STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495099	A. BUILDING _____ B. WING _____	C 05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX REHABILITATION AND NURSING CENTER	10701 MAIN STREET FAIRFAX, VA 22030

(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 5/3/2022 through 5/5/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard and complaint survey was conducted 5/3/2022 through 5/5/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Eight complaints were investigated during the survey, VA00054214-substantiated with deficiency, VA00054135-substantiated with deficiency, VA00053005-substantiated without deficiency, VA00050870-substantiated without deficiency, VA00050445-unsubstantiated without deficiency, VA00050416-unsubstantiated without deficiency, VA00050383-substantiated with deficiency and VA00050151-substantiated without deficiency. The census in this 200 certified bed facility was 183 at the time of the survey. The survey sample consisted of 42 current resident reviews and 13 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.	F 550		6/15/22

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

Electronically Signed | 05/18/2022

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §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, facility document review and in the course of complaint investigation, the facility staff failed to uphold a resident's dignity for two of 55 residents in the survey sample, Residents # 76 and # 419.	F 550	1. Resident #76 was re-assessed on 05/03/2022. Resident (#76) had care needs met. Employees #16, #11, & #17 were provided re- education on the importance of	

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F 550	Continued From page 2 The findings include: 1. Facility staff failed to respond to Resident # 76's (R76) vocalizations/yelling. (R76) was admitted to the facility with a diagnosis that included by not limited to: slurred speech. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/24/2022, the resident scored 3 (three) out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. On 05/03/22 at 1:54 p.m., auditory (hearing) observations from the hallway outside of (R76's) room revealed vocalizations/yelling coming from (R76) appeared to indicate a need for attention or assistance. Visual observation from the hallway outside of (R76's) room revealed CNA (certified nursing assistant) # 16 walking past (R76's) room while they were vocalizing/yelling without going into (R76's) room to respond to (R76). On 05/03/22 at 2:01 p.m., auditory (hearing) observations from the hallway outside of (R76's) room revealed vocalizations/yelling coming from (R76) appeared to indicate a need for attention or assistance. Visual observation from the hallway outside of (R76's) room revealed CNA # 16 and OSM (other staff member) # 17, activities assistant, walking past (R76's) room while they were vocalizing/yelling without going into (R76's) room to respond to (R76). On 05/03/22 at 2:07 PM p.m., auditory (hearing)	F 550	ensuring quality of life, maintaining dignity and respect for residents including when being re-directed during behavior exacerbation times such as yelling / vocalizing. Resident #419 was re-assessed on 05/04/2022. Resident #419 had no negative outcome noted. Employees #2, #10, were provided re-education on the importance of ensuring dignity, rights and respect for residents including sleeping when out of bed or during mealtimes in public view. Offer to lay in bed and/or honor rights to stay up in wheelchair and update care plan to their preferences and offer activity preferences if up in wheelchair at nursing station. 2. Audit of current residents that sit at the nursing station will be conducted to verify activity preferences are offered by the Director of Activities or designee and an audit will be conducted by the Unit Manager or Manager to verify resident□s sleeping at nursing station or during mealtime in public view will be offered to lay down and care plan will be updated to their sleeping preferences in wheelchair. An observation audit conducted on all nursing units to ensure no residents were vocalizing/yelling for assistance and if founded the staff went into the room to provide assistance to meet their concerns and/or needs. 3. Facility Educator or designee will provide in-service to facility staff on residents□ right to receive respect and	

