DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/08/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING ______ B. WING ______	C 03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL)	1719 BELLEVUE AVENUE RICHMOND, VA 23227

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/27/2022 through 03/30/2022. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The	E 037	**E037 EP Training Program** 1. No employees were individually cited. 2. The HRD or designee will audit employee files utilizing the Employee File review QAPI audit tool to validate Emergency preparedness training. 3. NHA or designee will educate employees on Emergency Preparedness. 4. HRD or designee will audit new employees weekly for 4 weeks to validate Emergency Preparedness training and report trends to the QA Committee. 5. The facility's alleged date of compliance will be April 28, 2022.	04/28/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 4/29/22

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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E 037	Continued From page 1 hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF	E 037		

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E 037	Continued From page 2	E 037		

must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The

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E 037	Continued From page 3 CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 4 procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to provide evidence of documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings and documentation that facility staff have received initial & annual emergency preparedness training. The findings include: On 03/30/2022 at approximately 8:10 a.m., the facility's emergency preparedness plan was reviewed. Review of the facility's emergency preparedness plan failed to evidence documentation of the facility's initial emergency preparedness training and annual emergency	E 037		

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E 037	Continued From page 5 preparedness training offerings and documentation that facility staff have received initial & annual emergency preparedness training. At approximately 8:57 a.m., ASM (administrative staff member) # 1, administrator and ASM # 5, former administrator were made aware of the above findings. At approximately 11:05 a.m., an interview was conducted with ASM # 1. When asked about the procedure for initial and annual emergency preparedness training ASM # 1 stated that initial training is conducted during the staff member's orientation and it is part of their annual retraining. No further information was provided prior to exit.	E 037		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/27/2022 through 3/30/2022. One complaint was investigated during the survey; VA00054768 (substantiated). Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 128 certified bed facility was 101 at the time of the survey. The survey sample consisted of 46 current resident reviews and 4 closed record reviews.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process,	F 553	**F 553 – Care Plan Invitations** 1. Residents # 50 and # 93 were offered a care plan and invited to attend.	

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F 553	Continued From page 6 including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that two of 50 residents in the survey sample were not invited to their care plan meetings/conference, Resident #50 and Resident #93. The findings include: 1. Resident #50 (R50) was not invited to their	F 553	2. A comprehensive review of current residents with upcoming care plan reviews for the month of April and May 2022 - per the MDS schedule will be completed. The SSD / MDS coordinator to validate that care conference invitations were sent accordingly. 3. The DON / designee will educate the facility interdisciplinary team on the "Focus on F-tag 553" and "Interdisciplinary care planning" procedure on or before the date of compliance. 4. Utilizing the "Right to Participate in planning care" tool the Social Service department will audit 5 residents / week x 4 weeks with scheduled care conferences to validate invitations were distributed. Results will be reviewed with QA&A. 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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care plan meeting/conference.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/15/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indication the resident is not cognitively impaired for making daily decisions.

An interview was conducted with R50 on 3/28/22 at 11:17 a.m. When asked if she attended her care plan meetings, a gathering when the facility staff discuss the care of plan for the resident, R50 stated they were not aware of any meetings like this. When asked if R50 was invited to the meetings, R50 stated no, they were not.

Review of the clinical record on 3/28/2022, failed to evidence documentation related to R50 being invited to their care plan meeting/conference.

On 3/29/2022 at 1:50 p.m. a request was made to ASM (administrative staff member) #1, the administrator, for documentation of inviting R50 to her care plan meeting/conference.

On 3/29/2022 at 4:15 p.m. ASM #3, the quality assurance consultant, stated the facility did not have any documentation of the resident's invitation to their care plan meeting.

An interview was conducted with ASM #2, the interim director of nursing and the MDS coordinator, on 3/29/2022 at 4:19 p.m. ASM #2. When asked the process for inviting residents to their care plan meeting, ASM #2 stated it was based on the MDS schedule. ASM #2 stated the social worker goes to the family and resident to

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determine a time and asks the family if they would like to participate, and they should ask the resident at that time and go over the time with them. When asked if it was documented that the resident have been invited, ASM #2 stated the social worker can answer that question.

An interview was conducted with OSM (other staff member) #5, the social worker, on 3/29/2022 at 4:28 p.m. When asked the process for inviting the residents to their care plan meetings, OSM #5 stated she calls the emergency contact, or whomever is listed on the profile. OSM #5 stated she talks to the resident as to whom she should call. When asked how she invites the resident to the care plan meeting, OSM #5 stated she lets them know when it is and whom to invite. When asked if she documents that she has invited the resident, OSM #5 stated, no. When asked if she invited [R50] to her care plan, OSM #5 stated she had not participated in a care plan with [R50] as she had just started at the facility in January.

The facility policy, "Interdisciplinary Care Conference" documented in part, "The patient, patient representative and family are invited to attend and participate in the care conference.

ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m.

No further information was provided prior to exit.

2. Resident #93 (R93) was not invited to their care plan meeting/conference.

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On the most recent MDS assessment, a quarterly assessment, with an ARD of 3/17/2022, the resident scored a 7 out of 15 on the BIMS score, indicating the resident is severely cognitively impaired for making daily decisions.

An interview was conducted with R93 on 3/28/2022 at 11:02 a.m. When asked if they attended the care plan meetings, R93 stated they did not know anything about any meetings. When asked if they were invited to the care plan meetings, R93 stated no.

Review of the clinical record on 3/28/2022 failed to evidence any documentation related to R93 being invited to their care plan meeting/conference.

On 3/29/2022 at 1:50 p.m. a request was made to ASM (administrative staff member) #1, the administrator, for documentation of inviting R50 to her care plan meeting/conference.

On 3/29/2022 at 4:15 p.m. ASM #3, the quality assurance consultant, stated the facility did not have any documentation of the resident's invitation to their care plan meeting.

An interview was with ASM #2, the interim director of nursing and the MDS coordinator, on 3/29/2022 at 4:19 p.m. ASM #2. When asked the process for inviting residents to their care plan meeting, ASM #2 stated it was based on the MDS schedule. ASM #2 stated the social worker goes to the family and resident to determine a time and asks the family if they would like to participate, and they should ask the resident at that time and go over the time with them. When asked if it was

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F 553	Continued From page 10 documented that the resident have been invited, ASM #2 stated the social worker can answer that question. An interview was conducted with OSM (other staff member) #5, the social worker, on 3/29/2022 at 4:28 p.m. When asked the process for inviting the residents to their care plan meetings, OSM #5 stated she calls the emergency contact, or whomever is listed on the profile. OSM #5 stated she talks to the resident as to whom she should call. When asked how she invites the resident to the care plan meeting, OSM #5 stated she lets them know when it is and whom to invite. When asked if she documents that she has invited the resident, OSM #5 stated, no. When asked if she invited [R93] to their care plan, OSM #5 stated the facility staff just had a care plan meeting for them and their son came. When asked if she invited the resident, OSM #5 stated, no. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m. No further information was provided prior to exit.	F 553		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing,	F 557	**F 557 – Care and Services to Promote Dignity** 1. Resident # 43 was provided a shower and hair washed. Plans of care reviewed to reflect current needs.	

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F 557	Continued From page 11 as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care to promote dignity for one of 50 residents in the survey sample, Resident #43 (R43). Resident #43 was observed with visible dandruff flakes and crusty patches on the scalp, a noticeable body odor, dry and cracked areas on the lips with visible film in the corners of the mouth and white filmy substance on the fold area under their neck during an incontinence care observation on 3/29/2022. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/31/2022, the resident was assessed as being severely impaired for making daily decisions. Section G of the assessment documented R43 as being totally dependent on one staff member for dressing, eating, toileting and personal hygiene. The MDS assessment further documented R43 being always incontinent of bowel and bladder and receiving tube feeding. On 3/29/2022 at 10:23 a.m., an observation was made of TNA (temporary nursing assistant) #10 providing ADL (activities of daily living) care to R43. TNA #10 prepared a basin of warm water with a washcloth and towel and began washing R43's face. When asked about the dandruff flakes and crusty patches on the scalp, TNA #10 explained that R43 had "cradle cap really bad."	F 557	2. A comprehensive review of current residents will be completed by the interdisciplinary team utilizing the "Dignity Observations" section of the Nursing Services audit QAPI tool, to observe current resident care / appearance; any identified areas of opportunity will be corrected and / or care planned as preference. 3. The DON / designee will educate the facility Nursing department on "Focus on F-tag 557" and "AM care" and "Bathing" nursing procedures on or before the date of compliance. 4. Utilizing the "Dignity Observations" section of the Nursing Services QAPI tool – the Interdisciplinary team will audit 5 residents / week x 4 weeks. Results will be reviewed with QA&A. 5. The facility's alleged date of compliance will be April 28, 2022.	4/2820/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 12 When asked if R43's hair was washed, TNA #10 stated that they did not shampoo R43's hair because they were not trained how to do this. When asked if R43's hair was washed on shower days, TNA #10 stated that they did not take R43 to the shower because they were not trained how to use the shower chair or shower stretcher. TNA #10 stated that they knew that R43's family wanted R43 to have showers because they had been told this but they could only do what they were trained to do. TNA #10 stated that R43 was very contracted and they did not want to hurt them so they did the best they could with R43. TNA #10 proceeded to wash under R43's chin and cleaned a filmy substance off of the area. An area on the right side of the neck and lower right jaw had small red raised bumps on it. TNA #10 stated that R43 had a rash on that area and they were afraid to wash the area too hard so it would not bleed. Body odor was smelled when TNA #10 washed R43's armpit areas through masks worn during care. TNA #10 began to provide incontinence care and apply a new gown to R43. When asked about R43's mouth care and dry lips, TNA #10 stated that they should use mouth swabs to provide mouth care for R43 but they were never trained how to use them and they did not want to hurt R43. TNA #10 stated that they put Vaseline on R43's lips at times that they got from R43's roommate. TNA #10 stated that these observations were from lack of care and that they were only able to get so much of R43 clean with the training they had received but they did the best that they could do for R43. The comprehensive care plan dated 2/19/2021 documented in part, "ADL Self care deficit. Date Initiated: 02/19/2021 ...Assist to bathe/shower as needed ...Assist with daily hygiene, grooming,	F 557		

F 557 Continued From page 13 F 557

dressing, oral care and eating as needed."

On 3/29/2022 at 12:24 p.m., an observation of R43 was made with ASM (administrative staff member) #2, the interim director of nursing/MDS coordinator. ASM #2 observed R43's visible dandruff flakes and crusty patches on the scalp and dry and cracked areas on the lips with film in corners of the mouth. ASM #2 was made aware of the body odor and substance on the fold area under the neck during ADL care on 3/29/2022 and stated that dignity was not being promoted. ASM #2 was made aware that showers, hair washing and mouth care were not being done due to lack of training and stated that they needed to review what training the TNA's were receiving for ADL care.

The facility policy, "Focus on FTag557" documented in part, "...Respect and Dignity. The resident has a right to be treated with respect and dignity..."

The facility policy, "Resident Rights" documented in part, "...The resident has a right to a dignified existence, self-determination, and communication with an access to persons and services outside the facility. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident..."

On 3/29/2022 at 4:41 p.m., ASM #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant and ASM #5, the former

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F 557	Continued From page 14 administrator were made aware of the above concern. No further information was provided prior to exit.	F 557		
F 558 SS=E	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, resident interview, staff interview, facility document review, it was determined the facility staff failed to accommodate the needs of seven of 50 residents in the survey sample, Residents #86, #50, #60, #6, #43, #29, and #58. The finding include: 1. The facility staff failed to place Resident #86 (R86)'s call bell within their reach. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 3/16/2022, the resident scored an 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately cognitively impaired for making daily decisions. An observation was made of R86 on 3/28/2023 at 2:02 p.m. R86 was lying in bed. The call bell was in the wheelchair, next to the bed, but behind the	F 558	**F 558 – Reasonable Accommodations / Needs / Preferences** 1. Call lights were checked for Residents # 86, # 50, # 60, # 6, # 29, and # 43 to validate within reach. Room set-up for resident # 58 was modified to allow independent access by the resident in her wheelchair to her closet. 2. A comprehensive review of current residents will be completed by the interdisciplinary team utilizing the "Dignity Observations" section of the Nursing Services QAPI tool to observe call light placement and access to closet; any identified areas of opportunity will be corrected. 3. The DON / designee will educate the facility staff on "Focus on F-tag 558" and the nursing procedure "call lights", access to personal items on or before the date of compliance.	

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F 558	Continued From page 15 resident's reach. A second observation was made of R86 on 3/29/2022 a.m. R86 was lying in bed. The call bell was on the floor behind the wheelchair, not within the resident's reach. An interview was conducted with CNA (certified nursing assistant) #4 on 3/29/2022 at 10:29 a.m. When asked where the call bells are to be placed, CNA #4 stated the call bell should be in the reach of the resident. CNA #4 stated the facility had clamps and the staff can clamp them to the sheets. CNA #4 further stated the call bells should be placed where the resident can reach it. The facility policy, "Call Light" documented in part, "6. Always position call light conveniently for use and within reach. A clip may be used to secure the light. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m. No further information was provided prior to exit. 2. The facility staff failed to place Resident #50 (R50)'s call bell within the resident's reach. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/15/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making	F 558	4. Utilizing the "Dignity Observations" section of the Nursing Services QAPI tool – the interdisciplinary team will audit 5 residents / week x 4 weeks. Results will be reviewed with QA&A 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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F 558	Continued From page 16 daily decisions. An interview was conducted with R50 on 3/28/2022 at 1:29 p.m. The call bell was observed to be hanging on the wall behind the night stand. When asked if they put it there, R50 stated, no, the staff put it there. A second observation was made of R50's room on 3/29/2022 at 8:45 a.m. The call bell was again observed hanging on the wall behind the night stand. An interview was conducted with CNA (certified nursing assistant) #4 on 3/29/2022 at 10:29 a.m. When asked where the call bells are to be placed, CNA #4 stated the call bell should be in the reach of the resident. CNA #4 stated the facility had clamps and the staff can clamp them to the sheets. CNA #4 further stated the call bells should be placed where the resident can reach it. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m. No further information was provided prior to exit. 3. The facility staff failed to place Resident #60 (R60)'s call bell within the resident's reach. On the most recent MDS assessment, a quarterly assessment, with an ARD of 3/3/2022, the resident scored a 10 out of 15 on the BIMS, indicating the resident was moderately cognitively impaired for making daily decisions.	F 558		

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Observation was made of R60 on 3/28/2022 at approximately 10:30 a.m. R60 was in the bed, asleep. The call bell was on the floor to R60's right side of the bed.

A second observation was made on 3/29/2022 at 8:41 a.m. R60 was sitting up in the bed with their breakfast tray in front of them. The call bell was on the floor to R60's right side of the bed.

An interview was conducted with CNA (certified nursing assistant) #4 on 3/29/2022 at 10:29 a.m. When asked where the call bells are to be placed, CNA #4 stated the call bell should be in the reach of the resident. CNA #4 stated the facility had clamps and the staff can clamp them to the sheets. CNA #4 further stated the call bells should be placed where the resident can reach it.

ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m.

No further information was provided prior to exit.

4. The facility staff failed to place Resident # 6 (R6)'s call bell within the resident's reach.

On the most recent MDS assessment, a quarterly assessment, with an ARD of 12/31/2021, the resident was coded as having both short and long term memory problems, and was severely impaired to make daily decisions.

Observation was made of 3/28/2022 at 10:24

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a.m. R6 was in the bed. The call bell was on the floor under the bed. Observations were made on 3/28/2022 at 11:36 a.m., 1:49 p.m. and 3:38 p.m., the call bell remained on the floor under the bed.

An interview was conducted with CNA (certified nursing assistant) #4 on 3/29/2022 at 10:29 a.m. When asked where the call bells are to be placed, CNA #4 stated the call bell should be in the reach of the resident. CNA #4 stated the facility had clamps and the staff can clamp them to the sheets. CNA #4 further stated the call bells should be placed where the resident can reach it.

ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m.

No further information was provided prior to exit.
5. The facility staff failed to place Resident #43's (R43) call light in a position where they could access it.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/31/2022, the resident was assessed as being severely impaired for making daily decisions. Section G coded R43 being totally dependent on one person for dressing, eating, toileting and personal hygiene. Section G further documented R43 having impairment in both upper extremities.

On 3/27/2022 at 12:30 p.m., R43 was observed lying in bed with the call bell located in the nightstand drawer beside the bed. R43 was

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unable to verbalize when asked about the call bell.

Additional observations on 3/27/2022 at 2:45 p.m., 3/28/2022 at 8:34 a.m. and 3/28/2022 at 4:39 p.m. revealed the findings above.

On 3/29/2022 at 2:12 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that call bells were placed within the residents reach whether they were able to use the bell or not. LPN #5 stated that all residents need a way to call for help regardless of their level of cognition. LPN #5 stated that they had never seen R43 use the call light but they always made sure it was near their hand and accessible to them. LPN #5 stated that call bell placement should be checked every time anyone enters the resident's room and at least every shift. LPN #5 was made aware of the observations of R43's call bell on 3/27/2022 and 3/28/2022 and stated that the nursing assistants may have placed it in the drawer while providing care and forgotten to put it back in place.

On 3/29/2022 at 4:41 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator were made aware of the findings.

No further information was presented prior to exit.

