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	495336	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 4/5/22 through 4/7/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced (Medicare/Medicaid) standard survey was conducted 04/05/22 through 4/07/22. Five complaints were investigated during the survey: VA00054801 was unsubstantiated with no deficient practice; VA00053616 was unsubstantiated with no deficient practice; VA00053146 was unsubstantiated with no deficient practice; VA00054040 was substantidated with no deficient practice; VA00054383 was substantiated with deficient practice. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 112 certified bed facility was 74 at the time of the survey. The survey sample consisted of 20 current resident reviews and four closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		5/10/22

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

Electronically Signed | 04/22/2022

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F 550	Continued From page 1 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide dignity/respect for two of 24 residents in the survey sample, Resident #51, and #42. Resident #51 was dressed in a soiled hospital gown and was provided physical therapy services with her	F 550	F550: Resident Rights/Exercise of Rights 1. Resident #51 is clean and dressed appropriately. Education provided to CNA on 4/6/2022 to ensure residents hands, face and clothing are clean after meals.	

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F 550	Continued From page 2 back, incontinence brief and legs exposed in the presence of a visitor. Resident #42 was abruptly awakened and positioned for breakfast while stating she did not want to eat. The findings include: 1. Resident #51 was admitted to the facility with diagnoses that included chronic kidney disease, cirrhosis of liver, diabetes, severe protein-calorie malnutrition, hypertension, anemia, portal vein thrombosis, metabolic encephalopathy, gastroesophageal reflux disease, breast cancer, anxiety, depression, cognitive communication deficit and hemiplegia of left leg. The minimum data set (MDS) dated 3/1/22 assessed Resident #51 with moderately impaired cognitive skills and as requiring the extensive assistance of one person for dressing and hygiene. On 4/5/22 at 11:04 a.m., Resident #51 was observed in bed. The resident was dressed in a hospital gown. There were dried red/orange colored stains on the front of the gown below the neckband. On 4/5/22 at 12:13 p.m., Resident #51 was observed in bed dressed in the stained hospital gown. The resident had a lunch tray on the bed table in front of her. Resident #51 was sticking her fingers in the bowls of pureed food, dropping mash potatoes on her chest and licking her fingers. On 4/5/22 at 12:18 p.m., certified nurses' aide (CNA) #2 came into the room without knocking and removed the roommate's tray. CNA #2 looked at and spoke to Resident #51, but offered no assistance with eating or cleaning the food	F 550	Education was provided to the therapist on 4/8/2022 to ensure residents are appropriately dressed for therapy. Resident # 42 no longer resides in the facility 2. Quality review to be conducted by the Director of Nursing/Assistant Director of Nursing to ensure residents are dressed appropriately and clean after meals 3. All therapy staff will be re-educated on ensuring residents are appropriately dressed for therapy treatments and if they choose to wear a gown they will ensure residents are covered, curtain is pulled or in a private area. Facility staff will be re-educated on knocking on resident doors prior to entry. Nursing staff will be re-educated on ensuring residents are awake prior to meal delivery and that residents are clean after meals. 4. Executive Director (ED)/Director of Nursing (DON)/designee will conduct quality monitoring on 10 residents 3x weekly for 4 weeks, 2x weekly for 4 weeks and weekly for 4 weeks, to ensure residents are dressed appropriately and clean after meals The results of the quality monitoring□s will be presented to the Quality Assurance/Performance Improvement Committee monthly for review, analysis and further recommendations. Quality monitoring schedule will be modified based on the findings.	

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F 550	Continued From page 3 from her chest. On 4/5/21 at 12:34 p.m., Resident #51 was in bed still dressed in the stained hospital gown. The lunch tray was gone and the mashed potatoes were still on the resident's chest. On 4/5/21 at 2:19 p.m., Resident #51 was observed in a clean hospital gown. On 4/5/21 at 3:54 p.m., Resident #51 was observed in her room dressed in a hospital gown. A physical therapy assistant (PTA, other staff #8) was assisting the resident from standing with a walker to a seated position in a wheelchair. The resident's gown was not tied at the back and the resident's entire back, buttock area with incontinence brief and legs were visible. The door to the room was open and a male visitor was standing against the wall beside the resident's bed. The PTA assisted Resident #51 to stand at the bedside with the gown back still open. The PTA then turned Resident #51, assisted her to sit on the bedside, lifted the resident's legs onto the bed and then pulled bedcovers over the resident. The resident's incontinence brief and legs were visible to the visitor and the resident was visible from the hallway. The PTA did not attempt to tie the gown or cover the resident in any manner during this observation. On 4/6/22 at 10:19 a.m., CNA #2 caring for Resident #51 was interviewed about the hospital gown. CNA #2 stated Resident #51 required "total care" for dressing but was able to eat independently. CNA #2 stated the resident had a bowel movement earlier in the shift and after she cleaned the resident, she put the hospital gown on her "to make it easy access." CNA #2 stated it	F 550	5. Date of Compliance: 5/10/2022	

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F 550	Continued From page 4	F 550		

was easier to roll Resident #51 over with the gown and she did not want to "mess up her clothes." CNA #2 stated Resident #51 was set-up only for meals and she did not know why the resident was putting her fingers in the food.

On 4/6/22 at 2:53 p.m., the licensed practical nurse (LPN) #1 caring for Resident #51 was interviewed. LPN #1 stated Resident #51 required fluid to be suctioned from an abdominal drain three times a day and it was easier to access the drain with a gown. LPN #1 stated the family had not expressed any concerns about the hospital gown. LPN #1 stated Resident #51 should not be left with food and/or stained clothing and staff were supposed to knock before entering the room.

On 4/6/22 at 3:25 p.m., the therapy director (other staff #2) was interviewed about the PTA (other staff #8) conducting therapy with the resident's back, bottom and legs exposed. The therapy director stated providing services with the resident exposed was a resident rights issue and dignity concern. The therapy director stated it was "dignity 101" to ensure appropriate dress and privacy during care.

Resident #51's plan of care (revised 3/24/22) documented the resident had a self-care deficit due to impaired mobility, weakness, activity intolerance, pain and incontinence. Interventions to maintain activities of daily living included, "Staff to provide assistance as needed or requested...Allow sufficient time for dressing and undressing...Assist (Resident #51) to choose simple comfortable clothing that enhances her ability to dress self...Monitor/document/report PRN (as needed) any changes, any potential for

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improvement, reasons for self-care deficit, expected course, declines in function..."

This finding was reviewed with the administrator and director of nursing during a meeting on 4/6/22 at 5:15 p.m.

2. Resident #42 was admitted to the facility with diagnoses that included fractured tibia/fibula, congestive heart failure, osteoporosis, bradycardia, cognitive communication deficit, diabetes, morbid obesity, dysphagia, delusional disorder, chronic respiratory failure, COPD (chronic obstructive pulmonary disease), insomnia, psychotic disorder with delusions, depression, atrial fibrillation, dementia with behaviors, anxiety and sleep apnea. The minimum data set (MDS) dated 2/21/22 assessed Resident #42 with severely impaired cognitive skills and as requiring extensive assistance of two people for bed mobility and hygiene.

On 4/5/22 at 12:15 p.m., certified nurses' aide (CNA) #2 entered Resident #42's room without knocking or with any verbal announcement and picked up the lunch tray.

On 4/6/22 at 7:40 a.m., Resident #42 was observed in bed. The resident was on her back, mouth open and eyes closed with no signs of being awake. On 4/6/22 at 7:42 a.m., CNA #1 and another staff member entered Resident #42's room without knocking and placed the breakfast tray on the over-bed table. CNA #1 told the resident it was time for breakfast and proceeded to raise the head of the bed. There were no attempts to wake the resident prior to raising the bed. CNA #1 and the other staff member pulled the resident up in bed while the resident stated

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she did not want to eat. CNA #1 told Resident #42 that she had to get up for breakfast. CNA #1 made no response to the resident's statements of not wanting to eat. CNA #1 and the other staff member completed the tray set-up and left the room. Resident #42 repeatedly stated after the staff members left the room, "I do not want it."

On 4/6/22 at 9:51 a.m., CNA #1 was interviewed about waking Resident #42 for breakfast with the resident stating she did not want to eat. CNA #1 stated, "We just get them up for breakfast." CNA #1 stated the resident was "half awake" when they got her up for breakfast.

On 4/6/22 at 3:06 p.m., licensed practical nurse (LPN) #1 caring for Resident #42 was interviewed about the breakfast service observation with the resident stating she did not want to eat. LPN #1 stated meal trays were sent to the floor at one time for service to residents. LPN #1 stated she was not sure if alternate meal times were available. Concerning the observation of CNA #1 waking Resident #42, raising her bed and setting up the breakfast tray against the resident's wishes, LPN #1 stated, "That sounds impersonal."