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F 550	Continued From page 3 observations from the hallway outside of (R76's) room revealed vocalizations/yelling coming from (R76) appeared to indicate a need for attention or assistance. Visual observation from the hallway outside of (R76's) room revealed CNA # 16 walking past (R76's) room while they were vocalizing/yelling without going into (R76's) room to respond to (R76). On 05/03/22 at 2:14 p.m., auditory (hearing) observations from the hallway outside of (R76's) room revealed vocalizations/yelling coming from (R76) appeared to indicate a need for attention or assistance. Visual observation from the hallway outside of (R76's) room revealed LPN (licensed practical nurse) # 11 walking past (R76's) room while they were vocalizing/yelling without going into (R76's) room to respond to (R76). On 05/03/22 02:19 p.m., an observation revealed that LPN # 11 entered (R76's) room and asked (R76's) if they wanted to go back to bed, (R76's) vocalized and LPN # 11 assisted them to bed. On 05/04/2022 at approximately 1:40 p.m. an interview was conducted with LPN # 11 regarding the above observations. LPN # 11 stated that they should have checked on (R76) when they were vocalizing/yelling because they could be in need of incontinence care or in need of something else. When asked if it was appropriate for a resident to wait 25 minutes to be responded to LPN # 11 stated that (R76) should not have had to wait that long. When asked why it was important to respond when they hear a resident vocalizing loud enough to be heard from the hallway LPN # 11 stated that the resident's need can be met. When asked if was dignified to walk by (R76's) room when they were	F 550	dignity including residents when vocalizing/yelling to respond to meet their needs. Ensuring residents are not left sleeping/eating while in public view, offer to lay down and care plan updated to include resident□s sleeping preferences in wheelchair. Staff will understand the care plan includes the resident□s activity preferences and should offer their activity preferences as interested. The Director of Activity and the activity staff will be in-serviced by the Administrator on the process for identifying and offering resident□s activity preferences and updating the care plan regarding their activity preferences. 4. Observation audits will be conducted by the unit managers or designee to verify residents are not vocalizing/yelling for assistance, sleeping up in wheelchair or during meals unless their preference is to sleep up in wheelchair weekly x 4 weeks then monthly x 2. The Director of Activity will audit resident□s that sit at the nursing station have their activity preferences offered weekly x 4 then monthly x 2. The audit findings will be reviewed and/or revised in the QAPI (Quality Assurance Improvement Committee) meeting monthly for the next 3 months.	

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F 550	Continued From page 4	F 550		

vocalizing/yelling out LPN # 11 stated no.

On 05/04/2022 at approximately 1:53 p.m. an interview was conducted with CNA # 16 regarding the above observations. CNA # 16 stated that they should have checked on (R76). When asked if was dignified to walk by (R76's) room when they were vocalizing/yelling out CNA # 16 stated no.

On 05/04/2022 at approximately 1:53 p.m. an interview was conducted with OSM # 17 regarding the above observations. OSM # 17 stated that they were late assisting residents to activities from the same hallway and should have stopped to check on (R76). When asked why it was important to respond when they hear a resident vocalizing loud enough to be heard from the hallway OSM # 17 stated that the resident may need something, be in pain or could be an emergency. When asked if was dignified to walk by (R76's) room when they were vocalizing/yelling out OSM # 17 stated no.

The facility's policy "Quality of Life - Dignity" documented in part, "1. Residents shall be treated with dignity and respect at all times. 2. "Treated with dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth."

On 05/04/2022 at approximately 5:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 3, vice president of operations, ASM# 4, vice president of clinical services and ASM # 6, assistant administrator, were made aware of the findings.

No further information was presented prior to exit.

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2. The facility staff failed to preserve Resident #419's (R419's) dignity by leaving the resident seated in a wheelchair, sleeping and eating in public view, during the day and evening on 5/3/22 and 5/4/22.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/29/22, R419 was coded as having short term and long term memory problems, and as being severely impaired for making daily decisions. R419 was coded as requiring the extensive assistance of two staff members for transferring and moving around the unit.

On the following dates and times, R419 was sitting in a wheelchair outside the dining room, adjacent to the nurse station and the wheelchair was in full public view: 5/3/22 at 2:08 p.m., 4:35 p.m., 6:17 p.m.; 5/4/22 at 7:15 a.m. (head bowed to the front and asleep), 7:51 a.m. (head bowed and asleep); 9:23 a.m. (breakfast tray on overbed table, breakfast uneaten, head bowed and asleep); 9:51 a.m. (head bowed and asleep); 12:02 p.m. (nurse practitioner examining resident); 1:40 p.m.; 2:17 p.m.; 5:15 p.m.; 6:00 p.m. (eating dinner).

A review of R419's care plan dated 3/28/22 revealed, in part: "The resident is dependent on staff...for meeting emotional, intellectual, physical and social needs r/t (related to) cognitive deficits, physical limitations...The resident will maintain involvement in cognitive stimulation, social activities as desired through review date...The resident's preferred activities are watching game shows and the news on TV, listening to music."

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F 550	Continued From page 6	F 550		

On 5/4/22 at 4:34 p.m., CNA (certified nursing assistant) #2 was interviewed. When asked about the practice of positioning a resident in a wheelchair at or near the nurse station, in full public view, for extended periods of time, including eating and sleeping, CNA #2 stated she would not do this. She stated the resident needed to be repositioned frequently to prevent skin breakdown. She stated: "I would not want to be slumping over in a wheelchair sleeping, with everybody looking at me." She stated if a resident is going to sleep, the resident should be taken to his/her room. She stated this is not dignified for the resident.