6. The facility staff failed to place Resident #29's (R29) call light in a position where they could access it.

On the most recent MDS (minimum data set), an

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F 558	Continued From page 20 annual assessment with an ARD (assessment reference date) of 1/19/2022, the resident scored a 5 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired for making daily decisions. Section G coded R29 requiring extensive assistance of one person for dressing, toileting and personal hygiene. Section G further documented R29 having no impairment in the upper extremities. The comprehensive care plan for R29 documented in part, "Falls due to decreased mobility. Date Initiated: 10/27/2017." Under interventions it documented in part, "...Reinforce need to call for assistance..." On 3/27/2022 at 12:36 p.m., R29 was observed in bed eating lunch, and the call bell was observed to be clipped to the sheet at the top of the mattress with the end of the call button located on the floor beside the nightstand. Additional observations on 3/27/2022 at 2:00 p.m. revealed the same as above. On 3/28/2022 at 8:35 a.m., the call bell was observed to be clipped to the sheet of the bed at the top of the mattress with the end of the call button located over the top of the mattress behind the residents head. On 3/29/2022 at 2:12 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that call bells were placed within the resident's reach whether they were able to use the bell or not. LPN #5 stated that all residents need a way to call for help regardless of their level of cognition. LPN #5 stated that R29 was able to use their call bell and had a history of throwing it in the floor. LPN #5 stated that they	F 558		

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checked it often because of this. LPN #5 stated that call bell placement should be checked every time anyone enters the resident's room and at least every shift. LPN #5 was made aware of the observations of R29's call bell on 3/27/2022 and 3/28/2022 and stated that it should have been accessible to the resident.

On 3/29/2022 at 4:41 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator were made aware of the findings.

No further information was presented prior to exit.

7. Facility staff failed to provide Resident # 58 (R58) access to their personal clothing.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/19/2022, 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 "Functional Status" coded R58 as being independent with "Locomotion on the unit - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair." Under "Mobility Devices" R58 was coded as using a wheelchair.

On 03/29/22 at approximately 8:36 a.m., an interview was conducted with R58. R58 stated

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F 558	Continued From page 22 that they were unable to access their clothes in their wardrobe. When asked how they access their clothes if they want to change them R58 stated that they have to call an aide and wait until they come to the room. During the interview, R58 demonstrated their attempts to reach the wardrobe on the other side of the room without success. With R58's permission, an observation of the inside of the wardrobe revealed it was full with R58's tops, pants and other personal items. An observation of R58's room revealed their bed was positioned in the middle of the second half of the room (B-side), the wardrobe between the outside wall and bed, approximately three and a-half feet between the foot of the bed and the wall. Further observations revealed two boxes of R58's additional clothing, were stacked at the far left corner of the room, near the foot of the bed, and a four drawer chest positioned to the left of the foot of the bed, against the wall. Observations during the days of the survey revealed R58 propelling themselves in their wheelchair in and out of their room and throughout the unit. On 03/29/2022 at approximately 10:15 a.m., an interview was conducted with CNA (certified nursing assistant) # 4. When asked if a resident should be able to independently access their personal items within their room, CNA # 4 stated that it is their home and they (residents) should have access to everything. After observing R58's room CNA # 4 stated that R58 could not access their wardrobe. On 03/29/2022 at approximately 3:25 p.m., an interview and observation of R58's room was	F 558		

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F 558	Continued From page 23 conducted with ASM (administrative staff member) # 3, quality assurance consultant. When asked if a resident should have access to their personal belongings in their room, ASM# 3 stated that the resident should have access to all of their belongings. After observing R58's room, ASM # 3 was asked if R58 had access to their wardrobe by use of their wheelchair. ASM # 3 stated there was not enough room around the foot of the bed to reach the wardrobe on the opposite side. The facility's policy "Virginia Patient/Resident Bill of Rights & Responsibilities" documented in part, "You have the right to: 14. Retain and use your personal clothing and possessions as space permits unless to do so would infringe upon rights of other patients and unless medically contraindicated as documented by your physician, physician assistant, or nurse practitioner in your medical record." On 03/29/2022 at approximately 4:40 p.m., ASM # 1, administrator, ASM # 2, interim director of nursing, ASM # 3, quality assurance consultant and ASM # 5, former administrator, were made aware of the above findings. No further information was provided prior to exit.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F 561	**F 561 – Self Determination** 1. Resident # 47 was interviewed, and care plan updated to reflect snack preferences and ability to take snacks in bed, sitting upright.	

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F 561	Continued From page 24 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview and clinical record review, it was determined that the facility staff failed to facilitate a resident's right for self-determination and choice for 1 of 50 residents in the survey sample, Resident #47. The facility staff failed to honor Resident #47's (R47) preference for night time snacks in bed. The findings include: On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/11/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively	F 561	2. A review of residents who must be out of bed for meals will be completed by DON or designee and individual plan for HS snacks will be identified with update to plan of care. 3. The DON or designee will educate facility staff on "Focus on F-tag 561 on or before the date of compliance. 4. NHA or designee to interview residents who need to be out of bed for meals weekly x 4 weeks to validate appropriate provision of HS snack based on plan of care. Results will be reviewed with QA&A. 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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F 561	Continued From page 25	F 561		

impaired for making daily decisions. R47's comprehensive care plan dated 2/7/22 documented, "Honor food preferences..." A physician's order for speech-language pathology dated 3/25/22 documented, "Patient to be OOB (out of bed) for all regular textured meals."

On 3/28/22 at 3:17 p.m., an interview was conducted with R47. R47 stated requests for snacks at night time have been verbalized but the staff will not provide snacks. R47 stated a couple of weeks ago, the speech therapist recommended the resident be seated in a wheelchair for meals and the staff have not been assisting the resident out of bed for breakfast. R47 stated a nurse said the resident could not eat meals in bed so the resident could not have snacks in bed at night.

On 3/29/22 at 6:42 a.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 stated R47 has asked for snacks while in bed at night time, and she asked the nurse who stated, "No."

On 3/29/22 at 7:05 a.m., an interview was conducted with CNA #3. CNA #3 stated she used to give R47 snacks while in bed at night time, but stopped because of a choking hazard and the therapy staff said they did not want R47 to eat in bed. CNA #3 stated R47 reported other staff was providing snacks while the resident was in bed so she spoke with a nurse who said she confirmed with the therapy staff that R47 could have snacks while in bed.

On 3/29/22 at 7:44 a.m., an interview was conducted with OSM (other staff member) #3 (the speech therapist). OSM #3 stated she

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F 561	Continued From page 26 recommended R47 eat all textured meals out of bed for safety because of the meat included in the meals. OSM #3 stated R47's snacks consist of chips and crackers and it is safe for the resident to eat these snacks while sitting up in bed. OSM #3 stated LPN (licensed practical nurse) #4 told her R47 always requests snacks while in bed and LPN #4 thought if R47 could not have meals in bed then it was not safe for the resident to eat snacks in bed. OSM #3 stated last week, she explained to LPN #4 that the way she wrote the order was for R47 to be up for three regular textured meals a day and it is safe for the resident to eat snacks in bed as long as the resident is positioned upright in bed. On 3/30/22 at 7:19 a.m., an interview was conducted with LPN #4. LPN #4 stated approximately three weeks ago, the speech therapist said R47 had to be up in the chair for each meal. LPN #4 stated the evening nurse told her to not worry about giving R47 snacks during the night shift because the resident eats a lot of snacks while in the chair during the evening shift. When asked if R47 was receiving snacks during the night shift, LPN #4 stated it was not made clear to her until last Friday or Saturday that R47 could eat snacks in the bed. LPN #4 stated R47 requested snacks during the night shift and she told the resident he had to be up in the chair to eat. LPN #4 stated R47 was not assisted to the chair to eat a snack. On 3/29/22 at 3:38 p.m., an interview was conducted with LPN #2. LPN #2 stated she would honor a resident's preference for snacks in bed even if she thought this was not safe, as long as the resident was cognitively intact and was sitting up in bed.	F 561		

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F 561	Continued From page 27 On 3/29/22 at 4:42 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the interim director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 561		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is	F 582	**F 582 – Medicare / Medicaid Coverage** 1. Resident # 200 no longer resides at the center. 2. A review of residents discharging from skilled services from 3.1.22 will be completed by the MDS / designee utilizing the "SNF Beneficiary Notification Review" audit tool. 3. The NHA / designee will educate the facility Social Service department on "Focus on F-tag 582" on or before the date of compliance. 4. Utilizing the "SNF Beneficiary Notification Review" – 5 residents per week x 4 weeks will be audited by the NHA / designee to validate notice was given appropriately. Results will be reviewed with QA&A. 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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F 582	Continued From page 28 reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide the notice of the right to appeal discharge from Medicare Part A services for 1 of 50 residents in the survey sample; Resident #200. The findings include: Resident #200 was admitted on 1/6/22 and discharged on 2/1/22. Resident #200 was receiving skilled services that ended on 1/26/22. The resident was not provided with an Advance Beneficiary Notice (ABN) which document a	F 582		

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resident's right to appeal the decision to discontinue skilled services.

On the most recent MDS (Minimum Data Set), an Admission/5-Day assessment, with an ARD (Assessment Reference Date) of 1/12/22, Resident #200 was unable to complete the resident portion of the BIMS (Brief Interview for Mental Status exam) interview and was coded as being moderately impaired in ability to make daily life decisions on the staff interview regarding the resident's cognition.

A review of the facility document, "Notice of Medicare Non-Coverage" (NOMNC) was reviewed. This form documented, "Your Medicare provided and/or health plan have determined that Medicare probably will not pay for your current Skilled Nursing and Skilled Rehabilitation services after the effective date indicated above. You may have to pay for any services you receive after the above date. Your Right to Appeal This Decision: You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal..."

A review of the physical therapy discharge note dated 1/26/22 documented, "Patient has made consistent progress with skilled interventions and Patient has reached maximum potential with skilled services. Patient is supposed to be discharged to home with family to assist and home health services to follow up on safety and mobility."

On 3/30/22 at approximately 10:00 AM, the NOMNC was requested from ASM #1

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F 582	Continued From page 30 (Administrative Staff Member) the Administrator, for Resident #200. On 3/30/22 at 10:41 AM, ASM #1 was unable to provide a NOMNC for Resident #200, stating that one was not provided because the resident had left the facility of their own choice prior to completing therapy. Information was requested regarding any documentation that reflected this discharge status, showing that an NOMNC was not required. On 3/30/22 at 11:20 AM, ASM #1 returned with therapy notes, as documented above, and stated that the last covered day was 1/26/22 and that the resident converted to private pay and remained in facility for 5 additional days under private pay until the spouse chose to take Resident #200 home. He stated that an NOMNC should have been issued when Resident #200 converted to private pay. No further information was provided by the end of the survey.	F 582		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. 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. The facility must provide- §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. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584	**F 584 – Safe / Clean / Homelike Environment** 1. The identified housekeeping and maintenance issues in rooms for residents # 97, # 86, # 50, # 60, # 6, # 87, # 452 have been corrected. 2. A review of resident areas will be completed by the Interdisciplinary team utilizing the "Housekeeping" audit tool to validate safe / clean / homelike environment.	

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F 584	Continued From page 31 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §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: 2. The facility staff failed to maintain a homelike environment for Resident #86 (R86). The wallpaper behind the bed was torn and ripped. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 3/16/2022, the resident scored an 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately cognitively impaired for making daily decisions.	F 584	3. The NHA / designee will educate the facility housekeeping / maintenance department on the "Focus on F-tag 584" on or before the date of compliance. 4. Utilizing the "Housekeeping" audit tool the NHA / designee will audit 5 resident rooms / week x 4 weeks to validate a safe / clean / homelike environment. Results will be reviewed with QA&A. 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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Observation was made on 3/28/2022 at 2:02 p.m. of R86's room. The wall behind the bed had torn and ripped wallpaper. A second observation was made on 3/29/2022 at 8:47 a.m. The wall behind the bed had torn and ripped wallpaper.

On 3/29/2022 at 9:50 a.m. an interview was conducted with OSM (other staff member) #4, the maintenance director at a sister facility. When asked how they are made aware of any maintenance repairs that are needed, OSM #4 stated they come over twice a week and make complete what needs to be done. OSM #4 stated the previous maintenance director was terminated a week ago. When asked the process for maintaining the facility, OSM #4 stated they make monthly room rounds where they check the bathrooms, light switches, plugs, window fixtures, TV, no screws sticking out and touch up paint if need. OSM #4 stated the wallpaper is an ongoing issue in the building due to humidity. OSM #4 stated they use [name of computer program to put in maintenance requests]. They (CNAs [certified nursing assistants]/nurses) put in a work order, if maintenance can do it, they do it and if not, they reach out to a contractor. OSM #4 stated the wallpaper is old, try to find a glue on and try to put that up. OSM #4 stated that the requests from [name of computer program] come across on their phones. On 3/29/2022 at 1:25 p.m. OSM #4 stated the wallpaper behind R86's room was not in [name of computer program].

ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above

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F 584	Continued From page 33 concern on 3/29/2022 at 5:02 p.m. No further information was provided prior to exit. 3. The facility staff failed to maintain a homelike environment for Resident #50 (R50). The wallpaper behind the bed was torn and ripped. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/15/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indication the resident is not cognitively impaired for making daily decisions. Observation was made of R50's room on 3/28/2022 at 11:17 a.m. The wallpaper behind the resident's bed was ripped and torn. An interview was conducted with R50 on 3/28/22 at 11:17 a.m. When asked how long the wallpaper has been that way, R50 stated it had been that way since they were moved to this room. On 3/29/2022 at 9:50 a.m. an interview was conducted with OSM (other staff member) #4, the maintenance director at a sister facility. When asked how they are made aware of any maintenance repairs that are needed, OSM #4 stated they come over twice a week and make complete what needs to be done. OSM #4 stated the previous maintenance director was terminated a week ago. When asked the process for maintaining the facility, OSM #4 stated they make monthly room rounds where they check the bathrooms, light switches, plugs, window fixtures, TV, no screws sticking out and touch up paint if need OSM #4 stated the wallpaper is an ongoing issue in the building due to humidity. OSM #4	F 584		

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F 584	Continued From page 34 stated they use [name of computer program to put in maintenance requests]. They (CNA [certified nursing assistants]/nurses) put in a work order, if we can do we do it and if not we reach out to a contractor. OSM #4 stated the wallpaper is old, we try to find a glue on and try to put that up. OSM #4 stated if we give me the room number, he will look up in [name of computer program]. OSM #4 stated that the requests from [name of computer program] comes across on their phones. On 3/29/2022 at 1:25 p.m. OSM #4 stated the wallpaper behind R50's room was not in [name of computer program]. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m. No further information was provided prior to exit. 4. The facility staff failed to maintain a homelike environment for Resident #60 (R60). The privacy curtain had a brown substance on it. On the most recent MDS assessment, a quarterly assessment, with an ARD of 3/3/2022, the resident scored a 10 out of 15 on the BIMS, indicating the resident was moderately cognitively impaired for making daily decisions. Observation was made of R60's room on 3/28/2022 at 10:30 a.m. and 3:39 p.m. The privacy curtain was partially pulled around the bed to approximately the level of the resident's waist. The resident was asleep.	F 584		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 35 A second observation was made on 3/29/2022 at 8:41 a.m. R60 was in the bed, sitting up and eating breakfast. The brown substance was still on the privacy curtain. An interview was conducted with OSM #1, the environmental services director, on 3/29/2022 at 10:54 a.m. When asked how often the privacy curtains are checked for stains or changed, OSM #1 stated the staff should be looking at them when they are cleaning the room, and let us know if there is any soil on them. When asked if she was made aware of R60's privacy curtain, OSM #1 stated she was aware of it two weeks ago and it was changed. The above observation was shared with OSM #1. OSM #1 returned at 11:27 a.m. and stated the curtain looked like it was coffee and pudding. When asked if that was a homelike environment, OSM #1 stated, no. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m. No further information was provided prior to exit. 5. The facility staff failed to maintain a homelike environment for Resident #6 (R6). There was a milky substance on the lower half of the closet door. On the most recent MDS assessment, a quarterly assessment, with an ARD of 12/31/2021, the resident was coded as having both short and long term memory problems and was severely impaired to make daily decisions. In Section K -	F 584		

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F 584	Continued From page 36 Nutritional Status, R6 was coded as receiving their nutrition by a feeding tube. Observation was made of R6's room on 3/28/2022 at 10:24 a.m. and 1:49 p.m. The closet door, next to the resident's bed, had a splattering of a milky substance on the lower half of the door. R6's tube feeding was not running at the time. A third observation was made on 3/28/2022 at 3:38 p.m. The closet door still had the milky substance on the lower half of the door and the R6's tube feeding was infusing. On 3/29/2022 at 8:40 a.m. an observation was made of R6's room. The tube feeding was infusing and the milky substance on the lower half of the closet door was still there. An interview was conducted with OSM #1, the environmental services director, on 3/29/2022 at 10:54 a.m. When asked how often does the furniture get cleaned or wiped down, OSM #1 stated furniture should be wiped down every Friday. OSM #1 stated if there is something they see in between, then they are to clean it. The above observation was shared with OSM #1. OSM #1 returned at 11:27 a.m. and stated the substance on the closet door was not syrup but whatever was spilled on the door, when she wiped it, it came right off. OSM #1 stated she did not know what it was. When asked if that is homelike to have that on the furniture, OSM #1 stated it was not. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above	F 584		

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concern on 3/29/2022 at 5:02 p.m.

No further information was provided prior to exit.
6. The facility staff failed to provide a homelike environment for Resident #87 (R87). An area with scrapes and exposed drywall was observed behind the head of R87's bed.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/16/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions.

On 3/27/2022 at 12:18 p.m., an observation was made of R87's room. The area behind R87's head of bed was observed to be scraped with areas of exposed drywall and peeling paint. At this time an interview was conducted with R87. R87 stated that the area on the wall was from the trapeze bar on the bed hitting the wall. R87 stated that they had requested the facility to put a protective board on the wall but no one had been in to fix the area or look at it. R87 stated that the area had been there over four months now, and they wanted the staff to fix the area when they were out of bed one day because they did not want to have to move to another room.

Additional observations on 3/28/2022 at 9:30 a.m. and 3/29/2022 at 11:12 a.m. revealed the findings as described above.

