialysis sheets the facility was responsible for completing, ASM # 2 stated, "The resident's name, date, vital signs (blood pressure, respiration, pulse, and temperature), and the nurse's signature. After reviewing the facility's "Transfer and Treatment Forms" for Resident # 24 as dated above, ASM # 2 was asked if the forms were completed. ASM # 2 stated, "No." When asked to describe the purpose of a care plan, ASM # 2 stated, "It's a plan of care, tells us what we have to do." When asked if Resident # 24's comprehensive care plan was implemented to maintain regular communication with the dialysis center for the dates listed above, ASM # 2 stated, "No."

On 03/09/2022 at approximately 5:00 p.m., ASM # 1, interim administrator and ASM # 2, director of clinical services, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Dialysis treats end-stage kidney failure. It removes waste from your blood when your kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000707.htm.

[2] The last stage of chronic kidney disease. This

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is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.

3. The facility staff failed to implement the comprehensive care plan for coordination with dialysis services for Resident #64.

Resident #64 was admitted to the facility on 1/31/22 and had the diagnoses of but not limited to kidney transplant, diabetes, dialysis, and chronic kidney disease. On the most recent MDS (Minimum Data Set), a 5-day assessment with an ARD (Assessment Reference Date) of 2/7/22, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status, indicating the resident was not cognitively impaired for making daily decisions. The resident was coded as requiring supervision for eating and extensive assistance for all other areas of activities of daily living. The resident was coded as receiving dialysis services during the look back period.

A review of the clinical record revealed a physician's order dated 2/2/22 for, "Resident receives Dialysis....Dialysis Days: Monday, Wednesday, and Friday...."

A review of the comprehensive care plan revealed one dated 1/31/22 for, "[Resident #64] has Renal Disease requiring dialysis...." Further review revealed an intervention dated 1/31/22 for "Coordinate with Dialysis center for dialysis treatments as ordered. Communicate with dialysis provider regularly via pre/post treatment notes."

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A review of the dialysis communication book revealed "Transfer and Treatment Forms" that were to be completed for Resident #64 prior to being sent to dialysis. This form included the following information: name, date, facility, address, provider, diagnosis, code status, allergies, current medical condition, vital signs, height, weight, and skin condition. The dates of 3/4/22, 3/7/22 and 3/9/22, the facility did not complete the communication forms for the required vital signs and current weight for communication to the dialysis center. The form dated 3/9/22 did have the blood pressure only documented but did not have complete vital signs documented.

On 3/10/22 at 7:45 AM an interview was conducted with RN #3 (Registered Nurse). When asked the purpose of the dialysis communication book, she stated it is to let dialysis know a resident's status, especially blood pressure and weight. When asked if the information was not completed, was the dialysis center was provided with the required information they needed, she stated they were not. When asked if the care plan documented to communicate pre treatment notes with dialysis, was the care plan followed, she stated it was not.

On 3/10/22 at 8:25 AM, ASM #2, (Administrative Staff Member) the Director of Nursing, was notified of the findings. When asked if the dialysis forms that were incomplete evidenced that the facility communicated with the dialysis center, she stated that the dialysis forms should have been completed When asked the purpose of the care plan, she stated "It tells us what we have to do, everything about the resident." When

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asked if the care plan was being followed regarding the missing communication data for the above dates, she stated it was not.

On 3/10/22 at approximately 10:15 AM, ASM #1, the Administrator, was made aware of the findings.

No further information was provided by the end of the survey.

4. The facility staff failed to implement the comprehensive care plan for coordination with dialysis services for Resident #56.

Resident #56 was admitted to the facility on 10/20/21 and had the diagnoses of but not limited to diabetes, end stage renal disease, and dialysis. On the most recent MDS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Date) of 1/26/22, the resident scored a 12 out of 15 on the BIMS (brief interview for mental status, indicating the resident was moderately cognitively impaired for making daily decisions. The resident was coded as requiring limited to extensive assistance for all areas of activities of daily living. The resident was coded as receving dialysis services during the look back period.

A review of the clinical record revealed a physician's order dated 10/22/21 for, "Resident receives Dialysis....Dialysis Days: Mon-Wed-Fri (Monday, Wednesday, Friday)."

A review of the comprehensive care plan revealed one dated 10/20/21 for, "[Resident #56]

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has Renal Disease requiring dialysis...Coordinate with Dialysis center for dialysis treatments as ordered. Communicate with dialysis provider regularly via pre/post treatment notes."