Resident #42's plan of care (revised 2/16/22) documented the resident had insomnia, a history of paranoia and delusions, communication problems, impaired hearing, disorganized thinking and was at times short-tempered and easily annoyed. Interventions to minimize delusions, confusion and to promote improved mood and cooperation included, "...Wait and reattempt when (Resident #42) is refusing care, if she continues to refuse have another staff member attempt...Ask yes/no questions in order to

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F 550	Continued From page 7 determine (Resident #42's) needs...Explain all procedures, care, medications to (Resident #42) before starting and allow her to adjust to changes...Staff will engage in conversations with (Resident #42) when they are assisting her in her room..." This finding was reviewed with the administrator and director of nursing during a meeting on 4/6/22 at 5:15 p.m.	F 550		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on review of employee files, and staff interview, and facility document review, the facility failed to fully implement their policy and procedure for licensure and certification verification of new employees. The facility failed to verify the license and/or conduct a criminal background check for eight of 25 employee files reviewed. The findings were:	F 607	F607: Develop/Implement Abuse/Neglect Policies 1. The eight employees identified are no longer employed with the facility at this time 2. Quality review conducted by the ED/Human Resources (HR) on current employees to ensure all files had a criminal background check, sworn	5/10/22

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F 607	Continued From page 8 A sample of 25 employee files of all employees hired within the last two years was reviewed. The files were reviewed for a criminal record check, sworn statement, valid license, and references. Out of the 25 employee files reviewed, eight did not have criminal record check and/or a sworn statement. The eight employee files included the following: CNA (Certified Nursing Assistant) hired 10/29/2020 missing a licensure verification. CNA hired 12/1/2020 missing a licensure verification and criminal record check. CNA hired 4/20/2021 missing a licensure verification, criminal record check, and sworn statement. CNA hired 11/15/2021 missing a licensure verification and criminal record check. LPN (Licensed Practical Nurse) hired 3/31/2020 missing a licensure verification and criminal record check. CNA hired 9/26/2019 missing a licensure verification and criminal record check. CNA hired 10/28/2019 missing a licensure verification. LPN hired 2/9/2021 missing a licensure verification. Review of the facility policy and procedure on "Licensure and Certification Verification" documented the following:	F 607	statement, and valid license. 3. HR re-educated on ensuring employees have a criminal background check, sworn statement and valid license prior to working. 4. ED/designee will conduct quality monitoring on new hires weekly for the next 8 weeks. The results of the quality monitoring's will be presented to the Quality Assurance/Performance Improvement Committee monthly for review, analysis and further recommendations. Quality monitoring schedule will be modified based on the findings. 5. Date of Compliance: 5/10/2022	

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"The individual's current license/certification will be verified on or prior to the date of hire by the Human Resources Representative using the original source. In addition, a copy of the electronic version stating the license is in good standing will also be maintained in the personnel file."

Review of the facility policy and procedure on "Background Checks" documented the following: "It is the policy of The Company to conduct background checks to include criminal background checks...required by federal regulation.... Each care center or office will maintain a copy of and comply with their respective state law requiring criminal background checks. Criminal background inquiries shall be maintained in a secure file.... In addition...you may be required to have the candidate/employee sign both the Employment Application, Authorization and the state form."

At approximately 9:45 a.m. on 4/7/2022, the Human Resources (HR) Manager was given a list of 16 personnel files that were missing a licensure verification, criminal record check, and/or sworn statement. A check with the HR Manager at approximately 11:00 a.m. found licensure verification, criminal record check, and/or sworn statement documentation was found for eight of the 16 personnel files. The HR Manager indicated she was unable to find the missing items for the eight above listed personnel files.

The HR Manager pointed to several file boxes in her office and said the documents might be in one of them. According to the HR Manager, the previous HR Manager did not have long term

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F 607	Continued From page 10 care experience and may have discarded the criminal record checks and license verification once they were verified instead of filing them. The HR Manager went on to say she had accessed the facility's criminal record check requests on the computer in an effort to locate the missing criminal record checks but was unable to find them. The findings were discussed at 11:30 a.m. on 4/7/2022 during a meeting that included the Administrator, Director of Nursing, nurse consultant, and the survey team.	F 607		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §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	F 622		5/10/22

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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 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)

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F 622	Continued From page 12 (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) 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, the facility staff failed to meet discharge/transfer documentation requirements for three of 24 residents, Resident #70, Resident #320, and Resident #67. Findings were: 1. Resident #70 was admitted to the facility after falling down the cellar stairs at home and sustaining multiple fractures. Additional diagnosis included but were not limited to: hypertension, anemia, osteoporosis, and chronic kidney disease.	F 622	F622: Transfer and Discharge Requirements 1. Resident # 70 and resident #320 no longer reside in the facility, resident # 67 was re-admitted on 2/17/2022. 2. Quality review conducted by the DON/designee of transfer/discharge paperwork of discharges to the hospital in the past 2 weeks. 3. Nurses will be re-educated by the DON/ADON on the appropriate documentation and paperwork that should	

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F 622	Continued From page 13 The admission MDS (minimum data set) with an ARD (assessment reference date) of 12/02/2021, assessed Resident #70 as moderately impaired with a cognitive summary score of "10". Resident #70 was sent to the emergency room on 12/12/2021 and 01/02/2022. The only documentation in the clinical record either time was a physician order to send her to the emergency room. On 04/06/2022 at 8:30 a.m., the DON (director of nursing) was interviewed regarding the discharge/transfer process specifically when residents are sent to the hospital. She stated, "When a resident goes out (to the hospital), we do an SBAR (situation, background, assessment, recommendation), that's a change in condition form, we do a skin check, a transfer form, a bed hold form, a copy of their current orders, and their face sheet." She was asked what should be in the resident's record at the facility. She stated, "The order to transfer, a change in condition form, a skin evaluation and a progress note unless it is written on the change of condition form." The above information was discussed during an end of the day meeting on 04/06/2022 at approximately 5:30 p.m. No further information was obtained prior to the exit conference on 04/07/2022. 2. Resident #320 was admitted to the facility with diagnoses including, but not limited to: Atrial fibrillation, hypokalemia, type 2 diabetes, and adult failure to thrive. The most recent MDS was still in progress as the	F 622	be completed when someone is being sent to the hospital. DON and the interdisciplinary team will review all discharges in the morning clinical meeting to ensure all of the necessary paperwork and documentation was completed. 4. The ED/DON/designee will conduct quality monitoring on discharges to the hospital for 8 weeks. The results of the quality monitoring will be presented to the Quality Assurance/Performance Improvement Committee monthly for review, analysis and further recommendations. Quality monitoring schedule will be modified based on the findings. 5. Date of compliance: 5/10/2022	

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F 622	Continued From page 14	F 622		

resident had been recently admitted to the facility.

On 04/06/2022 at approximately 8:00 a.m., Resident #320 was not in her room. LPN (licensed practical nurse) #1 was in the hallway giving medications. She was asked where Resident #320 was at that time. She stated, "She went to the hospital yesterday with a GI (gastro-intestinal) bleed." LPN #1 was asked if Resident #320 was expected to return. She stated, "I don't know, they said in report that she had been admitted."

The clinical record was reviewed at approximately 9:00 a.m. The only documentation regarding Resident #320 being sent to the emergency room was a physician's order.

The DON (director of nursing) was interviewed on 04/06/2022 at 8:30 a.m. regarding the discharge/transfer process specifically when residents are sent to the hospital. She stated, "When a resident goes out (to the hospital), we do an SBAR, that's a change in condition form, we do a skin check, a transfer form, a bed hold form, a copy of their current orders, and their face sheet." She was asked what should be in the resident's record at the facility. She stated, "The order to transfer, a change in condition form, a skin evaluation and a progress note unless it is written on the change of condition form." She was asked how soon after a resident was sent out to the emergency room she would expect to see the documentation in the clinical record. She stated, "As soon as possible." She was asked if the nurses were expected to add the documentation by the end of their shift. She stated, "Yes."

The facility policy, "Transfer/Discharge

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Notification and Right to Appeal," documented: "...the facility will ensure that the transfer or discharge is documented in the resident's medical record...Documentation to include: the basis for the transfer...the specific reason the resident's needs can not be met..."

On 04/06/2022 at approximately 5:30 p.m. during an end of the day meeting the above information was discussed.

No further information was obtained prior to the exit conference on 04/07/2022.

3. Resident # 67 in the survey sample was admitted with diagnoses that included anemia, non-pressure chronic ulcer of left foot, hypertension, peripheral vascular disease, renal insufficiency, diabetes mellitus, hyponatremia, hyperlipidemia, anxiety disorder, urogenital implants, functional dyspepsia, depression, overactive bladder, claustrophobia, restless leg syndrome, and generalized muscle weakness. According to the most recent Minimum Data Set, a Quarterly review with an Assessment Reference Date of 3/16/2022, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

Review of the Progress Notes in the resident's Electronic Health Record (EHR) noted the following entry:

2/13/2022 - 4:18 p.m. - Nursing Progress Note - "Resident c/o (complained) severe pain in abdomen radiating to back, also said she is passing blood in urine. Had Tylenol with no effect. Resident requested to go to the hospital. MD on call informed advised to send her. Son

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F 622	Continued From page 16 was informed. ER and 911 call. Resident lt (left) at 4:15 p.m." 2/13/2022 - 8:07 p.m. - Nursing Progress Note - "Nurse calls son to notify that resident has been taken to the hospital and been admitted for 'blood in pelvis'. ER doctor called nurse to have current meds (medications) given to him. Meds given orally to MD as requested." Resident # 67's EHR failed to reveal any documentation related to the transfer to the hospital including, the basis for the transfer, contact information for the resident's treating physician, resident representative information, Advance Directives, special instructions, and care plan goals. At 3:30 p.m. on 4/6/2022, the Director of Nursing (DON) was asked for any and all documentation related to Resident # 67's transfer to the hospital on 2/13/2022. At 3:55 on 4/6/2022, the DON stated, "I don't have anything." Asked if that meant there was no paperwork at all, the DON indicated there was none. The findings were discussed during an end of day meeting at 5:15 p.m. on 4/7/2022 that included the Administrator, Director of Nursing, nurse consultant, and the survey team.	F 622		
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	F 625		5/10/22

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F 625	Continued From page 17 nursing facility must provide written information to 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, facility document review, and in the course of a complaint investigation, the facility staff failed to provide information regarding bed holds at the time of transfer/discharge for four of 24 residents, Resident #70, Resident #320, Resident #67, and Resident #61. Findings were: 1. Resident #70 was admitted to the facility after falling down the cellar stairs at home and sustaining multiple fractures. Additional diagnosis included but were not limited to: hypertension,	F 625	F625: Notice of Bed Hold Policy Before/Upon Transfer 1. Resident # 70, Resident # 320 and Resident # 61 no longer reside in the facility. Resident # 67 returned to facility on 2/17/2022. 2. Quality review conducted by the DON/ED of documentation of bed hold policy being given to resident or representative on hospital transfers for the past two weeks.	