On 3/29/2022 at 12:45 p.m., an interview was conducted with OSM (other staff member) #4, the director of maintenance at a sister facility. OSM #4 stated that they came over twice a week because there was no maintenance director

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currently. OSM #4 stated that monthly room rounds were conducted in the facility. OSM #4 stated that they used the TELS (The Equipment Lifecycle System) for maintenance work orders entered by staff. OSM #4 stated that they would check to see if there were any work orders in place for R87's wall behind the bed. OSM #4 observed R87's wall behind the bed and stated that they would be able to get the repairs done. OSM #4 discussed the repairs with R87 and stated that they would not have to move to another room to have this completed, as it would not take the whole day.

On 3/29/2022 at 1:25 p.m., OSM #4 stated that there were no work orders in place for R87's wall behind the head of the bed.

On 3/29/2022 at 2:12 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that they called maintenance directly if there were any issues that needed repairs. LPN #5 stated that they had never entered a work order into the computer and always called or either spoke with maintenance staff face to face on the unit.

On 3/29/2022 at 4:41 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant and ASM #5, the former administrator were made aware of the above concern.

No further information was presented prior to exit.

Complaint deficiency

7. The facility staff failed to maintain a clean and

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F 584	Continued From page 39 homelike environment for Resident #452. During the initial resident interview on 3/27/22 at 3:30 PM, a two foot square of wallpaper was missing from behind Resident #452's bed. Resident #452's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/7/22, coded the resident as scoring 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of Resident #452's comprehensive care plan dated 2/1/19, revealed the following, "FOCUS: Hoarding belongings in room and bathroom- have a safe and clean living area. INTERVENTIONS: Monitor room as needed." An interview was conducted on 3/29/22 at 9:50 AM with OSM (other staff member) #4, the maintenance director for a sister facility. When asked his responsibilities in covering this facility, OSM #4 stated, they come over twice a week. When asked the process for environmental rounds, OSM #4 stated, they do monthly room rounds, bathroom, light switches, plugs, window fixtures, television, and resident room. When asked what work is completed, OSM #4 stated they touch up paint if needed, fix the wallpaper-ongoing issues with wallpaper in the building due to humidity. When asked how work orders are obtained, OSM #4 stated they use TELS (the equipment life safety system). The nurse or CNA (certified nursing assistant) puts in a work order, and if they can, they do the work themselves. If not, they reach out to a contractor. OSM #4 stated the wallpaper is old, and they attempt to find something that can be glued on to	F 584		

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F 584	Continued From page 40 make the repair. He stated he was not sure why there would be just dry wall behind Resident #452's bed. On 3/29/22 at 1:25 PM, OSM #4 stated none of the requests were in TELS, but they have been corrected now. An interview was conducted on 3/29/22 at 2:50 PM, with LPN (licensed practical nurse) #3. When asked if missing wallpaper created a clean, homelike environment, LPN #3 stated, No that is not homelike. On 3/29/22 at 4:40 PM, ASM #1, the administrator, ASM #2, the interim director of nursing, ASM #3, the quality assurance consultant, and ASM #5, the former administrator were informed of the above concern. No further information was provided prior to exit. Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide a clean, home-like environment for seven of 50 residents in the survey sample, Residents #97, #86, #50, #60, #6, #87, and #452 . The findings include: 1. The facility staff failed to clean the window tracks, under the furniture, and behind the toilet in the resident's room. Additionally, the facility failed to maintain the resident's bureau in a manner free	F 584		

F 584 Continued From page 41 F 584

of multiple scratches and gouges, failed to repair peeling wallpaper, and failed to repair a hole in the bathroom wall.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/21/22, Resident #97 (R97) was coded as scoring 15 out of 15 on the BIMS (brief interview for mental status), indicating she had no cognitive impairment for making daily decisions.

On 3/27/22 at 2:06 p.m., R97 was observed lying in bed. R97 was awake and alert. R97 directed attention to the areas under the bureau, in the window tracks, behind the toilet, on the bedroom wall where wallpaper was peeling (behind the television table), and to a fist-size hole in the bathroom wall. R97 also directed attention to the bureau, which contained numerous chips, scrapes, and gouges in the finish. The window tracks contained dried, black material that was not easily scraped with a fingernail. The area behind and around the toilet contained a dark brownish-black stain about 6 inches in width and 3 inches in length. R97 stated housekeepers are in and out of the room quickly, and the perception is that no one takes the time needed to notice or clean or repair items that need attention. R97 stated: "I am ashamed to invite my grandchildren to visit me here because of the condition of this place." R97 stated they feel like none of the staff members cares about the residents' living conditions.

On 3/28/22 at 10:47 a.m., OSM (other staff member) #1, environmental services director, was interviewed. When asked what is included in cleaning a resident's room, she stated some

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tasks are completed daily: dumping trash, wiping down all surfaces, cleaning bathrooms, and mopping. She stated other tasks are considered to be deep cleaning, and occur once weekly on a set schedule: air conditioning units, windows, detailing bathrooms, furniture. OSM #1 was asked to observe the cleanliness conditions of R97's room as detailed above. OSM #1 stated the area under the bureau did not appear to have been dusted "in some time," the window tracks had not been cleaned as they should, and the bathroom "should have been caught way before now." She stated the room was not at an acceptable standard for cleanliness. When asked who follows up to make sure housekeepers are cleaning as they should, she stated she should be following up, but if there is a call out, she has to cover for her staff and she does not have time to go behind housekeepers to monitor their performance. She stated R97's room location is problematic, because there is not one particular housekeeper assigned to clean the room consistently. When asked if she would describe R97's room as homelike, she stated she absolutely would not. When asked if environmental services staff should have noticed the gouges in the bureau, the peeling wallpaper, and the holes in the wall, she stated they should have noticed all these things and reported them to her.

On 3/28/22 at 11:20 a.m., ASM (administrative staff member) #1, the administrator, observed R97's room for cleanliness and for being homelike. After looking at the window, gouges in the bureau, peeling wallpaper, hole in the bathroom wall, and condition of the area behind and around the toilet, he stated there are concerns with the room, and that the room was

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F 584	Continued From page 43 not homelike. On 3/28/22 at 11:37 a.m., ASM #1, ASM #3, the quality assurance consultant, ASM #4, the regional director of operations, and ASM #5, the former administrator, were informed of these concerns. A review of the facility policy, "Focus on F Tag 584," revealed, in part: "The resident has a right to a safe, clean, comfortable, and homelike environment...The facility must provide...housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior...A determination of 'homelike' should include the resident's opinion of the living environment." No further information was provided prior to exit.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600	**F 600 – Free from Abuse / Neglect** 1. Resident # 43 was provided a shower, investigation initiated, and final was sent. 2. A comprehensive review of current residents will be completed by the interdisciplinary team utilizing the "Nursing Services" QAPI tool to observe current resident care / appearance; any identified areas of opportunity will be corrected and / or care planned as preference.	

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F 600	Continued From page 44 by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care to prevent neglect for one of 50 residents in the survey sample, Resident #43 (R43). Resident #43 was observed with visible dandruff flakes and crusty patches on the scalp, a noticeable body odor, dry and cracked areas on the lips with visible film in the corners of the mouth and white filmy substance on the fold area under their neck during an incontinence care observation on 3/29/2022. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/31/2022, the resident was assessed as being severely impaired for making daily decisions. Section G of the assessment documented R43 as being totally dependent on one staff member for dressing, eating, toileting and personal hygiene. The MDS assessment further documented R43 being always incontinent of bowel and bladder and receiving tube feeding. On 3/29/2022 at 10:15 a.m., a request was made to TNA (temporary nursing assistant) #10 to observe incontinence care for R43. On 3/29/2022 at 10:23 a.m., an observation was made of TNA #10 providing ADL (activities of daily living) care to R43. TNA #10 prepared a basin of warm water with a washcloth and towel and begam to wash R43's face. When asked about the dandruff flakes and crusty patches on the scalp, TNA #10 explained that R43 had "cradle cap really bad." When asked if R43's hair	F 600	3. The DON / designee will educate the facility staff on "Focus on F-tag 600" and "AM care" and "Bathing" nursing procedures on or before the date of compliance. 4. Utilizing the "Nursing services" QAPI tool and Abuse Prevention QAPI tool – the Interdisciplinary team will audit 5 residents / week x 4 weeks. Results will be reviewed with QA&A. 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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was washed, TNA #10 stated that they did not shampoo R43's hair because they were not trained how to do this. When asked if R43's hair was washed on shower days, TNA #10 stated that they did not take R43 to the shower because they were not trained how to use the shower chair or shower stretcher. TNA #10 stated that they knew that R43's family wanted them to have showers because they had been told this, but they could only do what they were trained to do. TNA #10 stated that R43 was very contracted and they did not want to hurt them so they did the best they could. TNA #10 washed under R43's chin and cleaned a white filmy substance off of the area. An area on the right side of the neck and lower right jaw was observed to have small red raised bumps on it. TNA #10 stated that R43 had a rash on that area and they were afraid to wash the area too hard so it would not bleed. Body odor was smelled when TNA #10 washed R43's armpit areas through masks worn during care. TNA #10 proceeded to provide incontinence care and apply a new gown to R43. When asked about R43's mouth care and dry lips, TNA #10 stated that they should use mouth swabs to provide mouth care for R43 but they were never trained how to use them and they did not want to hurt R43. TNA #10 stated that they put Vaseline on R43's lips at times that they got from R43's roommate. TNA #10 stated that these observations were from lack of care and that they were only able to get so much of R43 clean with the training they had received, but they did the best that they could do for R43.

The comprehensive care plan dated 2/19/2021 documented in part, "ADL Self care deficit. Date Initiated: 02/19/2021 ...Assist to bathe/shower as needed ...Assist with daily hygiene, grooming,

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F 600	Continued From page 46 dressing, oral care and eating as needed." On 3/29/2022 at 12:24 p.m., an observation of R43 was made with ASM (administrative staff member) #2, the interim director of nursing/MDS coordinator. ASM #2 observed R43's visible dandruff flakes and crusty patches on the scalp and dry and cracked areas on the lips with film in corners of the mouth. ASM #2 was made aware of the body odor and substance on the fold area under the neck during ADL care on 3/29/2022. ASM #2 was made aware that showers, hair washing and mouth care were not being done due to lack of training and stated that they needed to review what training the TNA's were receiving for ADL care. The facility policy, "Patient Protection, Abuse, Neglect, Mistreatment and Misappropriation Prevention" documented in part, "...Neglect is the failure of the facility, its employees or service providers to provide goods and service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress..." On 3/29/2022 at 4:41 p.m., ASM #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant and ASM #5, the former administrator were made aware of the above concern. No further information was provided prior to exit.	F 600		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge-	F 622		

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F 622	Continued From page 47 §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger	F 622	**F 622 – Ombudsman Notification** 1. Residents # 452, # 66, # 67, # 6, # 93 have all been re-admitted to the facility. An updated list of discharges was faxed to the ombudsman, 2. Utilizing the "Unexpected hospital Readmission" QAPI tool – the Director of Nursing / designee completed a comprehensive review from 3.1.22 – current to ensure that discharge requirements were met for each resident discharged. 3. The Director of Nursing / designee will educate the facility licensed nursing staff on "Focus on F-tag 622" and the "Interdisciplinary Care Transition Checklist" on or before the date of compliance. 4. Utilizing the "Unexpected hospital Readmission" QAPI tool; the Director of Nursing / designee will audit acute care send outs and facility-initiated discharges for 5 residents weekly x 4 weeks. Results will be reviewed with QA&A 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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F 622	Continued From page 48 that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;	F 622		

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(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence that all required information was provided to the hospital staff when five out of 50 residents in the survey sample were transferred to the hospital, Residents #452, #66, #67, #6, and #93.

1. The findings include:

The facility staff failed to provide evidence that all required information was provided to the hospital staff when Resident #452 was transferred to the hospital on 3/20/22. Per the facility's "Acute Care Documentation Checklist," the following documents should be sent to the receiving hospital when a resident is transferred there from the facility: INTERACT (interventions to reduce acute care transfers) care form, advanced directives, physician orders, facility's "Transfer/Discharge Record," and the comprehensive care plan goals. No evidence of these documents being provided was revealed.

Resident #452's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/7/22, coded the resident as scoring 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired.

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A review of the nursing progress note dated 3/20/22 at 7:04 PM, revealed the following, "CNA (certified nursing assistant) notified nurse at 5:00 P.M. of the aforementioned resident complaining of chest pain and SOB (shortness of breath). Vitals blood pressure-154/86, pulse-70, respirations-22, temperature-97.8, oxygen saturation-95% on room air. Resident appeared to be in respiratory distress. 911 assistance requested. Emergency assistance arrived and transported resident to hospital. RP (responsible party) and NP (nurse practitioner) notified."

On 3/28/22 at approximately 5:00 PM a request was made for the evidence the required information was provided to the hospital on 3/20/22 for Resident #452.

On 3/29/22 at approximately 9:00 AM, the nursing progress note dated 3/20/22 at 7:04 PM was provided.

ASM (administrative staff member) #3, the quality assurance consultant, stated, "We do not have any additional evidence of the transfer to hospital for this resident.

An interview was conducted on 3/29/22 at 3:32 PM, with LPN (licensed practical nurse) #2. When asked what documents are provided when a resident is transferred to the hospital, LPN #2 stated they provide the acute care transfer form, relevant laboratory results, face sheet and medication list. She stated they call report to the receiving facility. She stated they don't send the care plan. She stated there is a big envelope in which to put all of these. When asked how they evidence what has been sent with the resident to the hospital, LPN #2 stated they usually make a

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copy of the one sheet and put it in the chart. The acute care transfer is usually in the chart. She stated if it is an emergency 911 call, all the documents are not sent.

On 3/29/22 at 4:40 PM, ASM #1, the administrator, ASM #2, the interim director of nursing, ASM #3, the quality assurance consultant, and ASM #5, the former administrator were informed of the above concern.

According to the facility's "Interdisciplinary Care Transitions Checklists" policy, dated 10/19, which reveals, "Assess patient for change in condition. Notify physician of change in condition and obtain new orders. Initiate new orders. Complete 'Acute Care Transfer Documentation Checklist'. Collect necessary documents including a 'Transfer/Discharge Record' and copy of the patient's comprehensive care plan goals from medical record and place in envelope. Seal envelope. Remove top copy and place in the patient's clinical record."

No further information was provided prior to exit.
2. The facility staff failed to evidence the required documentation was provided to the receiving facility for a facility initiated transfer for Resident #66 (R66) on 2/22/2022.

On the most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 3/5/2022, the resident scored a 15 out of 15 indicating the resident is not cognitively impaired for making daily decisions.

The nurse's note dated 2/22/2022 documented in part, "[Name of nephrologist] from [initials of

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hospital] called facility and stated that resident needs to be sent to [initials of hospital] ER (emergency room) due to creatinine of 10.5, hemoglobin 6.2 and K (potassium) 6.5. States that resident needs to get dialysis right away and he wants him (sic) taken to [initial of hospital]. Called MD (medical doctor) and received order to send resident to ER per Nephrologist request. RP (responsible party) was called and ambulance called. Writer also called [initials of hospital] to assure that resident would be accepted since hospital was on Ambulance diversional, spoke with MD at ER that will accept resident to ER."

A request was made on 3/29/2022 at 10:45 a.m. of ASM (administrative staff member) #1, the administrator, for evidence of the medication list, care plan and other clinical documents were sent with R66 at the time of their transfer on 2/22/2022.

On 3/29/2022 at 12:11 p.m. ASM #3, the quality assurance consultant, stated the facility did not have any documentation related to the documents sent with R66 upon transfer to the hospital on 2/22/2022.

An interview was conducted with LPN (licensed practical nurse) #2 on 3/29/2022 at 3:32 p.m. When asked the process for sending a resident out to the hospital, LPN #2 stated on evening shift we assess them, call MD (medical doctor), family. We fill in an acute care transfer form. We send relative labs, face sheet and med (medication) list. The nurse calls report. When asked if they send the care plan goals with the resident, LPN #2 stated no, we don't send the care plan. When asked if there is a way to evidence that these items were sent with the

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resident, LPN #2 stated there is a form to check off what has been sent with the resident, there is a big envelope. When asked, how do you evidence what has been sent, LPN #2 stated, they usually make a copy of the one sheet and put it in the chart. LPN #2 stated the acute care transfer is usually in the chart. She further stated, sometimes you don't get all that information for a 911 call.

ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m.

No further information was provided prior to exit.

3. The facility staff failed to evidence the required documentation was provided to the receiving facility for a facility initiated transfer for Resident #67 (R67) on 3/19/2022.

On the most recent MDS assessment, with an ARD of 3/7/2022, the resident scored a 7 out of 15 on the BIMS score, indicating the resident was severely cognitively impaired to make daily decisions.

The nurse's note dated, 3/19/2022 at 7:04 p.m. documented, "Resident bs (blood sugar) reading high. Resident refused insulin coverage. RP (responsible party) spoke with resident to encourage insulin coverage via FaceTime and resident still refused. NP (nurse practitioner) called and new order obtained to send to er (emergency room) for eval (evaluation), RP aware. Ambulance called for transport to [name

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of hospital]."

A request was made on 3/29/2022 at 10:45 a.m. of ASM (administrative staff member) #1, the administrator, for evidence of the medication list, care plan and other clinical documents were sent with R66 at the time of their transfer on 3/19/2022.

On 3/29/2022 at 12:11 p.m. ASM #3, the quality assurance consultant, stated the facility did not have any documentation related to the documents sent with R67 upon transfer to the hospital on 3/19/2022.

An interview was conducted with LPN (licensed practical nurse) #2 on 3/29/2022 at 3:32 p.m. When asked the process for sending a resident out to the hospital, LPN #2 stated on evening shift we assess them, call MD (medical doctor), family. We fill in an acute care transfer form. We send relative labs, face sheet and med (medication) list. The nurse calls report. When asked if they send the care plan goals with the resident, LPN #2 stated no, we don't send the care plan. When asked if there is a way to evidence that these items were sent with the resident, LPN #2 stated there is a form to check off what has been sent with the resident, there is a big envelope. When asked, how do you evidence what has been sent, LPN #2 stated, they usually make a copy of the one sheet and put it in the chart. LPN #2 stated the acute care transfer is usually in the chart. She further stated, sometimes you don't get all that information for a 911 call.

ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of

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nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m.

No further information was provided prior to exit.

4. The facility staff failed to evidence the required documentation was provided to the receiving facility for a facility initiated transfer for Resident #6 on 2/24/2022.

On the most recent MDS assessment, a quarterly assessment, with an ARD of 12/31/2021, the resident was coded as having both short and long term memory problems and was severely impaired to make daily decisions.

The nurse's note dated, 2/24/2022 at 7:35 a.m. documented in part, "Went to resident room at 6:00 a.m. to give him his medication and found peg tube on the floor, not bleeding noted from site, call placed to doctor on call. [Name of person on call] received order to send to [Name of hospital], hospice also called and informed of above. Called (sic) placed to person on contact list, informed of what had happen and was told resident was going to be sent out to the hospital to have peg tube replaced. Vital signs stable. Call placed to ambulance. 7:35 (a.m.) ambulance here to pick up resident."

A request was made on 3/29/2022 at 1:50 p.m. of ASM (administrative staff member) #1, the administrator, for evidence of the medication list, care plan and other clinical documents were sent with R6 at the time of their transfer on 2/24/2022.

On 3/29/2022 at 4:03 p.m. ASM #3, the quality

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F 622	Continued From page 56 assurance consultant, stated the facility did not have any documentation related to the documents sent with R6 upon transfer to the hospital on 2/24/2022. An interview was conducted with LPN (licensed practical nurse) #2 on 3/29/2022 at 3:32 p.m. When asked the process for sending a resident out to the hospital, LPN #2 stated on evening shift we assess them, call MD (medical doctor), family. We fill in an acute care transfer form. We send relative labs, face sheet and med (medication) list. The nurse calls report. When asked if they send the care plan goals with the resident, LPN #2 stated no, we don't send the care plan. When asked if there is a way to evidence that these items were sent with the resident, LPN #2 stated there is a form to check off what has been sent with the resident, there is a big envelope. When asked, how do you evidence what has been sent, LPN #2 stated, they usually make a copy of the one sheet and put it in the chart. LPN #2 stated the acute care transfer is usually in the chart. She further stated, sometimes you don't get all that information for a 911 call. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m. No further information was provided prior to exit. 5. The facility staff failed to evidence the required documentation was provided to the receiving facility for a facility initiated transfer for Resident	F 622		

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F 622	Continued From page 57 #93 (R93) on 1/15/2022. On the most recent MDS assessment, a quarterly assessment, with an ARD of 3/17/2022, the resident scored a 7 out of 15 on the BIMS score, indicating the resident is severely cognitively impaired for making daily decisions. The nurse's note dated, 1/15/2022 documented, "Resident noted with low O2 (oxygen) saturation 81 - 86%. Initiated O2 at 2 l/m (liters per minute). MD on all notified. Gave order to give O2 at 2 l/m and to increase PRN (as needed). Also to give call back to on-call if O2 needs increased. Write check O2 sat (saturation) on 2l/m O2 at 94% with deep breaths. Resident was repositioned in bed. Rechecked O2 sat 2 hours later noted O2 sat down to 86% on 2l/m, increased O2 to 2 l/m called MD on call to inform. MD on call gave order to send to [initials of hospital] ER due to desaturation at this time. EMT (emergency medical technician) called for transport. Report given to EMT. MD on call informed of transfer. Resident is own RP and was made aware of transport to [initials of hospital]. Transfer sheet sent with EMT." A request was made on 3/28/2022 at 4:51 p.m. of ASM (administrative staff member) #1, the administrator, for evidence of the medication list, care plan and other clinical documents were sent with R93 at the time of their transfer on 1/15/2022. On 3/29/2022 at 8:10 a.m. ASM #3, the quality assurance consultant, stated the facility did not have any documentation related to the documents sent with R93 upon transfer to the hospital on 1/15/2022.	F 622		

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F 622	Continued From page 58 An interview was conducted with LPN (licensed practical nurse) #2 on 3/29/2022 at 3:32 p.m. When asked the process for sending a resident out to the hospital, LPN #2 stated on evening shift we assess them, call MD (medical doctor), family. We fill in an acute care transfer form. We send relative labs, face sheet and med (medication) list. The nurse calls report. When asked if they send the care plan goals with the resident, LPN #2 stated no, we don't send the care plan. When asked if there is a way to evidence that these items were sent with the resident, LPN #2 stated there is a form to check off what has been sent with the resident, there is a big envelope. When asked, how do you evidence what has been sent, LPN #2 stated, they usually make a copy of the one sheet and put it in the chart. LPN #2 stated the acute care transfer is usually in the chart. She further stated, sometimes you don't get all that information for a 911 call. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m. No further information was provided prior to exit.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623	**F 623 – Notice Requirements Prior to Transfer / Discharge** 1. Residents # 452, # 66, # 67, # 6, # 93 have all been re-admitted to the facility.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 59	F 623		

representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section

Provider's Plan of Correction (F 623):

2. Utilizing the "Unexpected Hospital readmission" audit tool, a comprehensive review of discharges from 3.1.22 - current; excluding AMA will be completed to ensure appropriate paperwork was completed.
3. The NHA / designee will educate the facility Social Service department on "Focus on F-tag 623" on or before the date of compliance.
4. Utilizing the "Unexpected Hospital Readmission" audit tool 5 residents / week will be audited by the NHA / designee to validate compliance. Results will be reviewed with QA&A.
5. The facility's alleged date of compliance will be April 28, 2022. — 4/28/2022

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F 623	Continued From page 60 must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to evidence written documentation to the Resident and/or RP (responsible party) and ombudsman upon a facility initiated transfer for five out of 50 residents in the survey sample, Residents #452, #66, #67, #6, and #93.

1. The findings include:

The facility staff failed to evidence written documentation to the Resident/RP and Ombudsman when Resident #452 was transferred to the hospital on 3/20/22.

Resident #452's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/7/22, coded the resident as scoring 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired.

A review of the nursing progress note dated 3/20/22 at 7:04 PM, revealed the following, "CNA

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(certified nursing assistant) notified nurse at 5:00 P.M. of the aforementioned resident complaining of chest pain and SOB (shortness of breath). Vitals blood pressure-154/86, pulse-70, respirations-22, temperature-97.8, oxygen saturation-95% on room air. Resident appeared to be in respiratory distress. 911 assistance requested. Emergency assistance arrived and transported resident to hospital. RP (responsible party) and NP (nurse practitioner) notified."

On 3/28/22 at approximately 5:00 PM a request was made for the evidence of written notification to the RP and ombudsman when Resident #452 was transferred to the hospital on 3/20/22.

On 3/29/22 at approximately 9:00 AM, the nursing progress note dated 3/20/22 at 7:04 PM was provided.

ASM (administrative staff member) #3, the quality assurance consultant, stated, "We do not have any additional evidence of the transfer to hospital for this resident.: When asked if there was additional evidence of RP or ombudsman written notification, ASM #3 stated there was none.

An interview was conducted on 3/29/22 at 3:32 PM, with LPN (licensed practical nurse) #2. When asked what written notification is provided to the RP and ombudsman when a resident is transferred to the hospital, LPN #2 stated the nurses make a phone call to the RP and document in the chart. She stated she did not know if anything else is sent to the family. She stated she did not know about the ombudsman.

An interview was conducted on 3/29/22 at 4:29 PM with OSM (other staff member) #5, the social

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worker. When asked about the written notification to the ombudsman, OSM #5 stated she started work at the facility in January 2022, and someone was else doing the ombudsman notification. She stated she actually found out about that ombudsman notification today.

On 3/29/22 at 4:40 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, ASM #3, the quality assurance consultant, and ASM #5, the former administrator were informed of the above concern.

According to the facility's "Interdisciplinary Care Transitions Checklists" policy, dated 10/19: "Transition from skilled nursing facility to acute care: notify patient, family and representative. Issue written notification per state specific guidelines; consult a representative from the legal department with questions. Notify ombudsman."

No further information was provided prior to exit.
2. The facility staff failed to provide written notification to the resident and/or responsible party for a facility initiated transfer, and failed to notify the ombudsman of a transfer to the hospital on 2/22/2022 for Resident #66 (R66).

On the most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 3/5/2022, the resident scored a 15 out of 15, indicating the resident is not cognitively impaired for making daily decisions.

The nurse's note dated 2/22/2022 documented in part, "[Name of nephrologist] from [initials of hospital] called facility and stated that resident

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needs to be sent to [initials of hospital] ER (emergency room) due to creatinine of 10.5, hemoglobin 6.2 and K (potassium) 6.5. States that resident needs to get dialysis right away and he want him (sic) taken to [initials of hospital]. Called MD (medical doctor) and received order to send resident to ER per Nephrologist request. RP (responsible party) was called, and ambulance called. Writer also called [initials of hospital] to assure that resident would be accepted since hospital was on Ambulance diversional, spoke with MD at ER that will accept resident to ER."

A request was made on 3/29/2022 at 10:45 a.m. of ASM (administrative staff member) #1, the administrator, for evidence of a written notification to the resident and/or responsible party and notification to the ombudsman for R66's transfer on 2/22/2022.

On 3/29/2022 at 12:11 p.m. ASM #3, the quality assurance consultant, stated the facility did not have any documentation of a written notification to the resident and/or responsible party and did not have evidence of the ombudsman's notification of the transfer for R66 to the hospital on 2/22/2022.

An interview was conducted with LPN (licensed practical nurse) #2 on 3/29/2022 at 3:32 p.m. When asked if anything is sent or given to the resident and/or responsible party for the reason for the transfer, LPN #2 stated an affidavit is sent with the resident. When asked if the nursing staff if responsible for notifying the ombudsman, LPN #2 stated not that she knew of, and that she didn't even know how to notify the ombudsman.

An interview was conducted with OSM (other staff

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member) # 5, social services, on 3/29/2022 at 4:39 p.m. When asked if she notified the ombudsman of transfers to the hospital, OSM #5 stated she had just started at the facility in January 2022, and someone else was doing that. OSM #5 stated she just found out about the ombudsman notification today.

ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m.

No further information was provided prior to exit.

3. The facility staff failed to provide written notification to the resident and/or responsible party for a facility initiated transfer, and failed to notify the ombudsman of a transfer to the hospital on 3/19/2022 for Resident #67 (R67).

On the most recent MDS assessment, with an ARD of 3/7/2022, R67 scored a 7 out of 15 on the BIMS score, indicating the resident was severely cognitively impaired to make daily decisions.

The nurse's note dated 3/19/2022 at 7:04 p.m. documented, "Resident bs (blood sugar) reading high. Resident refused insulin coverage. RP (responsible party) spoke with resident to encourage insulin coverage via FaceTime and resident still refused. NP (nurse practitioner) called and new order obtained to send to er (emergency room) for eval (evaluation), RP aware. Ambulance called for transport to [name of hospital]."

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F 623	Continued From page 66 A request was made on 3/29/2022 at 10:45 a.m. of ASM (administrative staff member) #1, the administrator, for evidence of a written notification to the resident and/or responsible party and notification to the ombudsman for R67's transfer on 3/19/2022. On 3/29/2022 at 12:11 p.m. ASM #3, the quality assurance consultant, stated the facility did not have any documentation of a written notification to the resident and/or responsible party and did not have evidence of the ombudsman's notification of the transfer for R67 to the hospital on 3/19/2022. An interview was conducted with LPN (licensed practical nurse) #2 on 3/29/2022 at 3:32 p.m. When asked if anything is sent or given to the resident and/or responsible party for the reason for the transfer, LPN #2 stated an affidavit is sent with the resident. When asked if the nursing staff if responsible for notifying the ombudsman, LPN #2 stated not that she knew of, and that she didn't even know how to notify the ombudsman. An interview was conducted with OSM (other staff member) # 5, social services, on 3/29/2022 at 4:39 p.m. When asked if she notified the ombudsman of transfers to the hospital, OSM #5 stated she had just started at the facility in January 2022, and someone else was doing that. OSM #5 stated she just found out about the ombudsman notification today. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above	F 623		

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F 623	Continued From page 67 concern on 3/29/2022 at 5:02 p.m. No further information was provided prior to exit. 4. The facility staff failed to provide written notification to the resident and/or responsible party for a facility initiated transfer, and failed to notify the ombudsman of a transfer to the hospital on 2/24/2022 for Resident #6 (R6). On the most recent MDS assessment, a quarterly assessment, with an ARD of 12/31/2021, the resident was coded as having both short and long term memory problems and was severely impaired to make daily decisions. The nurse's note dated 2/24/2022 at 7:35 a.m. documented in part, "Went to resident room at 6:00 a.m. to give him his medication and found peg tube on the floor, no bleeding noted from site, call placed to doctor on call. [Name of person on call] received order to send to [Name of hospital], hospice also called and informed of above. Called (sic) placed to person on contact list, informed of what had happen and was told resident was going to be sent out to the hospital to have peg tube replaced. Vital signs stable. Call placed to ambulance. 7:35 (a.m.) ambulance here to pick up resident." A request was made on 3/29/2022 at 10:45 a.m. of ASM (administrative staff member) #1, the administrator, for evidence of a written notification to the resident and/or responsible party and notification to the ombudsman for R6's transfer on 2/24/2022. On 3/29/2022 at 12:11 p.m. ASM #3, the quality assurance consultant, stated the facility did not	F 623		

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have any documentation of a written notification to the resident and/or responsible party and did not have evidence of the ombudsman's notification of the transfer for R6 to the hospital on 2/24/2022.

An interview was conducted with LPN (licensed practical nurse) #2 on 3/29/2022 at 3:32 p.m. When asked if anything is sent or given to the resident and/or responsible party for the reason for the transfer, LPN #2 stated an affidavit is sent with the resident. When asked if the nursing staff if responsible for notifying the ombudsman, LPN #2 stated not that she knew of, and that she didn't even know how to notify the ombudsman.

An interview was conducted with OSM (other staff member) # 5, social services, on 3/29/2022 at 4:39 p.m. When asked if she notified the ombudsman of transfers to the hospital, OSM #5 stated she had just started at the facility in January 2022, and someone else was doing that. OSM #5 stated she just found out about the ombudsman notification today.

ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m.

No further information was provided prior to exit.

5. The facility staff failed to provide written notification to the resident and/or responsible party for a facility initiated transfer, and failed to notify the ombudsman of a transfer to the hospital on 1/15/2022 for Resident #93 (R93).

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F 623	Continued From page 69 On the most recent MDS assessment, a quarterly assessment, with an ARD of 3/17/2022, the resident scored a 7 out of 15 on the BIMS, indicating the resident is severely cognitively impaired for making daily decisions. The nurse's note dated, 1/15/2022 documented, "Resident noted with low O2 (oxygen) saturation 81 - 86%. Initiated O2 at 2 l/m (liters per minute). MD on all notified. Gave order to give O2 at 2 l/m and to increase PRN (as needed). Also to give call back to on-call if O2 needs increased. Write check O2 sat (saturation) on 2l/m O2 at 94% with deep breaths. Resident was repositioned in bed. Rechecked O2 sat 2 hours later noted O2 sat down to 86% on 2l/m, increased O2 to 2 l/m called MD on call to inform. MD on call gave order to send to [initials of hospital] ER due to desaturation at this time. EMT (emergency medical technician) called for transport. Report given to EMT. MD on call informed of transfer. Resident is own RP and was made aware of transport to [initials of hospital]. Transfer sheet sent with EMT." A request was made on 3/29/2022 at 10:45 a.m. of ASM (administrative staff member) #1, the administrator, for evidence of a written notification to the resident and/or responsible party and notification to the ombudsman for R93's transfer on 1/15/2022. On 3/29/2022 at 12:11 p.m. ASM #3, the quality assurance consultant, stated the facility did not have any documentation of a written notification to the resident and/or responsible party and did not have evidence of the ombudsman's notification of the transfer for R93 to the hospital	F 623		

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F 623	Continued From page 70 on 3/17/2022. An interview was conducted with LPN (licensed practical nurse) #2 on 3/29/2022 at 3:32 p.m. When asked if anything is sent or given to the resident and/or responsible party for the reason for the transfer, LPN #2 stated an affidavit is sent with the resident. When asked if the nursing staff if responsible for notifying the ombudsman, LPN #2 stated not that she knew of, and that she didn't even know how to notify the ombudsman. An interview was conducted with OSM (other staff member) # 5, social services, on 3/29/2022 at 4:39 p.m. When asked if she notified the ombudsman of transfers to the hospital, OSM #5 stated, she had just started at the facility in January 2022, and someone else was doing that. OSM #5 stated she just found out about the ombudsman notification today. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m. No further information was provided prior to exit.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625	**F 625 – Bed Hold Notice** 1. Residents # 452, # 66, # 67, and # 93 have all been re-admitted to the facility.	