On 5/4/22 at 4:43 p.m., LPN (licensed practical nurse) #3 was interviewed. She stated leaving a resident in a wheelchair in full public view is not dignified. She stated: "I don't think anyone should just be sitting in a wheelchair all day long, especially out in public."

On 5/5/22 at 11:10 a.m., LPN #10 was interviewed. She stated R419 sometimes requests to sit at the nurse station. When asked if R419 asks to sit at the nurse station to sleep, LPN #10 stated the resident does not. LPN #10 stated she did not think R419 was aware of the sleeping for long periods in public view. She stated allowing a resident to sleep in public view does not promote a resident's dignity.

On 5/5/22 at 12:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4 the vice president of clinical services, and ASM #6, the assistant administrator, were informed of these

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F 550	Continued From page 7 concerns. A review of the facility policy, "Quality of Life - Dignity," revealed, in part: "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality...Treated with dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth." No further information was provided prior to exit.	F 550		
F 558 SS=D	COMPLAINT DEFICIENCY Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide accommodations of resident needs by ensuring the call bell [a device with a button that can be pushed to alert staff when assistance is needed] was within reach for one of 55 current residents in the survey sample, Resident # 76 (R76). The findings include: The facility staff failed to keep (R76's) call bell within their reach. (R76) was admitted to the facility with a diagnosis	F 558	1. Resident #76 call bell was placed within reach on 5/3/2022 and did not have any negative outcome noted. 2. Audit completed on current residents will be conducted to ensure that residents call bells are within reach by the Unit Manager or designee. 3. Facility Educator or designee will in-service the facility staff on residents right to reasonable accommodation by ensuring call bells are within residents reach for safety and to enable them to call	6/15/22

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F 558	Continued From page 8 that included by not limited to: slurred speech. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/24/2022, the resident scored 3 (three) out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. Section G "Functional Status" coded (R76) as no impairment of upper extremities (shoulder, elbow, wrist, hand). On 05/03/22 at 1:54 p.m., an observation of (R76) in their room revealed they were sitting in wheelchair toward the foot of the bed. Observation of the call bell revealed it was lying in the middle of resident's bed and out of reach of the resident. Further observation of (R76) revealed they were vocalizing/yelling. On 05/03/22 at 2:14 p.m., an observation of (R76) in their room revealed they were sitting in wheelchair toward the foot of the bed. Observation of the call bell revealed it was lying in the middle of resident's bed and out of reach of the resident. Further observation of (R76) revealed they were vocalizing/yelling. The comprehensive care plan for (R76) dated 03/06/2020 documented in part, "Focus. Resident is a risk for fall as R/T (related to) Decreased Mobility. Date Initiated: 03/06/2020." Under "Interventions/Tasks" it documented in part, "Call Light within reach Date Initiated: 03/06/2020." On 05/04/22 at approximately 1:50 p.m., an observation of (R76) was conducted with LPN (licensed practical nurse) # 11. (R76) was	F 558	for assistance as needed. 4. Audits will be conducted by the Unit Managers or designee to ensure call bells are in within reach weekly x 4, then monthly x 2. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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F 558	Continued From page 9 observed lying in their bed with the call bell next to their right hand. When asked (R76) to press the call bell, (R76) was able to press the button independently and activate the call bell system. When asked if (R76) was able to reach call bell when informed of observation of 5/3/22. LPN # 11 stated no. When asked why it was important to place call bell within reach for (R76) LPN stated so that they could call for help or assistance. On 05/04/2022 at approximately 5:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 3, vice president of operations, ASM# 4, vice president of clinical services and ASM # 6, assistant administrator, were made aware of the findings. No further information was presented prior to exit.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 580		6/15/22

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F 580	Continued From page 10 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to notify the provider (physician/nurse practitioner) when medications were not available for administration for one of 55 residents in the	F 580	1. Resident #52 medication list reviewed, verified medication available and administered. There was no adverse reaction to his medications being administered late.	