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F 625	Continued From page 18 anemia, osteoporosis, and chronic kidney disease. The admission MDS (minimum data set) with an ARD (assessment reference date) of 12/02/2021, assessed Resident #70 as moderately impaired with a cognitive summary score of "10". Resident #70 was sent to the emergency room on 12/12/2021 and 01/02/2022. The only documentation in the clinical record either time was a physician order to send her to the emergency room. On 04/06/2022 at 8:30 a.m., the DON (director of nursing) was interviewed regarding the discharge/transfer process specifically when residents are sent to the hospital. She stated, "When a resident goes out (to the hospital), we do an SBAR (situation, background, assessment, recommendation), that's a change in condition form, we do a skin check, a transfer form, a bed hold form, a copy of their current orders, and their face sheet." She was asked what should be in the resident's record at the facility. She stated, "The order to transfer, a change in condition form, a skin evaluation and a progress note unless it is written on the change of condition form." Review of Resident #70's clinical record did not reveal any documentation regarding a bed hold being offered to either Resident #70 or the responsible party at the time of transfer to a local emergency room on 01/02/2022 when the resident was found unresponsive and sent out. On 04/06/2022 at approximately 5:30 p.m. during an end of the day meeting with facility staff the above information was discussed. There was no	F 625	3. Nurses will be re-educated by the DON/ADON regarding the bed hold policy and it being sent or given to the patient/representative upon discharge/transfer and documented in the clinical record. 4. The ED/DON/designee to conduct quality monitoring of discharges/transfer to the hospital for 8 weeks to ensure bed hold policy was given to patient/RP upon transfer. The results of the quality monitoring□s will be presented to the Quality Assurance/Performance Improvement Committee monthly for review, analysis and further recommendations. Quality monitoring schedule will be modified based on the findings. 5. Date of Compliance: 5/10/2022	

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bed hold form for the transfer on 01/02/022.

No further information was obtained prior to the exit conference on 04/07/2022.

2. Resident #320 was admitted to the facility with diagnoses including, but not limited to: Atrial fibrillation, hypokalemia, type 2 diabetes, and adult failure to thrive.

The most recent MDS was still in progress as the resident had been recently admitted to the facility.

On 04/06/2022 at approximately 8:00 a.m., Resident #320 was not in her room. LPN (licensed practical nurse) #1 was in the hallway giving medications. She was asked where Resident #320 was at that time. She stated, "She went to the hospital yesterday with a GI (gastro-intestinal) bleed." LPN #1 was asked if Resident #320 was expected to return. She stated, "I don't know, they said in report that she had been admitted."

The clinical record was reviewed at approximately 9:00 a.m. The only documentation regarding Resident #320 being sent to the emergency room was a physician's order.

The DON (director of nursing) was interviewed on 04/06/2022 at 8:30 a.m. regarding the discharge/transfer process specifically when residents are sent to the hospital. She stated, "When a resident goes out (to the hospital), we do an SBAR, that's a change in condition form, we do a skin check, a transfer form, a bed hold form, a copy of their current orders, and their face sheet." She was asked what should be in the resident's record at the facility. She stated, "The

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F 625	Continued From page 20	F 625		

order to transfer, a change in condition form, a skin evaluation and a progress note unless it is written on the change of condition form." She was asked how soon after a resident was sent out to the emergency room she would expect to see the documentation in the clinical record. She stated, "As soon as possible." She was asked if the nurses were expected to add the documentation by the end of their shift. She stated, "Yes." She was asked about the bed hold form she had mentioned. She stated, "The business office contacts the responsible party to discuss that."

Review of Resident #320's clinical record did not reveal any documentation regarding a bed hold being offered to either the resident or the responsible party.

On 04/06/2022 at approximately 5:30 p.m. during an end of the day meeting the above information was discussed.

No further information was obtained prior to the exit conference on 04/07/2022.

3. Resident # 67 was admitted with diagnoses that included anemia, non-pressure chronic ulcer of left foot, hypertension, peripheral vascular disease, renal insufficiency, diabetes mellitus, hyponatremia, hyperlipidemia, anxiety disorder, urogenital implants, functional dyspepsia, depression, overactive bladder, claustrophobia, restless leg syndrome, and generalized muscle weakness. According to the most recent Minimum Data Set, a Quarterly review with an Assessment Reference Date of 3/16/2022, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

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F 625	Continued From page 21	F 625		

Review of the Progress Notes in the resident's Electronic Health Record (EHR) noted the following entry:

2/13/2022 - 4:18 p.m. - Nursing Progress Note - "Resident c/o (complained) severe pain in abdomen radiating to back, also said she is passing blood in urine. Had Tylenol with no effect. Resident requested to go to the hospital. MD on call informed advised to send her. Son was informed. ER and 911 call. Resident lt (left) at 4:15 p.m."

Review of Resident # 67's EHR failed to reveal any written documentation presented to the resident of the resident's family regarding the bed-hold policy.

At 3:30 p.m. on 4/6/2022, the Director of Nursing (DON) was asked for any and all documentation related to Resident # 67's transfer to the hospital on 2/13/2022. At 3:55 on 4/6/2022, the DON came to the surveyor and stated, "I don't have anything." Asked if that meant there was no paperwork at all, the DON indicated there was none.

The findings were discussed during an end of day meeting at 5:15 p.m. on 4/7/2022 that included the Administrator, Director of Nursing, and nurse consultant.

4. Resident #61 was admitted to the facility with diagnoses that included leukemia, benign prostatic hyperplasia, kidney failure, emphysema, history of pulmonary embolism, obstructive sleep apnea, insomnia, chronic respiratory failure, diabetes, hypertension, gastroesophageal reflux disease, history of COVID-19, dysphagia, COPD (chronic obstructive pulmonary disease), and

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anemia. The minimum data set (MDS) dated 3/10/22 assessed Resident #61 as cognitively intact.

Resident #61's clinical record documented a physician's order dated 3/31/22 to send the resident to the emergency department for evaluation of jaw swelling, redness and fever. Resident #61 was admitted to the hospital and remained hospitalized as of 4/5/22.

Resident #61's clinical record included no evidence the resident or a resident representative was provided information regarding the facility's bed-hold policy on 3/31/22 or since his discharge to the hospital. Clinical/progress notes made no mention of the bed-hold status.

On 4/7/22 at 10:37 a.m., the director of nursing (DON) was interviewed about bed-hold information provided at the time of transfers. The DON stated there was nothing documented about the bed-hold policy at the time of Resident #61's transfer.

The facility's policy titled Bed Hold (revised 11/1/17) documented, "Resident or Resident Representative will be notified on admission, and at the time of transfer (to the hospital or therapeutic leave) of the bed hold policies, according to Federal and/or State requirements....At the time of transfer to the hospital or therapeutic leave, the center will provide a copy of notification of bed hold..."

The policy also documented, "The resident and/or resident representative sign the Bed Hold Authorization, if possible, or if not available, telephone authorization may be used and

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F 625	Continued From page 23 documented in the clinical record or on a bed hold authorization form." This finding was reviewed with the administrator and DON during a meeting on 4/7/22 at 12:00 p.m. This is a complaint deficiency.	F 625		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of practice for one of twenty-four residents in the survey sample, Resident #42. Nursing failed to document an assessment and the circumstances regarding a fall in Resident #42's clinical record and incident reports had conflicting details regarding the fall with injury. The findings include: Resident #42 was admitted to the facility with diagnoses that included fractured tibia/fibula, congestive heart failure, osteoporosis, bradycardia, cognitive communication deficit, diabetes, morbid obesity, dysphagia, delusional disorder, chronic respiratory failure, COPD (chronic obstructive pulmonary disease), insomnia, psychotic disorder with delusions,	F 658	F658: Services Provided Meet Professional Standards 1. Resident # 42 no longer resides in the facility. 2. Quality review conducted by the DON/designee of falls and fall assessments in the past 2 weeks. 3. Nurses will be re-educated by the DON/ADON regarding falls and the appropriate paperwork/assessments to be completed. 4. The ED/DON/designee to conduct quality monitoring of falls 3 x weekly for 4 weeks, 2 x weekly for 4 weeks, then weekly x 4 weeks.	5/10/22