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F 625	Continued From page 71 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to evidence a bed hold was provided at the time of discharge to four out of 50 residents in the survey sample, Residents #452, #66, #67 and #93. The findings include: 1. The facility staff failed to evidence a bed hold was provided when Resident #452 was transferred to the hospital on 3/20/22. Resident #452's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/7/22, coded the resident as scoring 11 out of 15 on the BIMS (brief interview for mental status), indicating	F 625	2. Utilizing the "Unexpected hospital Re-admission" QAPI tool – the Director of Nursing / designee completed a comprehensive review from 3.1.22 – current to ensure that discharge requirements were met for each resident sent to acute care. Opportunities will be reviewed with QA&A. 3. The Director of Nursing / designee will educate the facility licensed nursing staff on "Focus on F-tag 625" and the "Interdisciplinary Care Transition Checklist" on or before the date of compliance. 4. Utilizing the "Unexpected hospital Re-admission" QAPI tool; the Director of Nursing / designee will audit acute care send outs and facility-initiated discharges for 5 residents / week x 4 weeks. Results will be reviewed with QA&A. 5. The facility's alleged date of compliance will be April 28, 2022.	4/2820/22

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F 625	Continued From page 72 the resident was moderately cognitively impaired. A review of the nursing progress note dated 3/20/22 at 7:04 PM, revealed the following, "CNA (certified nursing assistant) notified nurse at 5:00 P.M. of the aforementioned resident complaining of chest pain and SOB (shortness of breath). Vitals blood pressure-154/86, pulse-70, respirations-22, temperature-97.8, oxygen saturation-95% on room air. Resident appeared to be in respiratory distress. 911 assistance requested. Emergency assistance arrived and transported resident to hospital. RP (responsible party) and NP (nurse practitioner) notified." On 3/28/22 at approximately 5:00 PM a request was made for the evidence of the bed hold policy when Resident #452 was transferred to the hospital on 3/20/22. On 3/29/22 at approximately 9:00 AM, the nursing progress note dated 3/20/22 at 7:04 PM was provided. ASM (administrative staff member) #3, the quality assurance consultant, stated, "We do not have any additional evidence of the transfer to hospital for this resident." When asked if there was additional evidence of bed hold for Resident #452, ASM #3 stated, "No, there is none." An interview was conducted on 3/29/22 at 3:32 PM, with LPN (licensed practical nurse) #2. When asked how the facility makes sure a bed hold is provided when a resident is transferred to the hospital, LPN #2 stated there is a form to check off which documents are sent, and all documents are placed in an envelope that goes with the resident to the hospital. The bed hold is sent in the paperwork part. An affidavit is sent	F 625		

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with the resident. When asked how you evidence what has been sent, LPN #2 stated they usually make a copy of the check off sheet and put it in the chart.

On 3/29/22 at 4:40 PM, ASM #1, the administrator, ASM #2, the interim director of nursing, ASM #3, the quality assurance consultant, and ASM #5, the former administrator were informed of the above concern.

According to the facility's "Bed Hold Policy Before/upon Transfer" policy, no date noted: "Before a nursing facility transfers a resident to a hospital, the nursing facility must provide written information to the resident or resident representative that specifies, the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility."

No further information was provided prior to exit.
2. The facility staff failed to evidence that the bed hold notice was given to the resident and/or responsible party upon transfer to the hospital on 2/22/2022 for Resident # 66 (R66).

On the most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 3/5/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions.

The nurse's note dated 2/22/2022 documented in part, "[Name of nephrologist] from [initials of hospital] called facility and stated that resident needs to be sent to [initials of hospital] ER

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(emergency room) due to creatinine of 10.5, hemoglobin 6.2 and K (potassium) 6.5. States that resident needs to get dialysis right away and he want him (sic) taken to [initials of hospital]. Called MD (medical doctor) and received order to send resident to ER per Nephrologist request. RP (responsible party) was called an ambulance called. Writer also called [initials of hospital] to assure that resident would be accepted since hospital was on Ambulance diversional, spoke with MD at ER that will accept resident to ER."

A request was made on 3/29/2022 at 10:45 a.m. of ASM (administrative staff member) #1, the administrator, for evidence that the bed hold policy was given to the resident and/or responsible party for R66's transfer on 2/22/2022.

On 3/29/2022 at 12:11 p.m. ASM #3, the quality assurance consultant, stated the facility did not have any documentation that the bed hold policy was given to the resident and/or responsible party for R66 upon transfer to the hospital on 2/22/2022.

An interview was conducted with LPN (licensed practical nurse) # 2 on 3/29/2022 at 3:39 p.m. When asked if the bed hold notice is sent with the resident upon transfer to the hospital, LPN #2 stated the bed hold notice is sent in the envelope with the resident. When asked where that is documented, LPN #2 stated there is a big envelope that contains a check list. When asked if a copy of that check list is maintained in the clinical record, LPN #2 stated, no.

ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality

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F 625	Continued From page 75 assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m. No further information was provided prior to exit. 3. The facility staff failed to evidence that the bed hold notice was given to the resident and/or responsible party upon transfer to the hospital on 3/19/2022 for Resident # 67 (R67). On the most recent MDS assessment, with an ARD of 3/7/2022, the resident scored a 7 out of 15 on the BIMS, indicating the resident was severely cognitively impaired to make daily decisions. The nurse's note dated 3/19/2022 at 7:04 p.m. documented, "Resident bs (blood sugar) reading high. Resident refused insulin coverage. RP (responsible party) spoke with resident to encourage insulin coverage via FaceTime and resident still refused. NP (nurse practitioner) called and new order obtained to send to er (emergency room) for eval (evaluation), RP aware. Ambulance called for transport to [name of hospital]." A request was made on 3/29/2022 at 10:45 a.m. of ASM (administrative staff member) #1, the administrator, for evidence the bed hold notice was sent with R66 at the time of their transfer on 3/19/2022. On 3/29/2022 at 12:11 p.m. ASM #3, the quality assurance consultant, stated the facility did not have any evidence the bed hold notice was sent with R67 upon transfer to the hospital on 3/19/2022.	F 625		

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An interview was conducted with LPN (licensed practical nurse) # 2 on 3/29/2022 at 3:39 p.m. When asked if the bed hold notice is sent with the resident upon transfer to the hospital, LPN #2 stated the bed hold notice is sent in the envelope with the resident. When asked where that is documented, LPN #2 stated there is a big envelope that contains a check list. When asked if a copy of that check list is maintained in the clinical record, LPN #2 stated, no.

ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m.

No further information was provided prior to exit.

4. The facility staff failed to evidence that the bed hold notice was given to the resident and/or responsible party upon transfer to the hospital on 1/15/2022 for Resident # 93 (R93).

On the most recent MDS assessment, a quarterly assessment, with an ARD of 3/17/2022, the resident scored a 7 out of 15 on the BIMS, indicating the resident is severely cognitively impaired for making daily decisions.

The nurse's note dated, 1/15/2022 documented, "Resident noted with low O2 (oxygen) saturation 81 - 86%. Initiated O2 at 2 l/m (liters per minute). MD on all notified. Gave order to give O2 at 2 l/m and to increase PRN (as needed). Also to give call back to on-call if O2 needs increased. Write check O2 sat (saturation) on 2l/m O2 at 94% with

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F 625	Continued From page 77 deep breaths. Resident was repositioned in bed. Rechecked O2 sat 2 hours later noted O2 sat down to 86% on 2l/m, increased O2 to 2 l/m called MD on call to inform. MD on call gave order to send to [initials of hospital] ER due to desaturation at this time. EMT (emergency medical technician) called for transport. Report given to EMT. MD on call informed of transfer. Resident is own RP and was made aware of transport to [initials of hospital]. Transfer sheet sent with EMT." A request was made on 3/28/2022 at 4:51 p.m. of ASM (administrative staff member) #1, the administrator, for evidence the bed hold notice was sent with R93 at the time of their transfer on 1/15/2022. On 3/29/2022 at 8:10 a.m. ASM #3, the quality assurance consultant, stated the facility did not have any evidence the bed hold notice was sent with R93 upon transfer to the hospital on 1/15/2022. An interview was conducted with LPN (licensed practical nurse) # 2 on 3/29/2022 at 3:39 p.m. When asked if the bed hold notice is sent with the resident upon transfer to the hospital, LPN #2 stated the bed hold notice is sent in the envelope with the resident. When asked where that is documented, LPN #2 stated there is a big envelope that contains a check list. When asked if a copy of that check list is maintained in the clinical record, LPN #2 stated, no. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former	F 625		

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F 625	Continued From page 78 administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m. No further information was provided prior to exit.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete MDS (minimum data set) for 1 of 50 residents in the survey sample, Resident #51. The facility staff failed to complete the BIMS (brief interview for mental status) assessment for Resident #51's (R51) quarterly MDS assessment with an ARD (assessment reference date) of 2/16/2022. The findings include: Section B of R51's quarterly MDS assessment with an ARD of 2/16/2022 coded the resident as being understood. Section C0100 documented the BIMS assessment should be conducted. All of the questions related to the BIMS assessment (C0200 through C0400) and the BIMS summary score were coded with dashes, indicating the areas were not assessed. On 3/29/2022 at 8:00 a.m., an interview was conducted with ASM (administrative staff member) #2, interim director of nursing/MDS coordinator. ASM #2 stated that BIMS assessment was completed by social services,	F 641	**F 641 – Accuracy of Assessments** 1. BIMS was completed for resident # 51. 2. A comprehensive review of submitted MDS's from 3.1.22 – current will be reviewed by the MDS coordinator to validate accurate documentation and completion. 3. The Director of Nursing / designee will educate the facility Interdisciplinary team on "Focus on F-tag 641" and "Social Services Documentation & Quick Tips" on or before the date of compliance. 4. Utilizing the Assessment Scoring Report, the Director of Nursing / Designee will audit 5 residents with MDS weekly x 4 weeks. Results will be reviewed with QA&A. 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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and if it was not completed by the ARD that dashes were entered in the area that were not completed. ASM #2 reviewed R51's quarterly MDS with the ARD of 2/16/2022 and stated that the BIMS should have been completed. ASM #2 stated that they followed the RAI (resident assessment instrument) manual in completion of the MDS assessments.

On 3/29/2022 at 2:32 p.m., an interview was conducted with OSM (other staff member) #5, social services. OSM #5 stated that they had a list of residents due for the BIMS assessment that they used to determine when they were due. OSM #5 reviewed R51's quarterly MDS with the ARD of 2/16/2022 and stated that the BIMS was not completed and should have been completed. OSM #5 stated that they did not know why the assessment was not completed.

The CMS (centers for Medicaid and Medicare services) RAI manual documents the following:
C0100: Should Brief Interview for Mental Status Be Conducted?
Item Rationale
Health-related Quality of Life
·Most residents are able to attempt the Brief Interview for Mental Status (BIMS).
·A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance.
- Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis...
·Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method...
Coding Tips

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F 641	Continued From page 80 ·Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD)..." On 3/29/2022 at 4:41 p.m., ASM #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant and ASM #5, the former administrator were made aware of the above concern. No further information was presented prior to exit.	F 641		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide care and services in a manner to promote resident safety for four of 50 residents in the survey sample, Residents # 3, # 51, # 21 and # 47. The findings include: 1. Facility staff failed to re-evaluate (R3) for smoking.	F 689	**F 689 – Accidents / Supervision** 1. Smoking evaluations were completed for residents # 3, # 51 and # 21. Care plan and Kardex for resident # 51 updated to reflect use of smoking apron. Care plans for # 3 and # 21 updated. Positioning for resident # 47 during meals and snacks reviewed and care plan and Kardex updated. 2. A comprehensive review of current residents that smoke and those who need to be out of bed for meals was completed by the DON / designee. Opportunities related to smoking and positioning for HS snacks identified and corrected.	

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F 689	Continued From page 81 On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 12/30/2021, 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 J1300 "Current Tobacco Use" coded (R3) as using tobacco. On 03/28/22 at approximately 10:53 a.m., during an interview with (R3), they stated they smoked at the facility during each of the designated smoking times at 10:30 a.m., 2:30 p.m., 4:30 a.m., 8:00 p.m. On 03/28/2022 at approximately 2:45 p.m., an observation of the facility's gazebo area revealed several facility residents smoking with a staff member present. Further observation revealed (R3) sitting in their wheelchair smoking independently. The comprehensive care plan for (R3) dated 01/06/2021 documented in part: "Focus: History of smoking in community/ current smoker. Date Initiated: 01/06/2021 ...Complete Smoking Evaluation per facility guidelines. Date Initiated: 01/06/2021." The Facility's "Smoking Evaluation" for (R3) dated 01/06/2021 documented in part, "8. Additional Information: 8a. Comments: resident has HX (history) smoking, does not wish to smoke at this time." Review of (R3's) clinical record failed to evidence documentation of a smoking evaluation indicating (R3) could safely smoke.	F 689	3. The Director of Nursing / designee will educate the facility nursing staff on "Focus on F-tag 689" the "Smoking" nursing procedure and positioning for HS snacks on or before the date of compliance 4. The Director of Nursing / designee will complete observations of smoke times 5 / week x 4 weeks to validate safe smoking practice is in place. DON or designee will review HS snack provision for residents that should be out of bed for meals to validate provided based on individual needs. Results will be reviewed with QA&A. 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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On 3/29/22 at 9:49 a.m., an interview was conducted with RN (registered nurse) # 1. RN # 1 stated that a smoking assessment was completed prior to allowing a resident to smoke to determine if it was safe for them to do so. RN # 1stated that they were not sure how often the smoking assessment was to be completed but a resident should be reassessed if they started smoking after they were assessed as non-smoking.

On 03/29/22 at approximately 3:15p.m., an interview was conducted with ASM (administrative staff member) # 3, quality assurance consultant. When asked to describe the facility's protocol for allowing a resident to smoke, ASM # 3 stated that a smoking evaluation done. When asked how often the evaluation is done ASM # 3 stated that when there is a change in a resident's smoking status or if there was an overall change in the resident's in condition. When informed of the above observation and smoking evaluation for (R3) dated 01/06/2021, ASM # 3 stated that [Name of R3] should have had another evaluation due to their desire to smoke.

The facility's policy "Smoking Guidelines" documented in part, "Each patient who smokes will be assessed to determine if they are able to smoke safely. If you cannot smoke independently, you may be required to wear protective clothing and have assistance while smoking."

On 03/29/2022 at approximately 4:40 p.m., ASM # 1, administrator, ASM # 2, interim director of nursing, ASM # 3, quality assurance consultant and ASM # 5, former administrator, were made

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PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL)	1719 BELLEVUE AVENUE RICHMOND, VA 23227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 83 aware of the above findings. No further information was provided prior to exit. 2. The facility staff failed to implement application of a smoking apron during observations of Resident #51(R51) smoking on 3/27/2022 and 3/28/2022. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/16/2022, the BIMS (brief interview for mental status) was not completed. The assessment documented R51 as being able to understand others and able to express ideas and wants. R51's most recent annual assessment with an ARD of 8/18/2021 documented current tobacco use. On 3/27/2022 at 10:42 a.m., an observation was conducted of nine residents smoking in the designated smoking area at the facility. R51 was observed sitting in a wheelchair smoking a cigarette; no smoking apron was observed to be in place. R51s was observed with visible contractures of both hands. R51 was able to manipulate the cigarette during the observation and was observed to brush ashes off of their pants once with their hand. An additional observation on 3/28/2022 at 10:51 a.m. revealed R51 smoking in the designated smoking area without the use of a smoking apron. R51 was observed once wiping ashes off of the pants they were wearing with their hand. On 3/28/2022 at approximately 2:45 p.m., an interview was conducted with R51 in their room. R51 stated that they smoked four times a day in the designated smoking area, with the facility staff	F 689		

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F 689	Continued From page 84 supervising. R51 stated that a smoking apron was used "a couple of years ago" but it was not necessary because R51 thought it was ridiculous. The facility smoking evaluation dated 2/19/2020 for R51 documented in part, "...Patient is free of physical limitations interfering with the ability to perform safe smoking techniques, e.g., able to grasp and handle cigarette, lighter or matches without assistance. No...Patient has arthritis and gout that affects hands is able to smoke on most days when arthritis isn't acting up, however for safety has agreed to wear smoking apron." The areas on the assessment for Safe Smoker and At risk smoker were both left blank. R51's comprehensive care plan documented in part, "History of smoking and current smoker. Date Initiated: 12/06/2019. Revision on: 02/19/2020 ...Provide with a smoking apron and assist to put on..." On 3/27/2022 at 10:42 a.m., an interview was conducted with CNA (certified nursing assistant) #14. CNA #14 stated that a different aide was assigned to supervise smoking each day and they obtained the cigarettes and lighters from the nurse at the designated time. CNA #14 stated that smoking was allowed four times a day and was 15 minutes long. CNA #14 stated that the smoking box containing all cigarettes and lighters was kept in the locked medication room. CNA #14 stated that they were an agency CNA and were not aware of any residents who required any special interventions for smoking, and the nurse would let them know if anyone needed these. On 3/29/2022 at 12:25 p.m., an interview was conducted with LPN (licensed practical nurse) #3.	F 689		

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F 689	Continued From page 85 LPN #3 stated that they were not sure where the smoking aprons were kept and thought they were kept outside. LPN #3 stated that R51 used an extender for their cigarettes that was kept in the smoking box, was not aware of the use of a smoking apron. On 3/29/2022 at 12:28 p.m., an interview was conducted with CNA #5. CNA #5 stated that the nurses let them know if a resident required a smoking apron or not. CNA #5 stated that smoking aprons were stored outside in the designated smoking area in a plastic storage box and proceeded to show where they were. CNA #5 stated that R51 has not used an apron when she was supervising smoking and had used a guard that helped them get a better grip at times. Four smoking aprons were observed to be in a plastic storage box in the designated smoking area. On 3/29/2022 at 3:12 p.m., an interview was conducted with ASM (administrative staff member) #3, quality assurance consultant. ASM #3 stated that residents who smoke should have a smoking assessment completed. ASM #3 stated that if a smoking apron was documented to be in use on the assessment then the facility staff should be using one or the assessment should have been updated to reflect that it was not needed anymore. The facility policy "Smoking Policies" documented in part, "...Smoking Education for Patients and Families...As a patient in the center, your physical and cognitive function will need to be assessed by your nurse. That assessment will be reviewed by the interdisciplinary team and your attending physician who will then decide if you are a Safe or	F 689		

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F 689	Continued From page 86	F 689		

At-Risk Smoker..."

On 3/30/2022 at 4:41 p.m., ASM #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance coordinator and ASM #5, the former administrator were made aware of the above concern.

No further information was provided prior to exit.