A review of the dialysis communication book revealed "Transfer and Treatment Forms" that were to be completed for Resident #64 prior to being sent to dialysis. This form included the following information: name, date, facility, address, provider, diagnosis, code status, allergies, current medical condition, vital signs, height, weight, and skin condition. The dates of 3/9/22, 3/7/22, 3/4/22, 3/2/22, 2/28/22, 2/23/22, 2/14/22, and 2/7/22, the facility did not complete the communication forms for the required vital signs and current weight for communication to the dialysis center.

On 3/10/22 at 7:45 AM an interview was conducted with RN #3 (Registered Nurse). When asked the purpose of the dialysis communication book, she stated it is to let dialysis know a resident's status, especially blood pressure and weight. When asked if the information was not completed, was dialysis center provided with the required information they needed, she stated they were not. When asked if the care plan for communicating pre-treatment notes with the dialysis center was being followed, she stated it was not.

On 3/10/22 at 8:25 AM, ASM #2, (Administrative Staff Member) the Director of Nursing, was notified of the findings. When asked if the dialysis forms that were incomplete evidenced that the facility communicated with the dialysis center, she stated that the dialysis forms should have been completed. When asked the purpose

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of the care plan, she stated "It tells us what we have to do, everything about the resident." When asked if the care plan was being followed for dialysis communication data for the above dates, she stated it was not.

On 3/10/22 at approximately 10:15 AM, ASM #1, the Administrator, was made aware of the findings.

No further information was provided by the end of the survey.

5. The facility staff failed to implement the comprehensive care plan for the call light for Resident #103.

Resident #103 was admitted to the facility on 2/18/22 with diagnoses that include, but are not limited to, pneumonia and neuropathy. Resident #103's most recent MDS (minimum data set) assessment, a five day Medicare assessment, with an assessment reference date of 2/24/22, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired. MDS Section G coded the resident as requiring the extensive assistance of staff for bed mobility, transfers, dressing, hygiene; total dependence for bathing. Section H coded the resident as frequently incontinent for bowel and for bladder.

A review of the comprehensive care plan dated 2/18/22 revealed, in part, "FOCUS: At risk for falls related to recent history of falls at home ...Orient patient to room, call bell, lighting and bathroom. Encourage to use call bell for assistance with needs."

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An interview was conducted on 3/8/22 at 10:05 AM with Resident #103. When asked if she had her call bell, Resident #103 stated, "It's probably on the floor. It is on the floor frequently because it slides off of the bed I guess."

An interview was conducted on 3/8/22 at 10:07 AM with OSM (other staff member) #2, a physical therapist in Resident #103's room. When OSM #2 was asked about the location of Resident #103's call bell, OSM #2 stated, "Yes, it is on the floor." When asked where the call bell should be located, OSM #2 stated, "It should be within the resident's reach. I'm just going to wipe it and give it back to her, it should not be on the floor." OSM #2 observed sanitized the call bell and cord, and gave it back to the resident.

On 3/8/22 at 10:15 AM, an interview was conducted with LPN (licensed practical nurse) #2. When asked if she had administered Resident #103's morning medications, LPN #2 stated, "Yes, I gave her the morning meds but did not see the call bell on the floor. I'm sorry about that. It should not be on the floor."

An interview was conducted on 3/9/22 at approximately 1:10 PM with LPN #3. When asked the purpose of the care plan, LPN #3 stated, "It is to outline the plan of care for the resident." When asked if the care plan was implemented if the interventions listed were not implemented, LPN #3 stated, "No, it was not implemented."

On 3/9/22 at 4:58 PM, ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing were informed of the

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F 656	Continued From page 15 above findings. No further information was provided prior to exit.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to provide respiratory services according to the physician's orders for one of 46 residents in the survey sample, Resident # 45. The findings include: Facility staff failed to maintain Resident # 45's oxygen flow rate at 2 liters per minute according to the physician's orders. Resident # 45 was admitted to the facility with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (COPD). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/17/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is	F 695	1. Resident #45□s Oxygen flow rate was adjusted to two liters per minute via nasal cannula as per physician□s order. 2. Any resident receiving supplemental oxygen is at risk to be affected by this deficient practice. A 100% audit of residents receiving supplemental oxygen will be conducted to ensure flow rate being administered according to physician□s order. 3. The DON or designee will re-educate nursing staff on Respiratory Care related to administration of supplemental oxygen as per physician□s order. 4. Director of Nursing or designee will conduct an audit of 25% of residents receiving supplemental oxygen 3x per week x 4 weeks, then weekly x 4, then monthly x 1, and report findings to QAPI committee with any variances addressed. 5. Date of compliance is 4/19/2022	4/19/22

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cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 45 for "Oxygen Therapy" while a resident.