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F 658	Continued From page 24 depression, atrial fibrillation, dementia with behaviors, anxiety and sleep apnea. The minimum data set (MDS) dated 2/21/22 assessed Resident #42 with severely impaired cognitive skills and as requiring extensive assistance of two people for bed mobility and hygiene. Resident #42's clinical record documented nursing note dated 12/21/21 documented, "...LLE pain, small bit of swelling noted..." A PA progress note dated 12/22/21 documented, "...am seeing today because of a leg injury. She had an accident yesterday and fell out of her wheelchair...This was unwitnessed by staff, but she was found with her left lower leg bent backward and laying on the knee...tender area on the left anterior shin...asked them to ice the area and use her oxycodone for pain..." A nursing note dated 12/23/21 documented, "...LLE (left lower extremity) pain, swelling with purple/blue bruising present, area firm, and tender to touch, assessed by PA (physician's assistant)...yesterday...as area was swollen, and tight day before, with no abnormal coloring present... (PA) also notified the evening of 12/21...Xray ordered last evening, ice applied 12/21, and yesterday as resident allowed..." A nursing note dated 12/25/21 documented, "...hollering out, with LLE pain, called xray yesterday, as xray was ordered that past wed., and had not yet been performed...PA was updated, awaiting xray today. LLE continues to be swollen, bruised, yellow/blue noted, no redness and or warmth..." Resident #42's X-ray results of the left tibia/fibula	F 658	The results of the quality monitoring's will be presented to the Quality Assurance/Performance Improvement Committee monthly for review, analysis and further recommendations. Quality monitoring schedule will be modified based on the findings. 5. Date of Compliance: 5/10/2022	

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dated 12/25/21 documented the resident had no acute fracture, possible chronic fracture of the distal fibula and soft tissue swelling.

The clinical record documented the resident continued to complain and was treated for left leg pain. The PA ordered another X-ray on 1/11/22. The X-ray results dated 1/11/22 documented an acute fracture of the proximal tibia/fibula with mal-alignment, mild soft tissue swelling and joint space narrowing. The resident was referred and treated by orthopedics regarding the fracture.

A nursing note dated 1/12/22 documented, "...LLE pain, xray performed yesterday, second xray, as first was performed 12/25, as a result of new pain, d/t (due to) fall, ortho f/u (follow up) tomorrow..."

Resident #42's clinical record made no mention of a fall and/or incident during December 2021 as referenced in the PA note of 12/22/21. There was no mention of any problem with the left lower leg prior to the note dated 12/21/21 indicating pain and swelling. The record included no circumstances surrounding a fall, no post-fall monitoring or assessment and no post-fall strategies for further fall/injury prevention. Resident #42's care plan was not updated regarding the fall until after the fracture diagnosis on 1/12/22.

On 4/6/22 at 3:11 p.m., the director of nursing (DON) was interviewed about Resident #42's fractured left tibia/fibula. The DON stated the resident had a fall and a negative x-ray prior to the diagnosed fracture. The DON stated after the resident experienced new swelling, another x-ray was performed indicating the fracture. The DON

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did not recall the circumstances of the fall incident and stated she would investigate.

On 4/6/22 at 4:21 p.m., the DON was interviewed again about Resident #42's fall/fracture. The DON stated Resident #42 fell in December 2021 and the unit manager completed a paper incident form. The DON stated the nurse caring for Resident #42 at the time of the incident did not enter the fall into the computer system or electronic health record. The DON stated the incident form indicated the resident slid from her wheelchair reaching for an item, fell to the floor and was assessed with no injuries. The DON was not sure of the date/time of the fall or the staff caring for the resident at the time of the incident. The DON stated there was nothing in the clinical record about the incident but she would look for the paper incident form.

On 4/6/22 at 4:53 p.m., the PA caring for Resident #42 was interviewed about the fall/fracture. The PA stated he was notified about the leg pain/swelling and assessed the resident on 12/22/21. The PA stated it was reported to him that the resident fell out of the wheelchair but there was some confusion about what actually happened and the circumstances surrounding the incident. The PA stated the unit manager informed him of the leg swelling/pain and the unit manager said she got the story from another nurse.

On 4/7/22 at 9:34 a.m., the DON presented a copy of the hand-written incident form for Resident #42. The accident/incident form dated 12/20/21 documented the resident "slid from w/c (wheelchair) - attempting to reach for something on TV stand" in her room. The form documented

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the incident occurred on 12/20/21 at approximately 2:00 p.m. A note at the bottom of the form documented, "After speaking with staff from previous shift it was not (sic) that resident had slipped onto her knees from w/c, witnessed." The unit manager had signed the form.

On 4/7/22 at 9:35 a.m., the DON was interviewed again about Resident #42's fall/fracture and the conflicting details and circumstances about the incident. The DON stated the incident form was not part of the clinical record and she was not sure of the incident details. The DON stated a post-fall assessment should have been documented in the clinical record and a change of condition form completed. The DON stated their fall/injury policy required for 72 hours of assessment/monitoring after an incident. The DON stated the timeline of events surrounding this incident had conflicting information and without documentation of the incident, it was difficult to piece together.

There was no mention of the 12/20/21 fall in Resident #42's clinical record. The incident form did not identify staff caring for the resident at the time of the incident or the staff interviewed by the unit manager indicating the fall was witnessed. The clinical record included no assessment of the resident at the time of the fall. The PA note documented the resident had an unwitnessed fall and the incident form indicated the fall was witnessed. The record nor the incident form identified the fall witness.

The facility's policy titled Fall Management (revised 7/29/19) documented concerning post fall interventions, "...Resident will be evaluated and post fall care provided...Initiate Neurological

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F 658	Continued From page 28 checks as per policy or directed by physician order...Re-evaluate fall risk utilizing the Post Fall Evaluation...Update Care plan and Nurse Aide Kardex with intervention(s)...Initiate post fall documentation every shift for 72 hours...Interdisciplinary Team to review fall documentation and complete root cause analysis...Update plan of care with new interventions as appropriate..." The Lippincott Manual of Nursing Practice 11th edition documents on page 15 concerning standards of practice,"...A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events...Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion...follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record..." (1) These findings were reviewed with the administrator and director of nursing during a meeting on 4/7/22 at 12:00 p.m. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2019.	F 658		
F 684 SS=D	Quality of Care	F 684		5/10/22

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F 684	Continued From page 29 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician's order prior to obtaining palliative care services for one of twenty-four residents in the survey sample, Resdient #51. Resident #51 had consultation by a transitional/palliative care provider when there was no physician's order or plan of care for palliative/comfort care. The findings include: Resident #51 was admitted to the facility with diagnoses that included chronic kidney disease, cirrhosis of liver, diabetes, severe protein-calorie malnutrition, hypertension, anemia, portal vein thrombosis, metabolic encephalopathy, gastroesophageal reflux disease, breast cancer, anxiety, depression, cognitive communication deficit and hemiplegia of left leg. The minimum data set (MDS) dated 3/1/22 assessed Resident #51 with moderately impaired cognitive skills. A physician's assistant's (PA) progress note dated 2/4/22 documented under resident problems, "...Palliative care - Onset 2/4/22...being placed in our facility following hospitalization from 1/21	F 684	F684: Quality of Care 1. Resident #51 has a physician's order for Palliative Care 2. Quality review conducted by DON/ED of current residents with palliative care have physician orders. 3. Nurses will be re-educated by the DON/ADON regarding having a physician's order for palliative care. 4. The ED/DON/designee will conduct quality monitoring to ensure palliative care orders are in place weekly x 8 weeks. The results of the quality monitoring's will be presented to the Quality Assurance/Performance Improvement Committee monthly for review, analysis and further recommendations. Quality monitoring schedule will be modified based on the findings. Date of Compliance: 5/10/2022	

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through 2/3/22 due to severe self-care deficit, found at home week (weak) disheveled and with abdominal pain...After multiple discussions with the son by palliative care, a Pleurx drain was placed and comfort based do not rehospitalize approach elected...At this time, she is a do not rehospitalize palliative care approach with plans for hospice..."

A PA note dated 3/4/22 documented concerning palliative care, "...Per prior palliative care conversations, goals of care are focused on maximizing quality and comfort, avoiding re-hospitalization and aggressive/invasive measures...intention was to transition her to hospice care once she exhausted her skilled nursing benefits...I am not sure where she stands in this regard today...I will discuss this with her primary team. I have reached out to her son to discuss further but have not heard back..."

The physician assessed Resident #51 on 3/2/22, 3/9/22, 3/16/22, 3/20/22 and 3/30/22. These physician progress notes made no mention of palliative/comfort care measure or hospice.

The clinical record documented no order for comfort/palliative care. Resident #51's plan of care (revised 4/5/22) documented the resident had a Do Not Resuscitate (DNR) order but included no problems, goals and/or interventions related to palliative, comfort care or end of life care.

On 4/6/22 at 2:35 p.m., the licensed practical nurse (LPN) #1 caring for Resident #51 was interviewed. LPN #1 stated Resident #51 had no current order for palliative and/or comfort care. LPN #1 stated Resident #51 was a DNR, an

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order for no hospitalization but no order or plan of care regarding comfort care.

On 4/6/22 at 4:00 p.m., the PA (other staff #3) caring for Resident #51 was interviewed about the resident's weight loss. During this interview, the PA stated the resident had a poor appetite at the end of March and was about to transition to hospice from palliative care. The PA stated a palliative care service evaluated the resident prior to her admission and had seen the resident once since her admission to the nursing facility. When asked about any documentation of the palliative care visit, the PA stated there were no notes in the record but he would retrieve them. There was no comment when asked about a physician's order for palliative/comfort care.