3. The facility staff failed to evidence that they provided adequate supervision to prevent smoking accidents for Resident #21.

Resident #21's most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an assessment reference date of 1/20/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. Section J-Health Conditions coded the resident as "no" for current tobacco use.

Resident #21 was observed smoking on 3/28/22 at 10:30 AM and again on 3/29/22 at 10:30 AM.

A review of Resident #21's comprehensive care plan dated 3/28/22, revealed the following, "FOCUS-History of smoking in community current smoker. INTERVENTIONS-Complete smoking evaluation. Allow to smoke in designated area at designated smoking times."

A review of the smoking evaluation dated 3/28/22 at 11:53 AM, revealed the following, "Safe smoker-capable and safe, requires no assistance to smoke." Smoking evaluation completed by

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F 689	Continued From page 87 ASM (administrative staff member) #2. An interview was conducted on 3/28/22 at 11:56 AM with Resident #21. When asked if he smokes, Resident #21 stated, Yes, I smoke. When asked if he has smoked since entry into the facility, Resident #21 stated he did not because, initially, he could not get out of bed because of fractures to both legs, and he could not bear weight. When asked when he started smoking, Resident #21 stated it was early February. On 3/29/22 at 9:40 AM, an interview was conducted with Resident #21. When asked if he remembered if a smoking evaluation had been completed, Resident #21 stated that he did, and that the "lady" came yesterday and talked with him. On 3/29/22 at 10:30 AM, an interview was conducted with CNA (certified nursing assistant) #5. When asked if she normally supervised the smoking, CNA #5 stated she did not supervise it every day. When asked how long Resident #21 has been smoking, CNA #5 stated the resident had been smoking a couple of months. On 3/29/22 at 2:40 PM, ASM #2, the interim director of nursing, was interviewed. When asked if she had completed a smoking evaluation on Resident #21 on 3/28/22, ASM #2 stated she did. When asked when she had completed the smoking evaluation, ASM #2 stated she did it yesterday. When asked why she had completed the evaluation on 3/28/22, ASM #2 stated she was told that he was smoking and needed one. An interview was conducted on 3/29/22 at 3:20	F 689		

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F 689	Continued From page 88 PM with ASM #3, the quality assurance consultant. When asked what the protocol is for allowing a resident to smoke, ASM #3 stated a smoking assessment should be done. When asked how often a smoking assessment is done, ASM #3 stated that if the residents smoke on admission, if there is a change in their smoking status, if there is an overall change in their condition that might affect their ability to smoke then a smoking assessment is done. When asked if a smoking evaluation should be done when a resident started smoking, ASM #3 stated, "Yes, that would have been a change in his smoking status." On 3/29/22 at 4:40 PM, ASM #1, the administrator, ASM #2, the interim director of nursing, ASM #3, the quality assurance consultant, and ASM #5, the former administrator were informed of the above concern. No further information was provided prior to exit. 4. The facility staff failed to assist Resident #47 (R47) out of bed into a wheelchair to safely eat breakfast, per the speech therapist's recommendations. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/11/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. R47's comprehensive care plan revised on 3/23/22 documented, "Offer to get up into W/C (wheelchair) at end of night shift and to sit up in W/C for all meals..."	F 689		

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F 689	Continued From page 89	F 689		

A review of R47's clinical record revealed a speech therapy discharge summary dated 3/25/22 that documented R47 presented with a medical history of difficulty swallowing and further documented, "Compensatory Strategies/Positions: To facilitate safety and efficiency, it is recommended the patient use the following strategies during oral intake...Upright posture during meals and Upright posture for > (greater than) 30 mins (minutes) after meals...Collaborated with team regarding patient's discharge/transition planning..." A physician's order for speech-language pathology dated 3/25/22 documented, "Patient to be OOB (out of bed) for all regular textured meals."

On 3/28/22 at 3:17 p.m., an interview was conducted with R47. R47 stated that a few weeks ago, the speech therapist put on record that R47 was supposed to be out of bed in the morning to eat due to swallowing issues but the nurses and CNAs (certified nursing assistants) were giving R47, "A hard time" and not getting the resident out of bed for breakfast.

On 3/29/22 at 6:42 a.m., an interview was conducted with CNA (certified nursing assistant) #2 (a night shift CNA). CNA #2 stated the former director of nursing and LPN (licensed practical nurse) #4 has told her staff from the therapy department wants R47 out of bed before breakfast because the resident can't eat in bed. However, CNA #2 stated that on certain nights, LPN (licensed practical nurse) #4 tells the CNAs not to do certain tasks, depending on CNA staffing. CNA #2 stated over the previous weekend, LPN #4 instructed her to not assist R47 out of bed because of the amount of staff.

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F 689	Continued From page 90	F 689		

On 3/29/22 at 7:05 a.m., an interview was conducted with CNA #3 (a night shift CNA). CNA #3 stated R47 has verbalized the need to get up every morning but most of the time, there are not enough CNAs and the resident requires two staff to assist with transfers. CNA #3 stated the former director of nursing came to her one morning at 7:10 a.m. and asked why R47 was not out of bed. CNA #3 stated there was poor communication and she did not receive confirmation that R47 was supposed to be out of bed. CNA #3 stated R47 asked to get out of bed two different mornings but LPN #4 said, "No. That's a lot on y'all to get him up." CNA #3 stated R47 asked how to receive assistance with getting out of bed and she told the resident to talk to the day shift staff and therapy staff because she was not certain about the resident's care plan and the resident slides in the wheelchair. CNA #3 stated LPN #4 knows R47 slides in the wheelchair and it would be difficult for a staff member to stay with R47 after the resident is assisted into the wheelchair.

On 3/29/22 at 7:44 a.m., an interview was conducted OSM (other staff member) #3 (the speech therapist). OSM #3 stated R47 was admitted on a mechanical soft diet and wanted a speech therapy evaluation for an upgrade to a regular textured diet. OSM #3 stated she developed strategies and techniques so R47 could tolerate a regular texture without a risk of aspiration, choking and coughing. OSM #3 stated she recommended R47 eat all three meals in the wheelchair because this is the safest position at a 90 degree angle for the resident to eat and safely tolerate meat. OSM #3 stated she worked with CNAs, nurses, the former unit manager, the former director of nursing and the

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F 689	Continued From page 91	F 689		

former administrator on this strategy for the last week and a half. OSM #3 stated the nursing staff was trying to determine if the night shift staff or the day shift staff should assist R47 out of bed before breakfast. OSM #3 stated it didn't matter who assisted R47 out of bed but she did not want the resident served breakfast until the resident was out of bed for safety reasons.

On 3/29/22 at 2:45 p.m., an interview was conducted with CNA #1 (a day shift CNA who routinely cares for R47). CNA #1 stated she begins her shift at 8:00 a.m. and R47 is usually in bed when she arrives. CNA #1 stated nurses have asked her to assist R47 out of bed before she serves breakfast but the breakfast trays are already on the unit when she arrives so she asked if the night shift can assist R47 out of bed. CNA #1 stated R47 has been eating breakfast in bed most of the time.

On 3/30/22 at 7:19 a.m., an interview was conducted with LPN #4. LPN #4 stated approximately three weeks ago, the speech therapist said R47 has to be out of bed and in the chair to eat so the former director of nursing assigned the night shift staff to assist the resident out of bed. LPN #4 stated the night shift staff have been assisting R47 out of bed every morning except for one morning when there was only one CNA. LPN #4 stated she explained to R47 that she did not want the resident or the CNA to get hurt. LPN #4 stated the day shift staff arrives at 7:00 a.m. and they can assist R47 out of bed.

On 3/30/22 at 7:42 a.m., an interview was conducted with ASM (administrative staff member) #2 (the interim director of nursing).

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ASM #2 stated the nursing staff care planned R47 for being assisted out of bed for breakfast. ASM #2 stated R47 likes to get up before breakfast because the resident needs to sit up for meals. ASM #2 stated the decision for the night shift staff to assist R47 out of bed was made because the breakfast trays arrive to the unit shortly after the day shift staff arrives. ASM #2 stated she sees R47 multiple times a day and she has never visualized R47 sliding in the wheelchair.

On 3/29/22 at 4:42 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the interim director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

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 observations, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide respiratory therapy in a sanitary manner for one of 50 residents in the survey sample, Resident #59. The facility failed to store Resident

F 695 – Respiratory Therapy / Oxygen Tubing / Nebulizer

1. Oxygen tubing was changed and stored in a sanitary manner for resident # 59.
2. A comprehensive review of current residents receiving oxygen related therapy will be completed by the DON / designee.
3. The Director of Nursing / designee will educate the facility licensed nursing staff on "Focus on F-tag 695" and the nursing procedure "oxygen" on or before the date of compliance.

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F 695	Continued From page 93 #59's oxygen equipment in a sanitary manner. The findings include: Resident #59's most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 3/2/22, coded the resident as scoring 14 out of 15 on the BIMS (brief interview for mental status score), indicating the resident was not cognitively impaired. The resident was coded as requiring limited assistance in bed mobility, dressing, toileting, bathing and personal hygiene; supervision with transfers/locomotion and independence in eating. Resident #59 was observed with the nasal cannula oxygen tubing lying on the bed and the nebulizer face mask lying face down on bedside table on 3/28/22 at 9:00 AM, 3:55 PM and 3/29/22 at 12:15 PM. Resident #59's care plan dated 4/23/21 with no revision date, revealed the following, "Focus: At risk for respiratory impairment related to congestive heart failure. Interventions: Administer oxygen/medications/treatments per physician order." A review of the physician's orders dated 3/17/21, revealed the following, "Oxygen at 2 liters nasal cannula for shortness of breath as needed. Albuterol nebulizer 2.5 milligram/3 milliliters vial nebulizer every 6 hours as needed for shortness of breath." An interview was conducted on 3/28/22 at 9:00 AM with Resident #59. When asked if they use the oxygen, Resident #59 stated they use it every night and if they need it in the day. When asked	F 695	4. The Director of Nursing / designee will audit 5 residents / week x 4 weeks utilizing the "oxygen" QAPI tool. Results will be reviewed with the QA&A committee. 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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F 695	Continued From page 94 if they removes the oxygen herself, Resident #59 stated they take it off themselves. When asked if they turn the oxygen off, Resident #59 stated, "No, my roommate shuts it off." An interview was conducted on 3/29/22 at 12:20 PM with ASM (administrative staff member) #2, the interim director of nursing. When asked how the oxygen tubing and nebulizer mask should be stored when not in use, ASM #2 stated it should be stored in a plastic bag. ASM #2 asked Resident #59 if they use oxygen. Resident #59 stated they use it every night. ASM #2 stated would bring a new nebulizer mask and oxygen tubing to the resident. An interview was conducted on 3/29/22 at 2:19 PM with LPN (licensed practical nurse) #3. When asked the proper care and storage for respiratory therapy supplies, LPN #3 stated when the supplies are not in use, they go into a plastic bag to protect it. On 3/29/22 at 4:40 PM, ASM #1, the administrator, ASM #2, the interim director of nursing, ASM #3, the quality assurance consultant, and ASM #5, the former administrator were informed of the above concern. According to the facility's "Oxygen Administration" policy dated 7/17, revealed the following, "Equipment: plastic bag for oxygen cannula or mask storage." According to the facility's "Respiratory: Nebulizer Mist Therapy" policy dated 9/14, revealed the following, "Equipment: labeled and dated plastic bag for nebulizer and mouthpiece of mask storage."	F 695		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 95 No further information was provided prior to exit.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. 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. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement a complete pain management program for one of 50 residents in the survey sample, Residents # 3 (R3). For Resident #3, the facility staff failed to conduct complete pain assessments and attempt non-pharmacological interventions prior to the administration of a prn [as needed] pain medication oxycodone-acetaminophen (1). The findings include: R3 was admitted to the facility with a diagnosis that included nerve pain and spinal stenosis. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 12/30/2021, 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 J0300 "Pain Presence" coded R3 as having frequent pain in the past 5 (five) days.	F 697	**F 697 – Pain Management Program** 1. Non-pharmacological interventions for resident # 3 were added to care plan and Kardex. Base line pain assessments was conducted and additional assessment will be done as needed for resident # 3. 2. A comprehensive review of current residents with medication orders for PRN as needed pain management will be reviewed to validate non-pharmacological interventions are part of the plan of care and assessment of location of pain and pain level prior to administration. 3. The Director of Nursing / designee will educate the facility licensed nursing staff on "Focus on F-tag 697" and "pain practice guide" on or before the date of compliance. 4. The Director of Nursing / designee will audit 5 residents receiving PRN as needed pain medication weekly x 4 weeks to validate non-pharmacological interventions were documented. Results will be reviewed with the QA&A committee. 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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F 697	Continued From page 96 Section J0600 "Pain Intensity" coded R3 as having a pain level of seven out of ten, with ten being the worst pain. The physician's order for R3 documented in part, "Oxycodone-Acetaminophen Tablet 5-325 MG (milligram). Give 1 tablet by mouth every 6 (six) hours as needed for pain. Order Date: 01/01/2021 Start Date: 01/01/2021." The comprehensive care plan for R3 dated 01/04/2021 documented in part, "Focus: Pain related to Spinal Stenosis, OA (osteoarthritis), neuropathy. Date Initiated: 01/04/2021 ...Implement non-pharmacological interventions. Date Initiated: 01/04/2021." The eMAR (electronic medication administration record) for R3 dated March 2022 documented the physician's order as stated above. Further review of the eMAR revealed R3 received 5-325 mgs of oxycodone-acetaminophen on the following dates and times, with no evidence of the location of pain, type of pain and non-pharmacological interventions being attempted on: 03/01/2022 at 2:02 a.m., 03/03/2022 at 3:28 a.m., 03/11/2022 at 1:43 a.m., 03/14/2022 at 4:55 a.m., 03/15/2022 at 3:30 a.m., 03/20/2022 at 6:11 a.m., and on 03/24/2022 at 9:41 p.m. Further review of the eMAR failed to evidence the location of pain and non-pharmacological interventions being attempted on: 03/22/2022 at 7:39 a.m. On 03/28/22 at approximately 10:51 a.m., an interview was conducted with R3. When asked about pain, R3 stated there was pain in their legs. When asked what the pain felt like and how severe it was, R3 stated their legs were aching and it was a level ten from zero to ten. When	F 697		

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F 697	Continued From page 97 asked about pain medication R3 stated they receive scheduled and prn pain medication. When asked if the staff ask about the location, intensity and type of pain, and if they try to alleviate the pain before administering the prn pain medication, R3 stated no. On 03/29/2022 at approximately 12:50 p.m. an interview was conducted with LPN (licensed practical nurse) # 1 regarding the procedure for administering prn (as needed) pain medication and documentation of a pain assessment and non-pharmacological interventions. LPN # 2 stated the resident's pain is assessed by where the pain is allocated, thee type of pain and using a scale one to ten, with ten being the worst pain, and attempting interventions to alleviate the resident's pain before administering medication. If these are not successful, then she gives the medication. When asked about documenting the location, and type of pain and the attempts of non-pharmacological interventions LPN # 1 stated that it should be documented in the nurse's notes every time the prn pain medication if administered. After reviewing the physician's orders, the March 2022 eMAR and the nurse's progress notes dated 03/01/2022 through 03/24/2022 for R3, LPN # 2 was asked if there was documentation of the location and type of pain, and that non-pharmacological interventions were attempted prior to R3 receiving the physician ordered pain medication of oxycodone-acetaminophen on the dates listed above. LPN # 2 stated no. The facility's policy "Pain Management Guidelines" documented in part, "Non-pharmacologic interventions should be attempted first ..."	F 697		

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F 697	Continued From page 98 On 03/29/2022 at approximately 4:40 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, interim director of nursing, ASM # 3, quality assurance consultant and ASM # 5, former administrator, were made aware of the above findings. No further information was provided prior to exit. References: (1) Indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f2137f1a-b49a-40bd-97ac-cd6b36e295f4.	F 697		
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 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 two of 50 residents in the survey sample, Residents # 73 and # 66. The findings include:	F 698	**F 698 – Dialysis / Missing Communication Sheets and Monitoring Site** 1. Dialysis Unit notified of missing communication sheets for Residents # 73 and # 66 by acting DON, stated will send with each visit moving forward and no new orders or changes to plan of care. 2. A comprehensive review of current residents requiring hemodialysis will be completed by the Director of Nursing / designee.	

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F 698	Continued From page 99 1a. The facility staff failed to provide dialysis communication forms for Resident #73's (R73's) and the dialysis center from 03/01/2022 through 03/26/2022. Resident # 73 was admitted to the facility with diagnoses that included end stage renal disease [2]. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/08/2022, the resident scored 14 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 R73 for "Dialysis" while a resident. The physician's order for R73 documented in part, "[Name of Dialysis Center and Phone Number] chair @ (at) 9:00 (a.m.) Tues- Thurs and Sat (Tuesday, Thursday and Saturday) pick up time 8:15 a.m. scheduled transportation with [Name of Transportation Company]. Order Date: 05/18/2021." The comprehensive care plan for R73 dated 05/20/2021 documented in part, "Focus: Renal insufficiencies related to: ESRD (end stage renal disease). Date Initiated: 05/28/2021 ...Days of the week: Tues, Thurs, Sat. Date Initiated: 05/28/2021." On 03/29/2022 at approximately 8:10 a.m., ASM (administrative staff member) # 3, quality assurance consultant, provided copies the facility's dialysis communication forms for R73 dated 02/01/2022 through 02/282022. When	F 698	3. The Director of Nursing / designee will educate the facility licensed nursing staff on the "Focus on F-tag 698" and the "Hemodialysis" nursing procedure on or before the date of compliance. 4. The Director of Nursing / designee will audit 5 residents / week x 4 weeks that require hemodialysis to validate communication forms and evaluations of atrial vascular shunts, fistulas and graphs are completed. Results will be reviewed with QA&A 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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F 698	Continued From page 100	F 698		

asked about the dialysis communication forms for March 2022 ASM # 3 stated that what was provided is all that they had.