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F 580	Continued From page 11 survey sample, Resident #52 (R52). The facility staff failed to notify the provider that R52's scheduled medications were not available for administration on 4/14/22, 4/24/22, and 4/26/22. The findings include: On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/14/22, R52 was coded as having no cognitive impairment for making daily decisions. R52 was coded as receiving dialysis services and as receiving insulin injections during the look back period. On 5/3/22 at 1:38 p.m., an interview was conducted with R52. R52 stated that during the previous few weeks, they did not receive medications related to diabetes and to dialysis because they were not in the medication cart for the nurse to administer. Review of R52's clinical record revealed the following order with a start date of 3/15/22: "Auryxia (2) Tablet 1 GM (gram) 210 mg Fe (Iron)...Give 2 tablets by mouth three times a day for hyperphosphatemia (too much phosphorus in the blood), dialysis pt (patient)." A review of R52's MARs revealed the medication was not available for administration on 4/14/22 at 12:00 p.m. and 5:00 p.m. A progress note dated 4/14/22 documented: "4/14/2022 12:11 p.m. Orders - Administration Note Text: Auryxia Tablet 1 GM 210 MG (Fe)...all placed to [name of pharmacy], spoke to [name of pharmacist], stated 'medication will be delivered this evening.'" Further review of R52's clinical record revealed the following order with a start date of 3/26/22:	F 580	2. The Pharmacist will conduct a medication reconciliation audit on current resident physician orders to verify medications are available for administration. 3. The Facility Educator will in-service all Licensed Nurses on the process for unavailable medications. Includes notifying pharmacy for unavailable medications and notifying the MD/NP of unavailable medications including requesting for an alternative medication if applicable and notification of resident/RP of the new medication order with documentation on residents clinical record to include the notification to MD/NP and resident/RP. 4. The Unit Manager or designee will conduct audits to verify unavailable medications have notification to pharmacy and to the MD/NP with alternative medication ordered if applicable and resident/RP notified of new order for medication if applicable and medication was administered when available and documented on resident s clinical record weekly x 4 weeks then monthly x 2. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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"Liraglutide (Victoza) (1) Solution Pen Injector...Inject 1.8 mg (milligrams) subcutaneously one time a day for dm2 (diabetes mellitus type 2)." A review of R52's MARs (medication administration records) revealed the medication was not available for administration on 4/24/22 and 4/26/22. On 4/25/22 the resident was at dialysis, and was not in the facility at the time the medication was due. A progress note dated 4/24/22 documented: "4/24/2022 6:11 p.m. Orders - Administration Note Text: Liraglutide Solution Pen-injector 18 MG/3ML...pending." A progress note dated 4/26/22 documented: "4/26/2022 9:19 p.m. Orders - Administration Note Text: Liraglutide Solution Pen-injector 18 MG/3ML...Call placed to [name of pharmacy], spoke to [name of pharmacist], stated medicine will be delivered this in the morning."

Further review of R52's clinical record revealed the following order with a start date of 4/26/22: "Trulicity (3) Solution Pen Injector...Inject 0.5 ml (milliliters) subcutaneously one time a day every Tue (Tuesday) for DM2." A review of R52's MAR and progress notes revealed the medication was not available for administration on 4/26/22. A progress note dated 4/26/2022 at 11:08 a.m. documented: "Orders - Administration Note Text: Trulicity Solution Pen-injector 3 MG/0.5ML...Pending, call placed to [name of pharmacy], spoke to [name of pharmacist] stated 'medicine will be delivered this evening.'" There was no progress note MAR entry indicating the Trulicity was administered at all on 4/26/22.

A review of the clinical record revealed no evidence a provider was notified in any of the above instances when a medication was not available for administration. The review failed to

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revealed new orders related to medications not being available for administration to R52.

A review of R52's care plan dated 3/11/22 revealed, in part: "Diabetes medication as ordered by the doctor."

A review of the facility's list of medications available at all times from a mechanized dispenser for administration to residents revealed none of the three medications listed above was available on site for administration by nurses to R52.

On 5/4/22 at 4:43 p.m., LPN #3 was interviewed. She stated if a medication is not available in the medication cart, she would check the mechanical medication dispenser to see if the medication is available there. She stated if the medication is not there, she would call the pharmacy and ask for an immediate delivery. She stated if the medication was for a diabetic, the physician should be contacted, and new orders requested. She stated: "A diabetic needs their medication. Period." She stated she would document the physician notification in the progress notes.

On 5/5/22 at 12:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4 the vice president of clinical services, and ASM #6, the assistant administrator, were informed of these concerns.

A review of the facility policy, "Unavailable Medications," revealed, in part: "Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on

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occasion...The facility must make every effort to ensure that medications are available to meet the needs of each resident...B.Nursing staff shall...Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available."

No further information was provided prior to exit.

REFERENCES
(1) "Liraglutide injection (Victoza) is used with a diet and exercise program to control blood sugar levels in adults and children 10 years of age and older with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) when other medications did not control levels well enough." This information was taken from the website https://medlineplus.gov/druginfo/meds/a611003.html.