The director of nursing (DON) presented a copy of a note documenting care provided by a transitional care provider on 3/29/22. The note was dated 4/6/22 and documented, "...thank you for referring (Resident #51) to our practice for consultation and evaluation...on 3/29/22...Patient not seen today, this visit consisted of phone checkup given recent adjustment to plan of care...no hospice enrollment today, though remains a reasonable option should patient's health decline. Palliative care will follow up in the next 3 months. (Resident #51's family member) notified to contact palliative care team with any needs, changes to current plan of care...On my visit today, (family member) made it clear that he does not want to put his mother through any intensive therapy given the low likelihood of meaningful resolution of her chronic illnesses..."

This finding was reviewed with the administrator and director of nursing during a meeting on

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F 684	Continued From page 32 4/7/22 at 12:00 p.m. The administrator stated at this time she thought the palliative care service involved with Resident #51 was provided by the local hospital. There was no other information presented about an order for palliative care or the transitional care services.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a hand splint was applied for one of 24 residents in the survey sample, Resident # 8. Findings include: Resident # 8 was admitted to the facility following a history of strokes and left hand contracture.	F 688	F688: Increase/Prevent Decrease in ROM/Mobility 1. Resident # 8 is wearing hand splint as ordered. 2. Quality review conducted by DON/Therapy Manager of current residents with splints.	5/10/22

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F 688	Continued From page 33 The most recent MDS (minimum data set) was a quarterly review dated 1/19/22 and had Resident #8 coded with moderate impairment in cognition with a summary score of 11 out of 15. On 4/5/22 at 11:30 a.m. during initial tour, Resident # 8 was observed sitting in a chair in her room. Resident # 8 was not wearing a splint. The clinical record was reviewed 4/5/22 at approximately 2:30 p.m. The POS (physician order summary) included an order with a start date of 4/15/21 for, "Contraction brace to left hand at all times except during bathing, and manual therapy. Check for pressure areas every 1-2 hours." A review of the care plan revealed the following: "Focus: (name of resident) has a contracture to her left hand. Has edema (swelling) to left wrist at times. Goal: Will remain free from pain related to left hand contracture. Interventions: To wear hand/wrist splint orthotic on left upper extremity at all times except during bathing and manual therapy. Check for pressure areas every 1 to 2 hours." On 4/5/22 at 3:15 p.m. Resident # 8 was observed without the splint applied to the left hand. Resident # 8 was asked where the splint was and she replied "I don't know." LPN (licensed practical nurse) # 4 was asked for assistance in locating the splint. LPN # 4 went in the resident's room and stated "It's here in her nightstand drawer; let's put that on." LPN # 4 then laid the splint on the bed and there was an immediate malodor. LPN # 4 then began working with the resident's hand and attempting to apply	F 688	3. Licensed staff will be re-educated by the DON/ADON/designee regarding resident splints being applied. 4. The ED/DON/designee will conduct quality monitoring 3 x weekly for 4 weeks, 2x weekly for 4 weeks, then weekly for 4 weeks to ensure all splints are being worn as ordered by MD. The results of the quality monitoring will be presented to the Quality Assurance/Performance Improvement Committee monthly for review, analysis and further recommendations. Quality monitoring schedule will be modified based on the findings. 5. Date of Compliance: 5/10/2022	

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the splint. Resident # 8's left hand was clenched tightly, and when the fingers were manipulated open, there was a malodor from the hand as well. LPN # 4 told Resident # 8, "Let's get your hand cleaned up and put your splint on." LPN # 4 proceeded to wet some gauze pads with a cleaner, and began rubbing up under the fingers. White, dried material fell out on the overbed table, and LPN # 4 was asked what the material was. LPN # 4 stated "That's dried skin and 'gunk'..." LPN # 4 examined the area under the fingers and stated she did not see a wound, and applied the splint. Resident # 8 was asked if she had refused to have the splint applied, and she stated "No." LPN # 4 was then asked if therapy was working with Resident # 8, and she stated "I don't know. I don't think so, but I would need to check on that."

On 4/6/22 at 11:20 a.m. the rehab director, identified as other staff (OS) # 1, was asked if Resident # 8 was still being seen for the left hand. OS # 1 stated "No, I discharged her around mid-March." Resident # 8 was then observed with OS # 1. Resident # 8 had the splint on the left hand, but it was incorrectly applied. OS # 1 began working with the resident to reapply the splint correctly, and also checked her hand for pressure areas. When the hand was manipulated as open as possible, OS # 1 commented on the smell from the hand and stated, "Let's clean your hand, (name of resident)." OS # 1 got a warm soapy washcloth, and as the hand was cleaned, black debris was being pushed up through the fingers. OS # 1 stated "This hand isn't being cleaned, and I think they (staff) are afraid of hurting her...but that is a significant amount of 'gunk' and dry skin, and the smell tells me they are not washing her hand. The

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F 688	Continued From page 35 splint has an odor also, and the cover can be removed and washed, and that is what I am going to do right now. I trained the nursing staff, including the CNAs (certified nursing assistants) how to clean her hand, how to apply the splint, and how to wash the cover..." OS # 1 was asked, based on the observation, if she thought the splint was being applied daily. OS # 1 replied "No...maybe 3 times a week, but the amount of manipulation to get her fingers off the palm tells me that this is not being done daily." OS # 1 was then asked if Resident # 8 had experienced a decline, and she stated "No, but I am putting her back on my caseload today. I had been working with her every day, applying the splint and doing manual therapy, and I know it was done every day then...I thought once staff were trained it was being done, but I can tell it is not." The administrator, DON (director of nursing), and regional nurse consultant were made aware of the above findings during a meeting with facility staff 4/6/22 beginning at 5:00 p.m. No further information was provided prior to the exit conference.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		5/10/22

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F 690	Continued From page 36 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to implement care interventions regarding a urinary catheter for one of twenty-four residents in the survey sample, Resident #50. Resident #50's Foley urinary catheter tubing was not stabilized to prevent tension at the insertion site and the urine collection bag was observed in the floor. The findings include:	F 690	F690: Bowel/Bladder Incontinence, Catheter, UTI 1. Resident #50 has a catheter leg bag and urine collection bag is not on floor 2. Quality review conducted by DON of current residents with catheters. 3. Licensed staff will be re-educated by the DON/ADON regarding catheter securement and proper placement of	

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F 690	Continued From page 37 Resident #50 was admitted to the facility with diagnoses that included benign prostatic hyperplasia, obstructive uropathy, hypertension, atherosclerotic heart disease, cognitive communication deficit, cerebral infarction, dementia with behaviors, anemia and dysphagia. The minimum data set (MDS) dated 3/1/22 assessed Resident #50 with severely impaired cognitive skills. Resident #50's clinical record documented a physician's order dated 11/24/21 for a Foley urinary catheter due to failed voiding trials due to obstructive uropathy with instructions for catheter care each shift. The clinical record documented the resident pulled the catheter out on 1/24/22 causing penile trauma and an open wound on under side of the penis. On 4/5/22 at 11:09 a.m., Resident #50 was observed in bed. The collection bag for the resident's Foley urinary catheter was on the floor below the bed. On 4/5/22 at 12:20 p.m., the catheter bag was observed on the floor under the bed frame. On 4/7/22 at 8:30 a.m., Resident #50 was observed in bed with his hands holding his genital area. On 4/7/22 at 8:31 a.m., with the resident's permission and accompanied by certified nurses' aide (CNA) #3, Resident #50's penis and catheter tubing were observed. The catheter tubing was positioned from the penis and under the resident's right thigh to the urine collection bag. There was no anchor or stabilization device to prevent tension on the tubing. The insertion site was at the base of the penile trauma/split. Resident #50 moaned when his legs moved about with pulling noted on the catheter tubing	F 690	drainage bag. 4. The ED/DON/designee will conduct quality monitoring of catheters 3 x weekly for 4 weeks, 2x weekly for 4 weeks, then weekly for 4 weeks to ensure catheter securement and placement of the collection bag. The results of the quality monitoring's will be presented to the Quality Assurance/Performance Improvement Committee monthly for review, analysis and further recommendations. Quality monitoring schedule will be modified based on the findings. 5. Date of Compliance: 5/10/2022	

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under his leg. CNA #3 was interviewed at this time about any use of an anchor or positioning device for the tubing. CNA #3 stated she routinely cared for Resident #50 and had not seen an anchor or leg strap used with the tubing.

On 4/7/22 at 8:35 a.m., accompanied by the licensed practical nurse unit manager (LPN #3), Resident #50's catheter tubing was observed. The catheter tubing was observed with tension from the insertion point at the base of the penile split and the tubing positioned under the resident's right thigh to the collection bag. The split on the underside of the penis was approximately 1.25 inches in length with the wound bed beefy red. There was no bleeding but a small amount of pus-like substance was at the tube insertion site. LPN #1 was interviewed at the time about Resident #50's catheter. LPN #1 stated catheter care was performed each shift by nurses and an anchor was supposed to be in place at all times to prevent pulling/tension. LPN #1 stated that without the tubing stabilized, the tubing would pull at the insertion site and penile split area. LPN #1 stated the catheter tubing was not supposed to run under the leg but over top of the leg to prevent tension when the resident moved about in bed. LPN #1 stated the urine collection bag was supposed to hang from the bed rail and not be in the floor.