On 03/29/22 at approximately 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) # 3. When asked to describe the procedure regarding a resident's dialysis communication forms LPN # 3 stated that the nurse was responsible for completing section one of the form that included the resident's vital signs, dialysis access site, resident's status, laboratory tests, diet order, fluid restrictions, medications, sign and date the form and send it with the resident to the dialysis center. When asked how often the communication form is completed LPN # 3 stated it should be completed and sent with the resident every time they go to dialysis. When asked why it was important to complete the dialysis communication forms and send them with the resident for each dialysis visit LPN # 3 stated that it was important to make sure the resident is stable to go through the dialysis process.

On 03/29/2022 at approximately 4:40 p.m., ASM # 1, administrator, ASM # 2, interim director of nursing, ASM # 3, quality assurance consultant and ASM # 5, former administrator, 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:

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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.

1b. The facility staff failed to monitor the bruit (1) and thrill (2) of R73's dialysis fistula according to the physician's orders.

The physician's order for R73 documented in part, "Monitor/report AV (arteriovenous - relating to or affecting an artery or vein) fistula access site for s/s (signs or symptoms) of infection: redness, swelling, warmth or drainage. Every shift. Date Ordered: 06/30/2021. Start Date: 06/30/2021."

The comprehensive care plan for R73 dated 05/20/2021 documented in part, "Focus: Renal insufficiencies related to: ESRD (end stage renal disease). Date Initiated: 05/28/2021. Under "Interventions" it documented in part "Check access site for lack of thrill/bruit, evidence of infection, swelling, or excessive bleeding per facility guidelines. Report abnormalities to physician Date Initiated: 05/28/2021."

The eTAR [electronic treatment administration record] for R73 dated February 2022 documented the physician's order as stated above. Further review of the eTAR failed to evidence (R73's) bruit and thrill was checked on 02/05/2022, 02/10/2022 and 02/19/2022 on the 7:00 a.m. to 3:00 p.m. shift and on 02/09/2022 on the 3:00 p.m. to 11:00 p.m. shift.

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The eTAR for R73 dated March 2022 documented the physician's order as stated above. Further review of the eTAR failed to evidence (R73's) bruit and thrill was checked on 03/13/2022, 03/20/2022, and 03/21/2022 on the 7:00 a.m. to 3:00 p.m. shift and on 03/26/2022 on the 11:00 p.m. to 7:00 a.m. shift.

On 03/29/22 at approximately 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) # 3. After reviewing the physician's or for checking (R73") bruit and thrill and the eTARs dated February and March 2022, LPN # 3 was asked if the physician's order was followed. LPN # 3 stated that if it was not documented then it wasn't done. When asked why it was important to check the bruit and thrill LPN #3 stated to ensure the access site is working properly.

On 03/29/2022 at approximately 4:40 p.m., ASM # 1, administrator, ASM # 2, interim director of nursing, ASM # 3, quality assurance consultant and ASM # 5, former administrator, were made aware of the above findings.

No further information was provided prior to exit.

References:

[1] & [2] There are two signs that indicate a dialysis access site is functioning well. When you slide your fingertips over the site you should feel a gentle vibration, which is called a "thrill." Another sign is when listening with a stethoscope a loud swishing noise will be heard called a "bruit." If both of these signs are present and normal, the graft is still in good condition. This information was obtained from the website:

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F 698	Continued From page 103 https://www.vascularhealthclinics.org/institutes-divisions/vascular-surgery-and-medicine/dialysis-access/ 2a. The facility staff failed to evidence communication with the dialysis center for seven of 13 days for Resident #66 (R66). On the most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 3/5/2022, the resident scored a 15 out of 15 indicating the resident is not cognitively impaired for making daily decisions. In Section O - Special treatments, procedures and programs, the resident was coded as receiving dialysis while a resident at the facility. The nurse's note dated 2/26/2022 at 6:10 p.m. documented in part, "Resident is re-admit was admitted to hosp (hospital) for worsening kidney function...did have dialysis while in hospital, and to start on M - W - F (Monday - Wednesday - Friday) at [name of outpatient dialysis center), chair time is 12...has perma (permanent) cath (catheter) to right chest and fistula to left arm." The dialysis communication book for R66 was reviewed on 3/29/2022. There was no evidence of communication with the dialysis center for seven of the 13 days the resident went to dialysis. The missing dates were 2/28/2022, 3/2/2022, 3/4/2022, 3/16/2022, 3/18/2022, 3/21/2022, and 3/23/2022. The comprehensive care plan dated, 10/7/2021 and revised on 2/28/2022, documented in part, "Focus: Renal insufficiency related to ESRD (end stage renal disease) ...Coordinate dialysis care with dialysis treatment center. Confer with	F 698		

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F 698	Continued From page 104 physician and/or dialysis treatment center regarding changes in medication administration times/dosage pre-dialysis as needed." A request was made on 3/29/2022 at 10:34 a.m. to ASM (administrative staff member) #1, the administrator, for copies of all communication forms for R66 for February and March 2022. On 3/29/2022 at 1:26 p.m. ASM #3, the quality assurance consultant, stated the above communication forms is all the facility had. On 03/29/2022 at approximately 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) # 3. When asked to describe the procedure regarding a resident's dialysis communication forms, LPN # 3 stated that the nurse was responsible for completing section one of the form that included the resident's vital signs, dialysis access site, resident's status, laboratory tests, diet order, fluid restrictions, medications, sign and date the form, and send it with the resident to the dialysis center. When asked how often the communication form is completed, LPN # 3 stated it should be completed and sent with the resident every time they go to dialysis. When asked why it was important to complete the dialysis communication forms and send them with the resident for each dialysis visit, LPN # 3 stated that it was important to make sure the resident is stable to go through the dialysis process. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m.	F 698		

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No further information was provided prior to exit.

2b. The facility staff failed to assess and monitor R66's dialysis access in their left arm.

The nurse's note dated, 2/26/2022 at 6:10 p.m. documented in part, "Has perma cath to right chest and fistula to left arm."

Review of the physician orders failed to evidence a physician order to monitor the dialysis access sites.

The nurse's note dated, 3/11/2022 at 7:55 p.m. documented in part, "Returned from dialysis...right chest dialysis catheter intact."

The nurse's note dated 3/25/2022 at 5:33 p.m. documented in part, "Body audit: AV (arterial vascular) fistula left arm, dialysis cath (catheter) right chest." There was no other evidence documented that the dialysis access in the resident's left arm had been checked for a bruit and thrill.

Review of the MAR (medication administration record) and TAR (treatment administration record) for February and March 2022 revealed no documentation of checking the dialysis access in the resident's left arm for a bruit and thrill.

The comprehensive care plan dated 10/7/2021 and revised on 2/28/2022, documented in part, "Focus: Renal insufficiency related to: ESRD ...Check access site for lack of thrill/bruit, evidence of infection, swelling, or excessive bleeding per facility guidelines. Report abnormalities to physician."

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F 698	Continued From page 106 An interview was conducted with LPN #3 0n 3/29/2022 at 2:40 p.m. When asked where R66's dialysis access is, LPN #3 stated the resident had a port in their right upper chest. When asked if R66 had any other dialysis access sites, LPN #3 stated R66 had something else but it wasn't being utilized. When asked if the resident had another access site, should that site be accessed and monitored, LPN #3 stated she would have to check on this. On 3/29/2022 at 3; 05 p.m. LPN #3 returned and stated [R66] has a fistula in his left arm and the staff should be checking it for a bruit and thrill. When asked if she needed an order to check the bruit and thrill, LPN #3 stated, of course. An interview was conducted with ASM #3 on 3/29/2022 at 3:12 p.m. When asked do you need a physician's order for checking a fistula for a bruit and thrill, ASM #3 stated, no. When asked why not, ASM #3 stated because it is a nursing standard of practice of care to check it. When asked how often it should be checked, ASM #3 stated at least every shift and PRN (as needed). The facility policy, "Assessment of arteriovenous shunts, fistulas & grafts" documented in part, "Purpose: The evaluation of arteriovenous shunts, fistulas and grafts by a licensed nurse is intended to facilitate early detection of potential complications which includes signs and symptoms of infection, leakage, and thrombosis. Any abnormal signs and symptoms should be reported to the physician...7. Observe for signs and symptoms of infection including pain, tenderness, swelling or redness around the patient's access site. 8. Place a hand over the	F 698		

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PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL)	1719 BELLEVUE AVENUE RICHMOND, VA 23227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 107 site and palpate for the presence of thrill (motion of blood flowing through the site). 9. Using a stethoscope, auscultate over the site for the presence of bruit (a sound which may range from a whooshing noise to a whistle-like sound)...Document completion of observation or assessment on TAR. Record in Progress Note any abnormalities and subsequent interventions including communications with medical practitioner or family." ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator, were made aware of the above concern on 3/29/2022 at 5:02 p.m. On 3/30/2022 at 11:47 a.m. ASM #3, the quality assurance consultant, stated the facility follows their policies and procedures that are based on Lippincott as their standard of nursing practice. No further information was provided prior to exit.	F 698		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 726	**F 726 – Aide Competencies** 1. Cited employees TNA's # 10, # 13, # 16, # 17, # 18, and # 19 have had a competency completed. 2. A comprehensive review of current TNAs will be completed by the Human Resources Director to validate competencies are in place for current TNA's and that mandatory education has been completed.	

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F 726	Continued From page 108 at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and in the course of a complaint investigation it was determined the facility staff failed to ensure skills competencies for six of six TNA's (temporary nursing assistants) reviewed, TNA #10, TNA #13, TNA #16, TNA #17, TNA #18, and TNA #19. For TNA #10, #13, #16, #17, #18, and #19, the facility failed to ensure each TNA possessed the skills and competencies to provide basic ADL (activities of daily living) care for residents. The findings include: On 3/28/2022 at 8:45 a.m., a request was made to ASM (administrative staff member) #1, the administrator and ASM #5, the former administrator for a list of all TNA's currently	F 726	3. The NHA / designee will educate the facility interdisciplinary team management staff on "Focus on F-tag 726" on or before the date of compliance. 4. The Human Resource Director / designee will utilize "Nursing staff sufficient and competency" audit tool and mandatory education to review 5 new employee files weekly x 4 weeks to validate compliance. Results will be reviewed with QA&A. 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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F 726	Continued From page 109	F 726		

employed at the facility.

On 3/28/2022 at approximately 10:30 a.m., ASM #5 provided a list of 9 TNA's with their assigned unit and date of hire.

On 3/28/2022 at 12:11 p.m., a request was made to ASM #5 for evidence of training and skills competencies for TNA #13, TNA #16, TNA #17, TNA #18 and TNA #19.

On 3/29/2022 at 1:41 p.m., a request was made to OSM (other staff member) #12, human resource director for evidence of training and skills competencies for TNA #10.

On 3/29/2022 at approximately 8:00 a.m., ASM #5 provided copies of the completion certificates for "AHCA/NCAL Temporary nurse aide 8 hour training" online course for TNA #13, TNA #16, TNA #17, TNA #18 and TNA #19.

On 3/30/2022 at approximately 8:00 a.m., OSM #12 provided a copy of the completion certificate for "AHCA/NCAL Temporary nurse aide 8 hour training" online course for TNA #10.

On 3/27/2022 at 10:30 a.m., an interview was conducted with CNA (certified nursing assistant) #15. CNA #15 stated that they did not supervise or oversee the TNA's on the unit. CNA #15 stated that she had her own patient assignment and they had theirs.

On 3/27/2022 at 2:15 p.m., an interview was conducted with TNA #10. TNA #10 stated that they had been there for about 2 months. TNA #10 stated that they worked with a CNA for about 4 or 5 days for training on the floor and then were

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F 726	Continued From page 110 on their own. TNA #10 stated that they were told that they would be trained to become certified in February but had not been offered this yet. TNA #10 stated that at times that there were only two TNA's on the 100 unit by themselves on day shift. TNA #10 stated that they did not recall any formal skills checklist during their training and were taught what to do during the 4 or 5 days with the CNA. On 3/29/2022 at 9:15 a.m., an interview was conducted with TNA #13. TNA #13 stated that they had been there for about 1 and a half months. TNA #10 stated that they had worked with a CNA for about 4 or 5 days shadowing them. TNA #10 stated that now the TNA's were receiving 2 days with a CNA and then were on their own with a resident assignment. TNA #10 stated that on some days there were all TNA's on the 100 unit and at times she was there with a brand new TNA alone. TNA #10 stated that she had a hard time completing her tasks for her residents because the new TNA was needing training to complete their resident assignment also. TNA #10 stated that she had previous experience in healthcare prior to this position but some of the new TNA's do not know how to use a bedpan after the 2 days of training and she has to teach them. TNA #10 stated that the facility allowed wiggle room with the staff arriving for work because they rode the bus so there were days when she was the only aide on the floor until someone else got there. TNA #10 stated that no one enforced staff arriving at 7:00 a.m. as scheduled because they were so grateful that someone showed up. TNA #10 stated that staffing had not improved since she had been working there and they were only hiring TNA's currently.	F 726		

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F 726	Continued From page 111	F 726		

On 3/29/2022 at 10:23 a.m., an observation was made of TNA #10 providing ADL (activities of daily living) care. TNA #10 that they were not trained to use the shower stretcher or shower chair. TNA #10 stated that they were never trained how to use mouth swabs to provide mouth care. TNA #10 stated that they did the best that they could with the training they had received.

On 3/29/2022 at approximately 10:00 a.m., a request was made to ASM #3, the quality assurance consultant for any skills competencies for the TNA's selected.

On 3/29/2022 at 12:13 p.m., an interview was conducted with ASM #2, the interim director of nursing/MDS coordinator. ASM #2 stated that the TNA program was very new at the facility and they thought that TNA's required a CNA to work with them, but they had to defer to human resources.

On 3/29/2022 at 12:15 p.m., an interview was conducted with OSM #12, human resource director. OSM #12 stated that TNA's were partnered with a CNA for 2 to 3 days for training and after that they were on their own for resident care. A request was made for the procedure/policy for TNA training and skills competencies required.

On 3/29/2022 at 1:41 p.m., ASM #3 and OSM #12 stated that the skills competency for TNA's was a new process and provided a blank copy of a document titled "Temporary Nurse Aide Skills Competency Checklist." OSM #12 stated that they did not have a skills competency for any of the six sampled TNA's above. OSM #12 stated

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F 726	Continued From page 112 that as of yesterday they realized that they did not have anything in place so they started working to catch up on these. The facility policy "Skills and Techniques Evaluation (Temporary Nurse Aide/Patient Care Assistant)" dated 10/20/21 documented in part, "...For each skill identified, the facilitator enters the date and skill validation or demonstration was completed and enters a full signature in the column provided. The skills and techniques evaluation is completed during job specific orientation and re-validated at least annually at the time of the employee's annual performance evaluation. To be used for new employees who complete AHCA/NCAL's Temporary Nurse Aide Training Program (www.TempNurseAide.com)...Demonstration of competency- Competency may not be demonstrated simply by documenting that staff attended a training, listened to a lecture, or watched a video. A staff's ability to use and integrate the knowledge and skills that were subject of the training, lecture or video must be evaluated by the facility staff already determined to be competent in these skill areas..." On 3/29/2022 at 4:41 p.m., ASM #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant, and ASM #5, the former administrator were made aware of the concern. No further information was provided prior to exit. Complaint deficiency	F 726		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7)	F 730		

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F 730	Continued From page 113 §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide performance evaluations and mandatory training for five of five CNA's (certified nursing assistants) reviewed, CNAs #1, #6, #7, #8 and #9. The findings include: During the Sufficient and Competent Staffing facility task review on 3/29/22 at 1:38 PM revealed no evidence of performance evaluations and mandatory training for five of five CNA's (certified nursing assistants) reviewed. On 3/28/22 at 9:40 AM, the "Facility Assessment" was reviewed. The facility assessment addressed the resident population, care specifics, cultural and religious factors, services provided, staff competencies, physical environment, physical structures, equipment, information systems, patient transfer agreement, and all hazard risk assessment. The facility assessment had annual review dates of 1/28/21 and 2/24/22. On 3/29/22 at 1:38 PM, OSM (other staff member) #12, the Human Resources Director, brought in the five CNA employee records. A review of these five records revealed the	F 730	**F 730 – Performance Evals** 1. Cited employees CNA's # 1, # 6, # 7, # 8 and # 9 have had performance evaluations completed and mandatory education provided. 2. A comprehensive review of current employees will be completed by the Human Resource Director / designee to validate timely performance evaluations and mandatory education completed. 3. The NHA / designee will educate the facility Nurse Management staff on "Focus on F-tag 730" on or before the date of compliance. 4. The NHA / designee will utilize the "employee file review" audit 5 employees / week x 4 weeks to validate performance evaluations are completed per regulation and mandatory education completed. Results will be reviewed with QA&A. 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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F 730	Continued From page 114 following:	F 730		

1. CNA #1 with a date of hire of 8/29/20, evidenced no performance evaluation, dementia training was past due.

2. CNA #6 with a date of hire of 5/9/01, evidenced dementia training past due.

3. CNA #7 with a date of hire of 1/28/08, evidenced dementia training past due.

4. CNA #8 with a date of hire of 11/23/05, evidenced dementia and abuse training past due.

5. CNA #9 with a date of hire of 11/6/17, evidenced dementia and abuse training past due.

On 3/29/22 at 1:58 PM an interview was conducted with OSM #12. When shown the results of the CNA employee file review and asked if there was a performance evaluation for CNA #1 and evidence of the mandatory education for CNA #1, #6, #7, #8 and #9, OSM #12 stated there is no evaluation for CNA #1 and the CNAs did not complete their education. She stated these are the only education sheets staff.

On 3/29/22 at 4:40 PM, ASM #1, the administrator, ASM #2, the interim director of nursing, ASM #3, the quality assurance consultant, and ASM #5, the former administrator were informed of the above concern.