(2) "Ferric citrate (Auryxia) is used to control high blood levels of phosphorus in people with chronic kidney disease who are on dialysis (medical treatment to clean the blood when the kidneys are not working properly)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a622004.html.

(3) "Dulaglutide (Trulicity) injection is used with a diet and exercise program to control blood sugar levels in adults with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood)." This information is taken from the website

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F 580	Continued From page 15 https://medlineplus.gov/druginfo/meds/a614047.html.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.	F 583		6/15/22

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F 583	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to preserve a resident's privacy during a physical examination by the nurse practitioner for one of 55 residents in the survey sample, Resident #419 (R419). R419 was seated in a wheelchair in full public view when the nurse practitioner (NP) performed an examination of the resident on 5/4/22. The findings include: On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/29/22, R419 was coded as having short term and long term memory problems, and as being severely impaired for making daily decisions. R419 was coded as requiring the extensive assistance of two staff members for transferring and moving around the unit. On 5/4/22 at 12:09 p.m., R419 was sitting in a wheelchair outside the doorway to the dining room, adjacent to the nurses' station, in full public view. ASM (administrative staff member) #7, a nurse practitioner, knelt in front of the resident. ASM #7 placed her hands on R419's ankles, lower legs, and thighs as part of a physical examination. On 5/4/22 at 12:20 p.m., ASM #7 was interviewed. When asked about her encounter with R419, ASM #7 stated: "She is one of our patients. I just saw her to check in." When asked if she had performed any type of physical examination, she stated she had. She stated she	F 583	1. Resident #419 was not negatively affected by the Nurse Practitioner assessment being conducted at the nurse□s station. 2. ASM #7 was provided 1:1 education by the Administrator on dignity and personal privacy during physical examination/assessment. 3. NP and MDs will be in-serviced by the Administrator on dignity and personal privacy during physical examination/assessment. 4. The Administrator or designee will conduct observations audits to verify MD/NP are not performing physical assessments in public view weekly x 4 weeks, then monthly x 2 to verify no physical assessment are performed in public view. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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F 583	Continued From page 17 was checking on R419's lower extremity swelling. When asked if she regularly performs physical assessments of residents in full public view, she stated she usually sees residents in their rooms. She stated: "It's just because we know [R419]. [R419] has been more on the sick end." ASM #7 acknowledged that R419's privacy was not being preserved by examining the resident in full public view. She stated: "It's the first time I've ever done this." On 5/5/22 at 12:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4 the vice president of clinical services, and ASM #6, the assistant administrator, were informed of these concerns. A review of the facility policy, "Quality of Life - Dignity," revealed, in part: "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality...Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures." No further information was provided prior to exit.	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		6/15/22

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F 584	Continued From page 18 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to provide a clean, homelike dining experience in one of four dining rooms.	F 584	1. Residents on 4th floor dining room are being served meals in a clean and homelike environment.	

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F 584	Continued From page 19 On 5/3/22, the facility staff provided lunch to residents in the fourth floor dining room without removing meal trays and trash on meal trays before the residents dined. The findings include: On 5/3/22 at 1:20 p.m., observation of staff serving 14 residents lunch in the fourth floor dining room was conducted. Staff served the meals and did not remove the trays containing the meals before the residents dined. Also, staff was observed removing plastic wrap that covered dessert bowls and plastic lids that covered some of the beverages. Staff placed the plastic wrap and plastic lids on the trays beside the meals and the trash remained on the trays while the residents dined. On 5/4/22 at 1:27 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated all items on the food trays should be removed from the trays and the tray should be set aside out of the residents' reach. LPN #1 stated trash articles such as plastic wrap and plastic lids should be thrown away as soon as they are removed from food and beverages. LPN #1 stated meal trays and trash left on the trays during a meal is not homelike. On 5/4/22 at 4:30 p.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 stated food items should be placed on place mats on the tables, the food items should be unwrapped, the trays should be stacked somewhere away from the table and the trash should be placed in the trash can as soon as the meal is being served. CNA #2 stated meal trays and trash left on the trays during a meal is	F 584	2. An audit was conducted by the Unit Manager on the 4th floor dining room to ensure meals were removed from the meal tray and the disposable coverings were removed from the table and discarded in a trash receptacle. 3. The Facility Educator will in-service the 4th floor Licensed Nurses and CNAs on the process for serving meals in the dining room, removing meal from the meal tray and the disposable coverings are removed from the table and discarded in a trash receptacle to ensure residents are being served meals in a safe, clean comfortable and homelike environment. 4. The Unit Manager or designee will conduct observation audits on the serving of meals on the 4th floor to verify meals are not served on the meal tray and the disposable coverings are removed from the table and discarded in a trash receptacle weekly x 4 weeks then monthly x 2. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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F 584	Continued From page 20 not homelike. On 5/4/22 at 5:20 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Assistance with Meals" failed to document information regarding the above concern. No further information was presented prior to exit.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview it was determined that the facility staff failed to complete and electronically submit a significant change MDS (minimum data set) assessment for one of 55 residents in the survey sample, Resident #33 (R33). The facility staff failed to complete a significant change MDS assessment after R33 began receiving	F 637	1. Resident #33 had a significant change MDS completed on 5/6/2022 to reflect the change in her starting dialysis. 2. Audit conducted by the MDS Director or designee on new dialysis residents to verify a significant change was completed according to the RAI manual.	6/15/22