On 03/08/22 at approximately 1:36 p.m., an observation of Resident # 45 revealed they were lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of three liters per minute.

On 03/09/22 at approximately 8:35 a.m., an observation of Resident # 45 revealed they were lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of three liters per minute.

On 03/09/22 at approximately 12:50 p.m., an observation of Resident # 45 revealed they were lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of three liters per minute.

The physician order for Resident #45 documented, "O2 (oxygen) at 2 (two) L/min (liters per minute) via (by) nasal cannula every 4 (four) hours as needed for SOB (shortness of breath). Order Date: 02/19/2022. Start Date 02/19/2022."

The comprehensive care plan for Resident # 45 dated 09/04/2021 documented in part, "Focus: [Resident # 45] has respiratory problem (s) related to acute illness or chronic condition r/t (related to) COPD, Asthma. Date Initiated: 09/04/2021 ...Provide oxygen as ordered. Date Initiated: 09/04/2021."

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F 695	Continued From page 17 On 03/09/2022 at approximately 12:55 p.m., an observation of Resident # 45's flow meter on their oxygen concentrator, and an interview was conducted with LPN (licensed practical nurse) # 4. When asked how they read the oxygen flow rate on an oxygen concentrator LPN # 4 stated, "The liter line goes through the middle of the ball." When asked to read the oxygen flow rate on Resident # 45's oxygen concentrator, LPN # 4 read the flow meter and stated, "Three liters per minute." After reviewing the physician's order for Resident # 45's oxygen administration LPN # 4 stated, "It should be two liter per minute." When asked why it was important to maintain the oxygen flow rate according to the physician's orders LPN # 4 stated, "They could hyperventilate." The "User Manual" by [Name of Manufacturer] for [Name of Oxygen Concentrator] for Resident # 45 documented in part, "6. Adjust the flow to the prescribed setting by turning the knob at the top of the flow meter until the ball is centered on the line marking the specific flow rate." On 03/09/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, interim administrator and ASM # 2, director of clinical services, were made aware of the above findings. No further information was provided prior to exit.	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		4/19/22

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F 698	Continued From page 18 with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and service for a complete dialysis [1] program for three of 46 residents in the survey sample, Residents # 24, # 64 and # 56. The findings include: 1. The facility staff failed to maintain accurate communication regarding Resident #24's care with the dialysis center for January 2022 through March 2022. Resident # 24 was admitted to the facility with diagnoses included but were not limited to: end stage renal disease [2]. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/23/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 24 as having received dialysis while a resident. The physician's order sheet for Resident # 24 documented in part, "Resident receives Dialysis as follows: 1) [Name, Address and Phone Number of Dialysis Center]. Dialysis Days: Tues-Thurs-Sat 4) Dialysis Medical DX: ESRD 5) Dialysis Transport (company): [Name of Company]. 6) Chair time: 10:55am (a.m.). Start	F 698	1. It is noted that facility staff failed to provide dialysis care coordination and services for a complete dialysis program for resident #24, #64, and #56. Dialysis books updated to include communication with Dialysis center. Resident #64 no longer resides in facility. 2. Any resident who receives Dialysis treatment has the potential to be affected if the facility fails to provide a complete dialysis program and ensure there is effective communication between facilities. 100% audit of all residents who receive dialysis will be conducted to ensure the center has implemented an effective dialysis communication process for these residents. 3. The Director of Nursing or designee will educate licensed nurses and clinical nurse leaders on dialysis policy including communication. 4. Director of Nursing or designee will audit dialysis residents to ensure dialysis program and dialysis communication books are current and up to date 3x week x 4, weekly x 4 then monthly x1. Findings will be reviewed in QAPI, and variances addressed. 5. Compliance date 4/19/2022.	

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Date 08/10/2021."

The comprehensive care plan for Resident # 24 dated 08/10/2021 documented in part, "Focus: [Resident # 24] has Renal Disease requiring dialysis Date Initiated: 08/10/2021 ...Coordinate with dialysis center for dialysis treatments as ordered. Communicate with dialysis provider regularly via pre/post treatment notes ...Date Initiated: 08/10/2021."