According to the facility's "Performance Appraisals" policy, dated 9/21; 'A skills techniques evaluation for all nursing assistants is to be completed annually for all nursing assistants at the time of the annual performance appraisal."

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F 730	Continued From page 115 No further information was provided prior to exit.	F 730		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the	F 732	**F 732 – Staffing Posting** 1. The facility posting has been updated. 2. The Staffing Coordinator has been educated and the staffing posting is observed daily by the NHA / designee. 3. The NHA / designee has educated the facility IDT management staff on "Focus on F-tag 732." 4. The NHA / designee will utilize the "Nursing staff info posted" audit tool 5 times a week x 4 weeks to validate the staffing postings have been updated. Results will be reviewed with QA&A. 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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F 732	Continued From page 116	F 732		

posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to post daily staffing for three of four days reviewed. The facility failed to post daily nursing staffing on 3/27/22, 3/28/22, and 3/29/22.

The findings include:

During the Sufficient and Competent Staffing facility task review started on 3/27/22 and ending on 3/30/22, a review of the daily staffing evidenced the following:

On 3/27/22 at 10:17 AM, on the desk at the front entrance, the daily staff posting was dated 3/22/22.

On 3/28/22 at 8:00 AM, on the desk at the front entrance, the daily staff posting was dated 3/27/22.

On 3/29/22 at 10:45 AM, on the desk at the front entrance, the daily staff posting was dated 3/28/22.

On 3/29/22 at 1:10 PM an interview was conducted with OSM (other staff member) #7, the staffing coordinator. When asked who is responsible for posting the daily staffing, OSM #7 stated, "I am responsible but on weekends the MOD (manager on duty) is responsible to post it." When asked if she had been on duty on 3/27/22 to post the staffing, OSM #7 stated, "No, it was

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F 732	Continued From page 117 not me." When asked why the daily posting was not done 3/28 or 3/29, OSM #7 stated, "I was doing other tasks when I came to work." On 3/29/22 at 1:20 PM an interview was conducted with OSM #2, the food services director. When asked if he was the MOD on 3/27/22, OSM #2 stated, he was the MOD for the facility on Sunday. When asked is it your responsibility to post the staffing, OSM #2 stated, "No, not that I know of. I would not know where to get this information." OSM #2 asked where this would be posted. OSM #2 stated the only thing he posts is the menu for the day. On 3/29/22 at 4:40 PM, ASM #1, the administrator, ASM #2, the interim director of nursing, ASM #3, the quality assurance consultant, and ASM #5, the former administrator were informed of the above concern. According to the facility's "Posted Nurse Staffing Information" policy, no date noted, which reveals, "The facility must post the following information on a daily basis: Facility name, current date, total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses, certified nurse aides, and resident census. The facility must post the nurse staffing data specified on a daily basis at the beginning of each shift." No further information was provided prior to exit.	F 732		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

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F 758	Continued From page 118 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their	F 758	**F 758 – Free from Psychotropic Meds** 1. The diagnosis for Seroquel was updated and target behaviors added to the care plan for resident # 6. 2. A comprehensive review of residents receiving antipsychotic medication will be completed by the DON / designee to validate appropriate diagnosis and target behaviors are identified for the use of antipsychotic medications. 3. The DON / designee will educate the facility Nurse Management team on "focus on F-tag 758" and "psycho-tropic medication use" procedure on or before the date of compliance. 4. The DON / designee will audit 5 residents / week x 4 weeks of residents receiving antipsychotic medications utilizing the "Unnecessary Medication" QAPI tool to validate appropriate diagnosis and target behaviors identified for use of antipsychotic. Results will be reviewed with QA&A. 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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F 758	Continued From page 119 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined one of 50 residents in the survey sample received unnecessary psychotropic medications, Resident #6 (R6). For Resident #6, the facility staff failed to ensure a proper diagnosis for the use of Seroquel (Quetiapine Fumarate) (used to treat schizophrenia, Bipolar disorder and in addition to other medications to treat depression) (1); and failed to identify target behaviors for the Seroquel. The findings include: On the most recent MDS assessment, a quarterly assessment, with an ARD of 12/31/2021, the resident was coded as having both short and long term memory problems and was severely impaired to make daily decisions. In Section N - Medications, R6 was coded as receiving seven days of an antipsychotic during the look back period. The physician orders dated, 2/28/2022, documented, "Quetiapine Fumarate Tablet 25 MG (milligrams), give 50 MG via G-Tube (gastrostomy tube - a tube placed through the abdomen into the stomach for feeding) (2), two times a day for antipsychotic."	F 758		

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The physician order dated, 3/9/2022, documented, "Seroquel Tablet 50 MG, give 50 MG via G - tube two times a day for anxiety."

The physician order dated, 3/25/2022 documented, "Quetiapine Fumarate tablet 25 MG; give 25 MG via G- tube in the morning related to: Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side until 4/2/2022."

The physician order dated, 3/25/2022 documented, Seroquel 50 MG tablet, give 50 MG via G - tube at bedtime related to: Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side until 4/2/2022."

Review of the March 2022 MAR (medication administration record) revealed the above medications administered as ordered.

The comprehensive care plan dated, 10/7/2021, documented in part, "Focus: At risk for adverse effects related to: use of antipsychotic medication ...Administer medications as ordered. Notify physician of decline in ADL (activities of daily living) ability or mood/behavior related to a dosage change. Report to physician signs of adverse reaction such as decline in mental status, decline in positioning/ambulation ability, lethargy, complaints of dizziness, tremors, etc."

Review of the nurse's notes for March, February and January 2022 failed to evidence any documentation of any behaviors for R6.

An interview was conducted with LPN (licensed practical nurse) #1 on 3/29/2022 at 2:40 p.m. When asked what Seroquel is given for, LPN 31

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stated it depends on the patient, but it can be given for depression. When asked if a diagnosis of hemiplegia and hemiparalysis be an appropriate diagnosis for the use of Seroquel, LPN #1 stated no. When asked what R6's targeted behaviors were, LPN #1 stated they can be aggressive. When asked where she documents the behaviors for R6, LPN #1 stated she has not had to document any as he hasn't had any while she was on duty. LPN #1 stated some residents have a check box on the MAR for behaviors. LPN #1 stated she would need to check further.

On 3/29/2022 at 3:05 p.m., LPN #1 stated she had clarified the order for Seroquel with the hospice nurse and the diagnosis is psychosis. When asked where the behaviors are documented, LPN #1 stated the facility charts by exception and would only chart if the resident has behaviors.

An interview was conducted with ASM (administrative staff member) #3, the quality assurance consultant) on 3/29/2022 at 3:12 p.m. When asked what Seroquel is used for, ASM #3 stated it's used to treat psychosis, and is an antipsychotic. When asked if it is used for hemiplegia or hemiparalysis, ASM #3 stated not that she was aware of. When asked if the facility should have a targeted behavior of the use of an antipsychotic, ASM #3 stated the behavior would be psychosis. When asked where behaviors are monitored, ASM #3 stated they should be documented in the progress notes if the resident is having an episode. ASM #3 stated if there is no documentation of behaviors in the progress notes, then it is perceived the resident did not have any behaviors. The physician order above

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was reviewed with ASM #3. ASM #3 stated the order needs to be clarified, and that those are not proper diagnoses for the use of the Seroquel.

The facility policy, "Behavior Management Guidelines" documented in part, "The use of psychoactive medications should be utilized only as long as is necessary as demonstrated by the patient's behavior....Non-pharmacological interventions should be attempted prior to the use of any psychoactive medication...The individualized comprehensive care plan addresses the behavior management program, the goal for behavior management, individualized interventions to address the patient's specific risk factors and the plan for reductions of risk related to behaviors...In the event a patient experiences a new or escalating behaviors; behaviors are documented in [initials of computer program]."

ASM #1, the administrator, ASM #2, the interim director of nursing, ASM #3, and ASM #5, the former administrator, were made aware of the above concern on 3/30/2022 at approximately 8:45 a.m.

No further information was obtained prior to exit.

REFERENCES
(1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a698019.html
(2) This information was obtained from the following website: https://medlineplus.gov/ency/article/002937.htm

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 123 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to maintain kitchen equipment in a sanitary manner for one of one microwave, one of one cook's refrigerators, and in one of one traditional ovens in the kitchen. On observation on 3/27/22, the microwave contained numerous pieces of food and debris, the two ovens contained grease and multiple food chunks and debris, and the cook's refrigerators contained evidence of multiple sticky liquid spills on the bottom shelf. The findings include: On 3/27/22 at 10:44 a.m., the kitchen was observed with OSM (other staff member) #2, the	F 812	**F 812 – Kitchen Sanitation** 1. The kitchen was cleaned by the dietary staff on March 27, 2022. 2. The Dietary Manager completed a "Kitchen" QAPI tool to validate cleanliness. 3. The Dietary Manager will educate the facility dietary staff on "focus on F-tag 812" on or before the date of compliance. 4. Utilizing the "kitchen" QAPI tool the Dietary Manager / designee will audit the kitchen weekly x 4 weeks to validate compliance. Results will be reviewed with QA&A. 5. The facility's alleged date of compliance will be April 28, 2022.	4/28/2022

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food services director. Both sides of the cook's refrigerator contained evidence of multiple liquid spills. Some of the liquid material was sticky. OSM #2 stated the refrigerator definitely needed to be wiped down. He stated the refrigerator should be cleaned each evening, and it appeared that this task was missed the previous evening. The microwave contained multiple pieces of food and debris on all four sides, the top, and the base. OSM #2 stated the microwave did not look "good," and that it needed cleaning. Both sides of the traditional oven contained multiple areas of grease on the handles and exterior doors. The interior of both sides of the oven contained baked on food and greasy materials. OSM #2 stated the facility is in the process of attempting to purchase a new oven. He stated the current condition of the oven makes it impossible to get completely clean. He stated: "It's not acceptable, but it's what we've been dealing with for a while." When asked if he would describe this kitchen equipment as unsanitary, he stated there was definitely room for much cleaning to be done. He stated he was not sure when a thorough cleaning of the oven had been done.

On 3/28/22 at 11:37 a.m., ASM #1, ASM #3, the quality assurance consultant, ASM #4, the regional director of operations, and ASM #5, the former administrator, were informed of these concerns.

A review of the facility policy, "Ovens," revealed, in part: "Cleaning Procedure...Prepare a solution according to manufacturer's guidelines of grease cutter and water in a spray bottle...Spray entire surface of the oven and allow to soak for 15 minutes...Using a brush or scrub pad, scrub all surfaces to loosen the burned-on soil. Use a dull

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F 812 Continued From page 125
scraper on stubborn spots...Spray or wipe outside of oven with detergent solution."

A review of the facility policy, "Microwave Oven," revealed, in part: "Cleaning Procedure...Wipe up spills as they occur...Wash walls inside and outside with detergent solution."

No further information was provided prior to exit.

F 921 SS=D Safe/Functional/Sanitary/Comfortable Environ
CFR(s): 483.90(i)

§483.90(i) Other Environmental Conditions
The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.
This REQUIREMENT is not met as evidenced by:
2. The facility staff failed to maintain a functioning toilet in Resident #47's (R47) room.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/11/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions.

On 3/28/22 at 3:17 p.m., an interview was conducted with R47. R47 stated the toilet in the room has been broken for the past month and won't flush. R47 stated this was verbalized to someone in the maintenance department but the toilet has not been fixed. R47 stated they did not use the toilet but the staff used the toilet to empty urine from the resident's urinary catheter bag. At this time, an observation of the toilet was conducted. There was toilet paper in the toilet

F 921 – Clean / Sanitary Conditions

1. Toilet for resident # 47 repaired. Hole in BR door for resident # 36 was repaired. Room cleaned for resident # 97.
2. A review of resident areas will be completed by the Interdisciplinary team utilizing the "Housekeeping" audit tool to validate safe / clean / homelike environment.
3. The NHA / designee will educate the facility housekeeping / maintenance department on the "Focus on F-tag 921" on or before the date of compliance.
4. Utilizing the "Housekeeping" audit tool the NHA / designee will audit 5 resident rooms / week x 4 weeks to validate a safe / clean / homelike environment. Results will be reviewed with QA&A.
5. The facility's alleged date of compliance will be April 28, 2022.

Completion date: 4/28/2022

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and the toilet did not flush after the handle was pushed.

On 3/29/22 at 7:20 a.m., another observation of the toilet was conducted. There was no toilet paper in the toilet and the toilet did not flush after the handle was pushed.

On 3/29/22 at 9:54 a.m., an interview was conducted with OSM (other staff member) #4 (the maintenance director for a sister facility). OSM #4 stated the facility currently did not employ maintenance staff but someone from his facility comes to this facility twice a week. OSM #4 stated toilets are inspected on a monthly basis but other staff can enter a work order into the computerized work order system if repairs are needed. OSM #4 stated he was not aware that R47's toilet was not functioning until this morning but R47 may have reported the broken toilet to another maintenance employee that comes over from the sister facility.

On 3/30/22 at 10:32 a.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated the CNAs go into resident bathrooms every day and most of the time, residents report if a toilet isn't working. CNA #4 stated the nursing staff can submit a "maintenance slip" if a toilet is not functioning.

On 3/29/22 at 4:42 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the interim director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

3. The facility staff failed to provide a well

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F 921	Continued From page 127 maintained comfortable environment for Resident #36 (R36). A hole was observed in R36's bathroom door. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/22/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. On 3/28/2022 at 11:50 a.m., an observation was made of R36's room. The door to R36's bathroom had a hole in the door approximately two inches long by five inches wide. The area was observed to expose the sheetrock beneath the exterior door. At this time an interview was conducted with R36. R36 stated that a CNA (certified nursing assistant) had accidentally hit the door with the hoyer lift (mechanical patient lift equipment) back in November or December causing the hole, and the area had been there since then. R36 stated that they did not use the restroom because they were bedbound but would like the area fixed. R36 stated that no one had been in to look at the area since it happened. Additional observations on 3/28/2022 at 9:45 a.m. and 3/29/2022 at 10:15 a.m. revealed the findings as described above. On 3/28/2022 at 12:45 p.m., an interview was conducted with OSM (other staff member) #4, the director of maintenance at sister facility. OSM #4 stated that they came over twice a week because there was no maintenance director currently. OSM #4 stated that monthly room rounds were conducted in the facility. OSM #4 stated that they used the TELS (The Equipment Lifecycle	F 921		

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F 921	Continued From page 128 System) for maintenance work orders entered by staff. OSM #4 stated that they would check to see if there were any work orders in place for R36's bathroom door. OSM #4 observed R36's bathroom door and stated that they would be able to get the repairs done. On 3/29/2022 at 1:25 p.m., OSM #4 stated that there were no work orders in place for R36's bathroom door. On 3/29/2022 at 2:12 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that they called maintenance directly if there were any issues that needed repairs. LPN #5 stated that they had never entered a workorder into the computer and always called or either spoke with maintenance staff face to face on the unit. On 3/29/2022 at 4:41 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing/MDS coordinator, ASM #3, the quality assurance consultant and ASM #5, the former administrator were made aware of the above concern. No further information was presented prior to exit.	F 921		

F 921 Continued From page 129 F 921

Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide a sanitary environment for three of 50 residents in the survey sample, Residents #97, #36, and #47.

The findings include:

1. For Resident #97, the facility staff failed to clean the window tracks and behind the toilet in the resident's bathroom, creating an unsanitary environment.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/21/22, Resident #97 (R97) was coded as scoring 15 out of 15 on the BIMS (brief interview for mental status), indicating she had no cognitive impairment for making daily decisions.

On 3/27/22 at 2:06 p.m., R97 was observed lying in bed. R97 was awake and alert. R97 directed attention to the areas in the window tracks and behind the toilet in the bathroom.. The window tracks contained dried, black material that was not easily scraped with a fingernail. The area behind and around the toilet contained a dark brownish-black stain about 6 inches in width and 3 inches in length. R97 stated housekeepers are in and out of the room quickly, and the perception is that no one takes the time needed to notice or clean thoroughly.

On 3/28/22 at 10:47 a.m., OSM (other staff member) #1, environmental services director, was interviewed. When asked what is included in cleaning a resident's room, she stated some

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F 921	Continued From page 130 tasks are completed daily: dumping trash, wiping down all surfaces, cleaning bathrooms, and mopping. She stated other tasks are considered to be deep cleaning, and occur once weekly on a set schedule: air conditioning units, windows, detailing bathrooms, furniture. OSM #1 was asked to observe the cleanliness conditions of R97's room as detailed above. OSM #1 stated the area under the bureau did not appear to have been dusted "in some time," the window tracks had not been cleaned as they should, and the bathroom "should have been caught way before now." She stated the room was not at an acceptable standard for cleanliness. When asked who follows up to make sure housekeepers are cleaning as they should, she stated she should be following up, but if there is a call out, she has to cover for her staff and she does not have time to go behind housekeepers to monitor their performance. She stated R97's room location is problematic, because there is not one particular housekeeper assigned to clean the room consistently. When asked if she would describe the window tracks and area around the toilet as sanitary, she stated she would not. On 3/28/22 at 11:20 a.m., ASM (administrative staff member) #1, the administrator, observed R97's room for cleanliness. After looking at the window and the area behind the toilet, he stated there are concerns with the cleanliness of the room. On 3/28/22 at 11:37 a.m., ASM #1, ASM #3, the quality assurance consultant, ASM #4, the regional director of operations, and ASM #5, the former administrator, were informed of these concerns.	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING ______ B. WING ______	C 03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL)	1719 BELLEVUE AVENUE RICHMOND, VA 23227

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F 921	Continued From page 131 A review of the facility's housekeeping daily work assignment sheets and daily deep cleaning schedules revealed tasks and schedules which verified the information provided by OSM #1's interview. No further information was provided prior to exit.	F 921		