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F 637	Continued From page 21 hemodialysis for chronic kidney disease stage 4 on 4/6/2022. The findings include: On the most recent MDS, an admission assessment with an ARD (assessment reference date) of 2/27/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was not cognitively impaired for making daily decisions. Section O did not document R33 receiving dialysis at the time of the assessment. Review of the clinical record revealed a list of R33's MDS assessments. The list revealed an entry tracking record was completed on 2/22/2022 and an admission assessment was completed on 2/27/2022. The list failed to evidence documentation of a significant change assessment completed for R33. The physician orders for R33 documented in part, "Dialysis Days/Time: Mon, Tue, Wed, Fri at 10:30 AM every day shift every Mon, Tue, Wed, Fri related to Chronic Kidney Disease, Stage 4 (severe). Order Date: 04/14/2022..." The progress notes for R33 documented in part, "4/6/2022 11:59 (11:59 a.m.) Resident went out for Hemodialysis at 10:30 am at [Name, address, phone, fax number of dialysis center], all medication was given and resident tolerated it well, went with her son but denies [sic] took resident over and will bring her back." The comprehensive care plan for R33 documented in part, "Resident needs hemodialysis r/t (related to) ESKD (end stage	F 637	3. The Regional Director of MDS will in-service the MDS Coordinators on the process to open and complete a significant change assessment for new dialysis residents and on residents that have a significant change according to the RAI Manual. 4. Audit for Significant Changes for residents with newly started dialysis will be conducted by MDS Director or designee to verify a Significant Changes was completed per the RAI manual weekly x 4 weeks then monthly x 2 months. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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F 637	Continued From page 22	F 637		

kidney disease)...Date Initiated: 04/04/2022..."

On 5/5/2022 at 2:56 p.m., an interview was conducted with RN (registered nurse) #2, the MDS director. RN #2 stated that significant change MDS assessments were completed on residents for declines in condition that were not self-balancing, severe depression and significant weight losses. RN #2 stated that hemodialysis would not affect the ADL's (activities of daily living) so they would not complete a significant change assessment on the resident. RN #2 stated that they had updated the care plan for R33 starting dialysis. RN #2 stated that they followed the RAI (resident assessment instrument) manual as their policy/procedure in completing the MDS assessments.

According to the RAI Manual, Version 1.16, dated October 2018, section 2.6 documented that a significant change assessment is to be completed no later than the 14th calendar day after determination that a significant change in the resident's condition occurred (determination date plus 14 calendar days), making the required date of electronic submission for this assessment on or approximately 4/20/2022. The RAI Manual documented in part, "...A "significant change" is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting"; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan..."

On 5/5/2022 at 3:53 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the

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F 637	Continued From page 23 director of nursing, ASM #3, the vice president of operations, ASM #4, the vice president of clinical services, ASM #6 the assistant administrator and ASM #8, the regional director of MDS were made aware of the findings. No further information was provided prior to exit.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility failed to accurately complete an MDS (minimum data set) for one of 55 residents in the survey sample, Resident #419 (R419). The facility staff failed to accurately code R419's interview status on the 3/29/22 MDS. The findings include: On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/29/22, R419 was coded as having short term and long term memory problems, and as being severely impaired for making daily decisions in Section C. On the 3/29/22 MDS, in section B, R419 was coded as always being understood by others, and as always understanding others for communication. However, in Section C, question C0100 documented: "Should Brief Interview for Mental Status be Conducted - Attempt to conduct	F 641	1. Resident #419 MDS assessment was completed on 5/17/2022 to accurately reflect Section B item B0700, C and D interviews of resident□s mental status and mood in compliance with RAI manual guidelines. Social Services no longer completes section C and D of the MDS. 2. The MDS Coordinators/Designee will audit current residents most recent OBRA MDS item B0700 and C, D interviews to ensure all residents have been accurately assessed for their BIMS and Mood interviews. 3. The Regional MDS Consultant or designee will in-service the MDS Coordinators and Occupational Therapists on the process on conducting interviews and the importance of accurate MDS assessment and coding for section B, C and D are following the RAI manual coding instructions and documentation	6/15/22