Resident #50's plan of care (revised 1/27/22) documented the resident was at risk of skin impairment due to fragile skin, impaired mobility, indwelling catheter and non-compliance with care. Interventions to prevent skin damage and prevent urinary tract infection included, "...Identify/document potential causative factors and eliminate/resolve where possible...Keep skin

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clean and dry...Skin assessments weekly...Administer medications/ointments per MD orders...Check tubing for kinks each shift...Foley Catheter per MD orders...Monitor/document for pain/discomfort due to catheter...Monitor/record/report to MD for s/sx (signs/symptoms) UTI (urinary tract infection)...Notify MD as needed for malodorous urine, purulent, bloody drainage, pain/discomfort to Foley insertion site...

The facility's policy titled Catheterization, Male and Female Urinary (revised 9/19/17) documented concerning male catheterization, "...Connect catheter to drainage system...Secure catheter to thigh to prevent tugging...tubing to be off of the floor..."

Procedure Guideline 21-3 in the Lippincott Manual of Nursing Practice 11th edition documents regarding management of patient with an indwelling catheter, "...Secure the indwelling catheter to the patient's thigh using tape, strap, adhesive anchor, or other securement device...Allow some slack of the tubing to accommodate the patient's movements...Properly securing the catheter prevents catheter movement and traction on the urethra...Keep tubing over the patient's leg...This tubing position helps prevent kinking or forming loops of stagnant urine...Keep the drainage bag in a dependent position, below the level of the bladder...Keep the bag off the floor..." (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 4/7/22 at 12:00 p.m.

(1) Nettina, Sandra M. Lippincott Manual of

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F 690	Continued From page 40 Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2019.	F 690		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide a therapeutic diet and nutritional supplements as ordered/recommended for one of twenty-four residents in the survey sample, Resident #51. Resident #51, with severe protein-calorie malnutrition, significant weight loss and poor intake, did not have fortified foods provided as ordered, and was not provided Pro-Stat, Magic Cup or a liberalized regular diet as recommended	F 692	F692: Nutrition/Hydration Status Maintenance 1. Resident # 51 is receiving diet and supplements as ordered. 2. Quality review conducted by the DON/ADON/Dietary Manager of Dietician recommendations and orders.	5/10/22

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F 692	Continued From page 41 by the registered dietitian (RD) and/or physician. Resident #51 was not provided assistance with meals when having trouble with eating and drinking. The findings include: Resident #51 was admitted to the facility with diagnoses that included chronic kidney disease, cirrhosis of liver, diabetes, severe protein-calorie malnutrition, hypertension, anemia, portal vein thrombosis, metabolic encephalopathy, gastroesophageal reflux disease, breast cancer, anxiety, depression, cognitive communication deficit and hemiplegia of left leg. The minimum data set (MDS) dated 3/1/22 assessed Resident #51 with moderately impaired cognitive skills and to require supervision at meals (oversight, encouragement, cueing) along with setup help. On 4/5/22 at 12:13 p.m., Resident #51 was in bed with her lunch tray in front of her on the over-bed table. The resident had three bowls of pureed food items. Resident #51 was sticking her index finger in the food and licking her fingers. There was a spoon stuck in the bowl of pureed bread. Resident #51 did not attempt to use the spoon, continued to stick her finger in the foods and was licking her fingers and napkin. Resident #51 dropped a portion of mash potatoes on her chest. On 4/5/22 at 12:18 p.m., certified nurses' aide (CNA) #2 came into the room and retrieved the roommate's lunch tray. CNA #2 spoke to Resident #42 but provided no cueing, encouragement or interactions with the resident about her food. On 4/5/22 at 12:34 p.m., Resident #51's lunch	F 692	3. Nurses will be re-educated by DON/ADON to ensure a communication slip is sent to the kitchen when there is an order change with a residents diet 4. The ED/DON/designee will conduct quality monitoring on 10 % of residents dietary recommendations and orders weekly x 8 weeks. The results of the quality monitoring's will be presented to the Quality Assurance/Performance Improvement Committee monthly for review, analysis and further recommendations. Quality monitoring schedule will be modified based on the findings. 5. Date of Compliance: 5/10/2022	

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tray was no longer in the room. Resident #51 still had the mashed potatoes on her chest. There was a small can of gingerale spilled in the floor beside the resident's bed.

On 4/6/22 at 7:41 a.m., Resident #51 was in bed with her breakfast tray. Resident #51 had pureed French toast, ground sausage, oatmeal and a small cup of orange juice. The resident was attempting to use the spoon by sticking it into the French toast. Resident #51 was not scooping any measurable amount of food into the spoon. When asked if she needed help eating, Resident #51 stated she did not want to interfere with dinner and then stated she was tired sometimes. The resident proceeded to rub the spoon on her napkin. There was no staff person in the room during this observation. The meal ticket on the tray documented a CCD (consistent carbohydrate diet) - dysphagia mechanical soft diet with no salt. There was no indication of fortified foods on the ticket.

On 4/6/22 at 7:53 a.m., Resident #51 was licking her napkin and not consuming any of the food items.

On 4/6/22 at 7:55 a.m., Resident #51 knocked over the cup of orange juice spilling the juice on her gown and into the bed. The central supply clerk (other staff #9) entered the room along with the medical records clerk (other staff #7). The supply clerk asked Resident #51 if she wanted anymore to eat. Resident #51 made no response and the medical records clerk took the uneaten meal tray to the cart in the hall and proceeded to clean the resident's bed and clothing.

On 4/6/22 at 11:45 a.m., Resident #51 was

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seated in a wheelchair in her room with her lunch tray. There were no staff members in the room. The resident had baked carrots, mashed potatoes, pureed bread, ground beef, tea and water. Resident #51 picked up several slices of the carrots and licked her fingers without consuming any food items. The resident did not attempt to use her spoon or fork to eat. The meal ticket on the tray documented a CCD - dysphagia mechanical soft diet with no salt. There was no indication of fortified foods on the ticket.

Resident #42's clinical record documented a current physician's order dated 3/31/22 for fortified foods, dysphagia mechanical soft texture with regular thin liquids. There was a current order dated 2/28/22 for Med Pass 60 milliliters three times per day as a supplement. The resident had a physician's order dated 2/4/22 to attach an abdominal drain to a Pleurx device for fluid removal three times per day due to ascites associated with liver cirrhosis.

The clinical record documented weights for Resident #51 as follows.
2/3/22 - 110.8 pounds (lbs) (admission)
3/2/22 - 108 lbs (per MD note)
3/31/22 - 99.4 lbs
4/1/22 - 99.4 lbs

The physician assessed Resident #51 on 3/2/22, 3/9/22, 3/16/22, 3/20/22 and 3/30/22 and included notes regarding weight loss as follows.

3/2/22 - "...Weight today 108 pounds... Slight reduction compared to one month ago (108 versus 110). Continue to recommend nutritional supplements such as Magic Cup. Appetite good on soft mechanical diet, Monitor weights..."

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3/9/22 - "...Patient still reports good appetite. Continue to recommend nutritional supplements including Magic Cup. Monitor weights..."

3/16/22 - "...now with continued weakness, deconditioning and debility...Patient reports good appetite but does not like the food. I encouraged her to eat as much as she can despite this and to focus on eating the protein - meat, etc. Continue to recommend nutritional supplements including Magic Cup..."

3/23/22 - "...Continue nutritional supplements including Magic Cup..."

3/30/22 - "...Continue nutritional supplements including Magic Cup..."

The physician assistant (PA) assessed Resident #51 on 2/4/22, 2/9/22, 2/10/22, 2/17/22, 3/4/22, 3/7/22 and 3/22/22. The PA notes listed the resident was on palliative care and made no mention of the resident's weight loss. The PA notes documented treatment for anxiety and the resident's refusal of abdominal fluid drainage via the Pleurx drain.

The RD's initial nutrition assessment for Resident #51 was dated 2/10/22 and listed the resident as 67.0 inches height, weight 110.8 lbs., BMI (body mass index) of 17 and diet order as CCD, NAS (no added salt), dysphagia mechanical soft, thin liquids. This assessment listed the resident needed meal setup assistance, was independent with eating and had 50% meal intake. The RD documented Resident #51 was at risk for weight loss and malnutrition due to altered nutrition status, self-care deficit, liver cirrhosis, cognitive

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communication deficit, diabetes and noncompliance with abdominal fluid drainage. The RD plan/recommendation was to continue the NAS CCD diet with a recommendation for Pro-Stat protein supplement each day.

The RD assessed the resident again on 3/29/22. The RD listed the resident's most recent weight was on 2/3/22 as 110.8 lbs. and documented the resident received Med Pass three times per day. The RD documented severe muscle and fat loss as evident with severe malnutrition. The RD listed the resident had poor intake eating less than 50% of all meals. The RD documented, "...underweight (BMI 17) and self care deficit...dependence on staff for provision of all foods/fluids...inadequate oral intake (protein and kcal)..." The RD plan/recommendation documented, "...has ensure HP at bedside brought by family. Tells me she is sick of them...requires a soft diet order for safe chewing. Recommend to liberalize her diet order to regular. She likes pie, pudding, chopped meats, and cut apples..."

Resident #51 was weighed again on 3/31/22 at 99.4 lbs. A physician's order was entered on 3/31/22 for fortified foods. The resident was reweighed on 4/1/22 at 99.4 lbs. These weights indicated an 11.4 lb. weight loss (10.3%) loss since admission. The record documented ongoing and frequent refusal of the fluid removal from the abdominal drain. There was no indication if weights were obtained before or after fluid drainage.