Review of the facility's "Transfer and Treatment Forms" for Resident # 24's dialysis failed to evidence documentation of the following: all vital signs on 01/03/0221 and 01/08/2021; respiration and temperature on 01/11/2021 and the nurse's signature on 01/03/0221, 01/08/2021, 01/11/2021, 01/13/0221, 01/18/2021, 01/25/2021, 01/27/2021, 02/05/2021, 03/01/2021 and 03/05/2021.

On 03/09/2022 at approximately 4:05 p.m. an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked what portions of the dialysis sheets the facility was responsible for completing, ASM # 2 stated, "The resident's name, date, vital signs (blood pressure, respiration, pulse, and temperature), and the nurse's signature." After reviewing the facility's Transfer and Treatment Form" for Resident # 24 as dated above, ASM # 2 was asked if the forms were complete. ASM # 2 stated, "No." When asked why it was important for the forms to be completed ASM # 2 stated, "To document and changes in the resident and the nurse that completed the form."

Then facility's policy documented in part, "Hemodialysis. Compliance Guidelines: 1. The licensed nurse will communicate to the dialysis

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facility via telephonic communication or written format, such as a dialysis communication form or other form, that will include, but not limit itself to: b. Physician/treatment orders, laboratory values, and vital signs ..."

On 03/09/2022 at approximately 5:00 p.m., ASM # 1, interim administrator and ASM # 2, director of clinical services, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Dialysis treats end-stage kidney failure. It removes waste from your blood when your kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000707.htm.

[2] The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.

2. The facility staff failed to evidence communication and coordination of dialysis care and services for Resident #64 between the facility and the dialysis center.

Resident #64 was admitted to the facility on 1/31/22 with the diagnoses of, but not limited to,

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kidney transplant, diabetes, dialysis, and chronic kidney disease. On the most recent MDS (Minimum Data Set), a 5-day assessment with an ARD (Assessment Reference Date) of 2/7/22, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status, indicating the resident was not cognitively impaired for making daily decisions. The resident was coded as requiring supervision for eating and extensive assistance for all other areas of activities of daily living. The resident was coded as receiving dialysis services during the look back period.

A review of the clinical record revealed a physician's order dated 2/2/22 for, "Resident receives Dialysis....Dialysis Days: Monday, Wednesday, and Friday...."

A review of the dialysis communication book revealed Transfer and Treatment Forms that were to be completed for Resident #64 prior to being sent to dialysis. This form included the following information: name, date, facility, address, provider, diagnosis, code status, allergies, current medical condition, vital signs, height, weight, and skin condition. On 3/4/22, 3/7/22 and 3/9/22, the facility did not complete the communication forms for the required vital signs and current weight for communication to the dialysis center. The form dated 3/9/22 did have the blood pressure only documented but did not have complete vital signs documented.

On 3/10/22 at 7:45 AM an interview was conducted with RN #3 (Registered Nurse). When asked the purpose of the dialysis communication book, she stated it is to let dialysis know a resident's status, especially blood pressure and weight. When asked if the information was not

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completed, was the dialysis center was provided with the required information they needed, she stated they were not.

On 3/10/22 at 8:25 AM, ASM #2, (Administrative Staff Member) the Director of Nursing, was notified of the findings. When asked if the dialysis forms that were incomplete evidenced that the facility communicated with the dialysis center, she stated that the dialysis forms should have been completed.

A review of the comprehensive care plan revealed one dated 1/31/22 for, "[Resident #64] has Renal Disease requiring dialysis...Coordinate with Dialysis center for dialysis treatments as ordered. Communicate with dialysis provider regularly via pre/post treatment notes."

On 3/10/22 at approximately 10:15 AM, ASM #1, the Administrator, was made aware of the findings.

No further information was provided by the end of the survey.

3. The facility staff failed to evidence communication and coordination of dialysis care and services for Resident #56 between the facility and the dialysis center.

Resident #56 was admitted to the facility on 10/20/21 and had the diagnoses of, but not limited to, diabetes, end stage renal disease, and dialysis. On the most recent MDS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Date) of 1/26/22, the resident scored a 12 out of 15 on the BIMS (brief

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interview for mental status, indicating the resident was moderately cognitively impaired for making daily decisions. The resident was coded as requiring limited to extensive assistance for all areas of activities of daily living. The resident was coded as receiving dialysis services during the look back period.

A review of the clinical record revealed a physician's order dated 10/22/21 for, "Resident receives Dialysis....Dialysis Days: Mon-Wed-Fri (Monday, Wednesday, Friday)."