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F 641	Continued From page 24 interview with all residents," R419 was coded as zero, meaning the resident is rarely/never understood for communication. The Brief Interview for Mental Status interview was not attempted. This section was signed by OSM (other staff member) #16, a social worker. Similarly, in Section D, question D0100 documented: "Should Resident Mood Interview be Conducted - Attempt to conduct interview with all residents," R419 was coded as zero, meaning the resident is rarely/never understood for communication. The Resident Mood Interview was not attempted. This section was signed by OSM #16, a social worker. On 5/4/22 at 2:28 p.m., RN (registered nurse) #2 the MDS director, was interviewed. She stated sometimes the admitting nurse assess the new resident's cognition, and sometimes the speech therapist does this. When asked what it means if someone signs off on an assessment, she stated it means that the person completed that certain portion. On 5/4/22 at 2:59 p.m., RN #6, an MDS nurse, was interviewed. She stated an MDS nurse usually completes section B of the MDS (regarding the resident's ability to understand and be understood). She stated sections C and D are usually completed by a social worker. She stated when she assessed R419 for communication, the resident was able to communicate with her, and was able to understand what was being said. On 5/4/22 at 3:10 p.m., OSM #16 was interviewed. When asked about the discrepancy in the MDS answers, she stated: "That's what I got when I went in there. She couldn't answer."	F 641	and accuracy in compliance for all assessments. 4. The Facility MDS Coordinator or designee will audit newly completed OBRA MDSs for Section B item B0700, C and D interviews to verify coding accuracy of 5 assessments per week x 4 weeks then 5 assessments monthly x 2 months. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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F 641	Continued From page 25 When asked if she ever returned to a resident who did not appear to be interviewable, she stated she sometimes does, but not always. She stated she does not check for consistency between sections C and D, and section B. She stated she was not aware that the questions regarding communication needed to be consistent throughout the entire MDS. She stated that by not interviewing a resident, she might miss some important aspects of the assessment that may affect the resident's care. On 5/5/22 at 12:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4 the vice president of clinical services, and ASM #6, the assistant administrator, were informed of these concerns. A review of the facility policy, "Certifying Accuracy of the Resident Assessment," revealed, in part: "All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment." No further information was provided prior to exit.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident	F 655		6/15/22

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F 655	Continued From page 26 that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of	F 655	1. Resident # 369 is no longer a resident of Fairfax Nursing and Rehabilitation and	

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F 655	Continued From page 27 a complaint investigation, the facility staff failed to provide a written summary of the baseline care plan for 1 of 55 residents in the survey sample, Resident #369. The facility staff failed to provide a written summary of Resident #369's (R369) baseline care plan to the resident and/or the resident's representative. The findings include: On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/20/20, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. Resident #369 was discharged from the facility on 12/28/20. A review of R369's clinical record revealed the resident's baseline care plan was initiated on 11/17/20. Further review of R369's clinical record (including progress notes and care conference notes) failed to reveal the resident and/or the resident's representative was provided a written summary of the care plan. On 5/4/22 at 3:31 p.m., an interview was conducted with OSM (other staff member) #4 (social worker). OSM #4 stated the case management or social services departments are responsible for providing a copy of baseline care plans to resident representatives and residents, if they are cognizant. OSM #4 stated this should be evidenced in a note or a care conference note. On 5/5/22 at 12:38 p.m., ASM (administrative	F 655	discharged on 12/28/2020. 2. An audit will be conducted by Unit Managers for residents admitted as of 5/11/2022 to ensure baseline care plan are completed and a copy given to the resident/RP. 3. The Facility Educator or designee will in-service all licensed and registered nurses responsible for completing the resident baseline care plan on admission and the baseline care plan is reviewed within 48 hours of admission with care plan goals provided to the resident/RP upon admission. 4. The Director of Nursing or designee will audit new admissions to the facility to verify the base line care plan was completed upon admission and will include verification that the care plan is sign by resident/RP/ nurse or two nurses if review of care plan was completed via phone and uploaded into the resident's clinical record and documented a copy p was provided to the resident/RP weekly x 4 weeks then monthly x2. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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F 655	Continued From page 28 staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Care Plans- Baseline" documented, "4. The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary." No further information was presented prior to exit. COMPLAINT DEFICIENCY	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		6/15/22