The clinical record documented no order for Magic Cup as referenced by the physician. There was no order or administration of Pro-Stat protein

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supplement as recommended by the RD on 2/20/22 assessment. There was no order entered for the liberalized regular diet recommended on 3/31/22. Meal tickets for breakfast and lunch on 4/6/22 had no listing of fortified foods as ordered by the physician on 3/31/22. The resident had a "do not hospitalize" order but no order or plan of care for comfort/palliative care as indicated by the PA progress notes.

On 4/6/22 at 9:46 a.m., CNA #1 that routinely cared for Resident #51 was interviewed. CNA #1 stated Resident #51 "was not a feeder" and required setup assistance only. CNA #1 stated, "We don't feed her" and said the resident was "not a big eater."

On 4/6/22 at 10:19 a.m., CNA #2 was interviewed about Resident #51's eating/meals. CNA #2 stated Resident #51 required setup assistance only for meals. CNA #2 stated the resident "does her own eating" and was able to hold her cups/drinks.

On 4/6/22 at 2:18 p.m., the dietary manager (other staff #4) was interviewed about Resident #51's meals. The dietary manager stated the resident was provided a dysphagia - mechanical soft diet and had been on that diet since admission on 2/3/22. The dietary manager reviewed the 4/6/22 meal tickets and stated fortified foods were not provided. The dietary manager stated fortified foods included added butter, sugar and milk to food items for extra calories. The dietary manager stated he had no ticket instructions for fortified foods, a regular diet or Magic Cup. The dietary manager stated the RD sometimes entered diet orders or nursing

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entered the orders with a dietary slip sent to the kitchen indicating the changes.

On 4/6/22 at 2:35 p.m., the licensed practical nurse (LPN) #1 caring for Resident #51 was interviewed. LPN #1 stated nursing usually entered diet orders into the electronic health record and sent a dietary slip to the kitchen with the order instructions. LPN #1 reviewed the 3/31/22 order for fortified foods and stated she did not know why the kitchen did not have the fortified foods order. LPN #1 stated Resident #51 had a "do not hospitalize" order but there was no order or plan of care regarding palliative/comfort care. LPN #1 did not know why the liberalized regular diet recommended by the RD on 3/30/22 was not entered. LPN #1 stated Magic Cup was provided by the kitchen if ordered for a resident. LPN #1 stated she thought the resident was able to eat independently. LPN #1 stated no staff members had reported Resident #51 having any difficulty with eating/drinking. LPN #1 stated the resident frequently refused the abdominal fluid drainage. LPN #1 stated she removed 600 milliliters (ml) today from the resident's drain and routinely drained about 600 to 900 ml.

On 4/6/22 at 3:15 p.m., the therapy director/occupational therapist (other staff #2) was interviewed about Resident #51. The therapy director stated the resident had speech and occupational therapies until 3/1/22. The therapy director stated at that time the resident was able to feed herself but frequently chose not to eat. The therapy director stated the resident had weakness but no swallowing problems. The therapy director stated upon discharge from therapy on 3/1/22 the resident was assessed to need setup to minimal assistance for eating with

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verbal/tactile cueing. The therapy director stated she had received no reports from nursing about a decline or change the resident's eating/drinking.

On 4/6/22 at 4:00 p.m., the PA caring for Resident #51 was interviewed. The PA stated the February 2022 weight might have been inflated due to the resident's refusals to have abdominal fluid removed. The PA stated the resident was now more compliant with the fluid drainage. The PA stated the resident had been seen by palliative care services since her admission to the facility.

On 4/7/22 at 8:55 a.m., the RD was interviewed about Resident #51. The RD stated she did not know why the order for fortified foods was not implemented. The RD stated she assessed the resident on 3/29/22 and made recommendation to liberalize with a regular diet to give the resident more food options. The RD stated she made the recommendation about the regular diet to nursing and she did not know why the order was not entered or implemented. The RD stated the resident's weight loss was due to fluid fluctuations and the resident was assessed as not taking in enough calories. The RD stated Resident #51 was eating about 50% of meal after admission. The RD stated when she assessed the resident on 3/29/22 the resident had declined with intakes less than 50%. The RD stated she was not made aware of the 3/31/22 weight of 99.4 lbs. until today (4/7/22). The RD stated she was in the facility on 4/4/22 but spent most of her time with new admission assessments and did not review Resident #51's status.

On 4/7/22 at 9:30 a.m., the RD was interviewed about the Magic Cup referenced in physician progress notes. The RD stated the only

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F 692	Continued From page 49 supplement ordered for Resident #51 was Med Pass. The RD stated no order was entered for Magic Cup and she did not recall that supplement being discussed. Resident #51's plan of care (revised 4/5/22) documented the resident required assistance with activities of daily living (ADLs) due to impaired mobility and weakness, had impaired thought processes due to metabolic encephalopathy and refused care at times. The nutrition portion of the care plan listed the resident had poor oral intake, was underweight (BMI 17), had increased protein needs and cognitive communication deficit with weight changes expected due to paracentesis. The care plan documented under altered communication, "...Her alertness and orientation can vary..." Interventions to address ADL deficits and maintain nutrition included, "...provide assistance as needed or requested with all ADLs...Fortified foods diet as ordered... Monitor/document/report PRN [as needed]...Refusing to eat....significant weight loss...Provide and serve supplements as ordered...Provide and serve diet as ordered...RD to evaluate and make diet change recommendations PRN..." These findings were reviewed with the administrator and director of nursing during a meeting on 4/6/22 at 5:15 p.m. and on 4/7/22 at 12:00 p.m.	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		5/10/22

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F 698	Continued From page 50 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, resident interview, and clinical record review, the facility staff failed to obtain a physician's orders for hemodialysis, along with care and maintenance of a dialysis resident, for one of 24 resident in the survey sample, Resident #69; and failed to assess a new dialysis graft site for one of 24 residents in the survey sample, Resident #21. Findings include: Resident #69 was admited to the facility with diagnoses that included, but were not limited to: anemia, acute kidney failure with hemodialysis, hyponatremia, atrial fibrillation and pulmonary embolism. The most current MDS (minimum data set) was an admission assessment dated 03/21/22. This MDS assessed Resident #69 with a cognitive score of 15, indicating the resident was cognitively intact for daily decision making skills. The resident was also assessed as receiving dialysis treatments while a resident and while not a resident in Section O. Special Treatments, Procedures, and Programs: J. Dialysis. Resident #69 was interviewed on 04/05/22 at approximately 3:30 PM. Resident #69 stated that she was new to dialysis and that it was started while she was in the hospital. Resident #69 stated that she went to dialysis on Monday, Wednesday and Friday each week.	F 698	F698: Dialysis 1. Resident #69 has a dialysis order. Resident #21 bruit and thrill is being properly assessed per order 2. Quality review conducted by the DON/ADON of current dialysis residents to verify dialysis orders and checking dialysis sites. 3. Nurses will be re-educated on physician orders for dialysis and how to check bruit and thrill. 4. The ED/DON/designee will conduct quality monitoring on dialysis patients 3x weekly for 4 weeks, 2 x weekly for 4 weeks and weekly for 4 weeks. The results of the quality monitoring's will be presented to the Quality Assurance/Performance Improvement Committee monthly for review, analysis and further recommendations. Quality monitoring schedule will be modified based on the findings. 5. Date of Compliance: 5/10/2022	

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F 698	Continued From page 51	F 698		

On 04/06/22, the resident's physician's orders were reviewed. No order for dialysis or care of a dialysis patient were found.

Resident #69's CCP (comprehensive care plan) documented, "...needs hemodialysis related to acute kidney failure...three times a week...check and change dressing daily, check right chest perma cath every shift for signs and symptoms of infection or bleeding...monitor intake and output...give medications as ordered by physician..."

The resident's current progress notes were reviewed and revealed the following:

A progress note dated 4/1/2022 and timed 10:17 am documented, "...eMar - Medication Administration Note Resident stated she does not take meds before dialysis..."

A progress note dated 4/4/2022 and timed 8:10 am documented, "...Resident declined morning medications at this time and requested to administer morning medications to her once she come back from Dialysis..."

On 04/06/22 at approximately 5:30 PM, the DON (director of nursing), administrator, and corporate nurse were made aware of the above information regarding Resident #69. The facility staff were asked if there were supposed to be physician's orders to hold certain types of medications prior to dialysis, as some medications are not recommended to be administered prior to dialysis treatments. The DON stated, "I understand what you mean." The facility staff were then asked for assistance regarding physician's orders for Resident #69's dialysis treatments, care and

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F 698	Continued From page 52	F 698		

maintenance.

On 04/07/22 at 12:15 PM, the administrator stated, "You are exactly right, there were no orders for dialysis (for Resident #69). The DON stated, that they were working on it.

No further information and/or documentation was presented prior to the exit conference on 04/07/22 at 1:30 PM to evidence Resident #69 had physician's orders for dialysis or the care and maintenance of a dialysis resident.

2. Resident #21 was admitted to the facility with the following diagnoses, including, but not limited to: paraplegia, chronic kidney disease requiring dialysis, stage 4 pressure ulcer, and obesity.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 01/28/2022 assessed Resident #21 as cognitively intact with a summary score of "15".