A review of the dialysis communication book revealed Transfer and Treatment Forms that were to be completed for Resident #64 prior to being sent to dialysis. This form included the following information: name, date, facility, address, provider, diagnosis, code status, allergies, current medical condition, vital signs, height, weight, and skin condition. On 3/9/22, 3/7/22, 3/4/22, 3/2/22, 2/28/22, 2/23/22, 2/14/22, and 2/7/22, the facility did not complete the communication forms for the required vital signs and current weight for communication to the dialysis center.

On 3/10/22 at 7:45 AM an interview was conducted with RN #3 (Registered Nurse). When asked the purpose of the dialysis communication book, she stated it is to let dialysis know a resident's status, especially blood pressure and weight. When asked if the information was not completed, was dialysis center provided with the required information they needed, she stated they were not.

On 3/10/22 at 8:25 AM, ASM #2, (Administrative Staff Member) the Director of Nursing, was

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F 698	Continued From page 24 notified of the findings. When asked if the dialysis forms that were incomplete evidenced that the facility communicated with the dialysis center, she stated that the dialysis forms should have been completed. A review of the comprehensive care plan revealed one dated 10/20/21 for, "[Resident #56] has Renal Disease requiring dialysis...Coordinate with Dialysis center for dialysis treatments as ordered. Communicate with dialysis provider regularly via pre/post treatment notes." On 3/10/22 at approximately 10:15 AM, ASM #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey.	F 698		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		4/19/22

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	495038	A. BUILDING _____ B. WING _____	03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

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(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert 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;

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F 842	Continued From page 26 (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 resident interview, clinical record review, facility document review and staff interviews it was determined that the facility failed to maintain a complete and accurate clinical record for one of 46 residents in the survey sample, Resident #42. The findings include: The facility staff failed to maintain a complete and accurate ADL (activities of daily living) record for Resident #42. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (Assessment Reference Date) of 1/15/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section G documented Resident #42 requiring extensive assistance of two or more persons for bed mobility and one person for dressing and personal hygiene. On 3/8/2022 at 10:00 a.m., an interview was conducted with Resident #42. Resident #42 stated that the facility staff used a mechanical lift to get him out of bed to take him to the shower.	F 842	1. It is noted that facility failed to maintain a complete and accurate ADL (Activities of Daily Living- showers) record for resident #42. 2. Any resident is at risk to be affected by this deficient practice. A 100% audit of ADL Shower documentation accuracy will be conducted. 3. The Director of Nursing or designee will educate Certified Nursing Aides (CNAs) and nurses on maintain an accurate record of Shower documentation to accurately reflect the resident. 4. Director of Nursing or designee with audit shower documentation of 10 residents per unit 3x week x 4, weekly x 4 then monthly x1. Findings will be reviewed in QAPI, and variances addressed. 5. Compliance date 4/19/2022.	

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Resident #42 stated that he was scheduled for showers on Tuesdays and Fridays and at times they were not offered, and he was not sure why. Resident #42 stated that he did refuse showers on some days, but not always.

The comprehensive care plan documented in part, "[Resident #42] demonstrates the need for ADL assistance as related to impaired mobility, s/p (status post) Lt. (left) AKA (above the knee amputation), also old/healed Rt (right) AKA. Generalized weakness, altered balance, Incontinence, pain and glaucoma... Date Initiated: 06/26/2020..."

The "Documentation Survey Report" dated 2/1/2022-2/28/2022 was reviewed for bathing/shower documentation. The report failed to evidence documentation for the bathing/shower area on 2/4/2022, 2/11/2022 and 2/25/2022. The areas for those dates were blank.

On 3/10/2022 at 9:45 a.m., an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 stated that baths and showers were provided twice a week and documented in the computer. CNA #3 stated that they entered documentation if a resident refused, was out of the building, or received the shower, and how much assistance the resident required. CNA #3 stated that they were not sure about blanks on the ADL documentation but thought the CNA who was caring for the resident may not have charted the bath or shower.

On 3/10/2022 at 10:00 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 stated that blanks on the bathing/shower

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documentation probably meant that the CNAs did not document the care or the refusal of care on those dates. LPN #6 stated that the blanks indicated the charting was not complete.

The facility policy "Documentation in Medical Record" dated 6/1/21 documented in part, "Each resident's medical record should contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation...Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy..."

On 3/10/2022 at approximately 10:00 a.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.