Resident #21 was interviewed on 04/06/2022 at approximately 9:00 a.m. He stated that he had been on dialysis using a port in his chest and had recently had a port for dialysis placed in his left arm. He was asked if the nurse's had been coming in and checking the site, feeling for a thrill, and listening for a bruit. He stated, "What?" He was asked again if the nurses checked his new site by feeling it when they were in the room or listening to it with their stethoscopes. He stated, "Hell, no, nobody looks at it." He was asked to place his forefinger and middle finger gently over the site and report what he felt. He did as instructed and started to smile and stated, "I'll be damn, I feel it grinding in there...is that what it is supposed to be doing?"

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F 698	Continued From page 53 On 04/06/2022 at 10:10 a.m., LPN (licensed practical nurse) #1 was asked about Resident #21's graph site and what she did to assess it. She stated, "When I do his wound care I check it, but I haven't done that yet." She was asked to check the graph site at that time. She went to Resident #21's room and felt the site. She did not listen for a bruit. When she left the room she was asked if why she had not listened for the bruit. She stated, "I just feel for the thrill...if it's weak I will listen but if not I don't." The physician orders for Resident #21 included: "03/22/2022 Check Left arm fistula for bruit and thrill every shift..." The facility policy "Care of Resident Hemodialysis-A/V Fistula/Shunt", included: "...Bruit should be audible and thrill palpable. Report absence of either." The above information was discussed during and end of the day meeting on 04/06/2022 at approximately 5:30 p.m.. No further information was obtained prior to the exit conference on 04/07/2022.	F 698		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation,	F 759	F759: Free of Medication Error Rate of	5/10/22

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F 759	Continued From page 54 staff interview, and clinical record review the facility staff failed to ensure a medication error rate less than 5 percent. There were 5 errors out of 26 opportunities resulting in a medication error rate of 19.23 percent. Findings include: A medication pass and pour observation was conducted 4/6/22 beginning at 7:45 a.m. with LPN (licensed practical nurse) # 2. LPN # 2 prepared the medications for resident # 222. LPN # 2 provided a bottle of house stock aspirin 81 mg (milligrams) and stated "(name of Resident # 222) gets one of these" and put it in the medication in a cup with the other medications. The medications were then administered. Medications for Resident # 272 were then prepared, and LPN # 2 made the same comment about the aspirin. LPN # 2 then stated Resident # 8 would be administered two tablets of Baclofen 5 mg, and 2 tablets of Famotidine 20 mg. Resident # 8 was also to receive a Spiriva inhaler 18 mg with directions on the label "to be administered over 2 inhalations." The labels on the Famotidine and Baclopfen both documented to give 2 tablets of each medication. LPN # 2 then administered the medications, and only directed Resident # 8 to inhale once from the inhaler. On 4/6/22 at 9:15 a.m. the medications were reconciled with physician orders. Resident # 222 and # 272 were ordered "Aspirin Tablet Chewable 81 mg Give 1 tablet by mouth one time a day." Medications reconciled for Resident # 8 were "Baclofen Tablet 5 mg Give one (1) tablet by	F 759	5% or More 1. Employee # 2 was provided education on 4/6/2022. 2. Quality review conducted by the DON/ADON of medication carts and orders. 3. Nurses will be re-educated on verifying the medication card matches the physicians order and what they are administering matches the physicians order. 4. The ED/DON/designee will conduct quality monitoring on 10% of residents 2x weekly for 4 weeks, weekly for 4 weeks. The results of the quality monitoring's will be presented to the Quality Assurance/Performance Improvement Committee monthly for review, analysis and further recommendations. Quality monitoring schedule will be modified based on the findings. 5. Date of Compliance: 5/10/2022	

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F 759	Continued From page 55	F 759		

mouth two times a day for left leg spasticity, Pepcid Tablet 20 mg (Famotidine) Give one tablet by mouth one time a day, and Spiriva Handi-Haler Capsule (Tiotropium Bromide Monohydrate) 2 inhalation inhale orally one time a day."

At 9:40 a.m. on 4/6/22 LPN # 2 was interviewed about the discrepancy between the orders in the clinical records, the labels, and the orders for the chewable aspirin. LPN # 2 then looked through the house stock medications, and stated "There are no chewable aspirin in the cart. I think they are changing (name of Resident # 272) to a regular aspirin." LPN # 2 was advised the current order was for chewable aspirin for both residents. LPN # 2 then pulled the medication cards for Resident # 8. There were four (4) cards of Baclofen 5 mg for Resident # 8; two cards were labeled to give one tablet, and 2 cards were labeled to give 2 tablets. LPN # 2 stated "Well, I didn't know there were different directions on the labels of these medication cards." She also pulled the medication cards for the Famotidine, and one label directed to give two 20 mg tablets, and a second card, with 40 mg tablets, directed to give one tablet. Neither label matched the physician order for the Famotidine. The card with 20 mg tablets had no pills missing; the card for the 40 mg tablets had two tablets missing. LPN # 2 was then asked if she had given two 40 mg tablets to Resident # 8. She stated "I don't know, I don't think so." LPN # 2 was also asked about the inhaler directing to give 2 inhalations of the medication. LPN # 2 did not respond.

On 4/6/22 at 10:10 a.m. the administrator and DON (director of nursing) were informed of the above findings, and were given the medication cards for the Baclofen and Famotidine. The DON

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F 759	Continued From page 56 stated she was not sure how the medication cards for the Baclofen were obtained from the pharmacy when the label on the card to give two tablets was incorrect, and stated the nurse should go by the order on the MAR (medication administration record) and ensure the label matched the order prior to administering. The labels for the Famotidine were incorrect, and the DON stated "Well, neither of these labels match the order. I will have to investigate this and see what happened." No further information was provided prior to the exit conference.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		5/10/22

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F 761	Continued From page 57 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure drugs and biologicals were labeled appropriately on one of two nursing unit medication rooms, Unit 2. The facility failed to appropriately label one, multi dose vial of Tuberculin on Unit 2. Findings include: On 04/07/22 at 8:25 AM, the Unit 2 medication room was observed with the ADON (assistant director of nursing). The refrigerator was observed with two multi dose vials (5 milliliter vial each) of Tuberculin, each in the original box. One vial had been opened and accessed and had approximately 1/8 to 1/4 of medication left in the vial. There was an illegible mark on the opened vial that was smeared off and could not be read. The ADON stated, "I can't make it out...it looks like a 3." The ADON was asked when should multi dose vials be discarded after being opened/accessed. The ADON stated, "I'll say 30 days after opening." The ADON was asked for a policy at that time. On 04/07/22 at approximately 10:00 AM, the corporate nurse presented a policy titled, "Storage and Expiration Dating of Medications, Biologicals." The policy documented, "...If a multi dose vial or an injectable medication has been	F 761	F761: Label/Store Drugs and Biologicals 1. Tuberculin with smeared date was discarded. 2. Quality review by DON/ADON to be completed of Tuberculin to ensure labeling is legible and discarded 28 days after opening 3. Nurses will be re-educated by DON/designee on labeling and ensuring the label (date) remains legible while in use and discard time frame. 4. The ED/DON/designee will conduct quality monitoring weekly for 8 weeks to verify that the Tuberculin solution is dated and legible. The results of the quality monitoring's will be presented to the Quality Assurance/Performance Improvement Committee monthly for review, analysis and further recommendations. Quality monitoring schedule will be modified based on the findings. 5. Date of Compliance: 5/10/2022	

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F 761	Continued From page 58 opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial..." On 04/07/22 at 12:30 PM, the DON (director of nursing), administrator and corporate nurse were made aware in a meeting with the survey team. No further information and/or documetnation was presented prior to the exit conference.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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 and staff interview, the facility staff failed to follow professional standards for food safety in the main kitcehn. Sheet pans	F 812	F812: Food Procurement, Store/Prepare/Serve Sanitary	5/10/22

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F 812	Continued From page 59 identified as clean, dry, and ready to use were not nested wet in the main kitchen. Findings include: On 4/5/22 at 10:47 a.m. the kitchen was inspected with the dietary manager. A stack of sheet pans and quarter sheet pans were stacked on the bottom shelf of a table in the main kitchen. The dietary manager was asked if the pans were clean and ready to use. He stated "Yes." The dietary manager was asked to lift the sheet pans to check for wetness. In the stack of full size sheet pans, 5 of 12 pans were observed nested wet, and one pan had debris on it. The dietary manager put the five pans aside stating "Those will be rewashed." He then lifted the quarter size sheet pans, and 2 of 4 pans were nested wet. Those were removed and put with the full size sheet pans to be rewashed. The dietary manager stated "Looks like some re-education in order to ensure pans are completely dry and free of debris before they are stacked as ready to use..." The administrator, DON (director of nursing) and the regional nurse consultant were informed of the observation during a meeting with facility staff 4/6/22 beginning at approximately 5:00 p.m. No further information was provided prior to the exit conference.	F 812	1. Wet nested pans removed and re-washed. 2. The ED will complete a quality review to ensure all pans are completely dry prior to stacking 3. Dietary staff will be re-educated by DM/RDM on washing and storage of pans. 4. The ED/DM/designee will conduct quality monitoring 3x weekly for 4 weeks, 2x weekly for 4 weeks then weekly for 4 weeks to ensure all pans are dry prior to stacking. The results of the quality monitoring's will be presented to the Quality Assurance/Performance Improvement Committee monthly for review, analysis and further recommendations. Quality monitoring schedule will be modified based on the findings. 5. Date of Compliance: 5/10/2022	