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F 656	Continued From page 29 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and facility document review, it was determined the facility staff failed to develop and/or implement the comprehensive care plan for 14 of 55 residents in the survey sample; Residents #98, #144, #50, #132, #85, #9, #97, #18, #76 #419, #52, #82, #147 and #4. The findings include: 1. The facility staff failed to develop the	F 656	1. Resident #98 is no longer a resident at this facility. Residents: #144, #50, #132, #85, #147 were assessed, consent obtained, and care plan updated for bedrails on 05/11/2022. Resident #9 Comprehensive Care Plan has been reviewed and initiated to reflect use of antidepressant medication,	

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comprehensive care plan for the use of bed rails for Resident #98.

Resident #98 was admitted to the facility on 1/25/22 with diagnosis that included but were not limited to: traumatic subdural hemorrhage, Parkinson's disease, encephalopathy and dementia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/1/22, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; total dependence for eating.

A review of the comprehensive care plan dated 5/3/22 documented in part, "FOCUS: ADL (activities of daily living) self-care performance deficit related to physical limitations. INTERVENTIONS: Bilateral 1/4 side rails while in bed to enable mobility." A review of the physician orders dated 1/26/22, which revealed, "Bilateral 1/4 side rails while in bed to enable mobility." The care plan was not updated at the time of the physician order nor prior to the survey start date.

An interview was conducted on 5/4/22 at 1:35 PM with RN (registered nurse) #3. When asked the purpose of the care plan, RN #3 stated, the purpose of the care plan is to have the goals and interventions in one place for the team to see. When asked if bed rails should be on the care plan, RN #3 stated, yes, the bed rails should be

diagnosis of congestive heart failure and use of compression stockings.

Resident #97 order was updated for dialysis fistula/graft site to be monitored and documented functioning bruit and thrill each sift.

Resident #18 care planned was updated to reflect bilateral lower extremity contracture/interventions.

Resident #76 call bell is in reach and facility is following the care plan. Resident #419 activity preferences were updated, and the facility is following the care plan.

Resident #52 is receiving double portions of food per physician□s order and EMAR updated to document fluid intake every shift/24-hour period to ensure care plan is followed.

Resident #82 PICC line has been discontinued as of 5/5/2022 and no longer uses siderails as of 5/11/2022.

Resident #4 was assessed on 05/03/2022 and no longer has a siderail.

2. Audit of care plans will be conducted by Unit Managers or designee on current residents using bedrails to verify initiation, discontinue or update use of bedrails. An Audit of current residents on antidepressants, residents with congestive heart failure, residents with contracture, dialysis fistula/graft site to check for bruit and thrill, PICC line, call bells in place, activity preferences, fluid

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F 656	Continued From page 31 on the care plan. I updated these resident's care plans yesterday. On 5/4/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator, ASM #3, the regional vice president of operations, ASM #4, the vice president of clinical services and ASM #6, the assistant administrator were made aware of the above concerns. The facility's "Proper Use of Side Rails" policy dated 12/16, which reveals, "The use of side rails as an assistive device will be addressed in the resident care plan." The facility's "Care Planning-Interdisciplinary Team" policy dated 9/13, which reveals, "Our facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. The care plan is based on the resident's comprehensive assessment." No further information was provided prior to exit. 2. The facility staff failed to develop the comprehensive care plan for the use of bed rails for Resident #144. Resident #144 was observed in bed with right side one quarter rails on 5/3/22 on initial resident observation at 1:00 PM, 5/3/22 at 4:45 PM and 5/4/22 at 8:15 AM. Resident #144 was admitted to the facility on 4/7/22. Resident #144's diagnoses included but were not limited to: metabolic encephalopathy, diabetes, dementia, retention of urine and urinary tract infection.	F 656	restrictions, double portions, and use of ted hose to be conducted by MDS or designee to verify the care plan is initiated and/or updated or discontinued. 3. The Director of Nursing will in-service the Licensed Nurses, MDS staff, activity staff on the process for care plans to be initiated, and/or updated or discontinued and followed per plan of care. Including the initiation or updated of care plans for disease processes with interventions such as CHF, treatments such as ted hose, psychotropics such as antidepressants, devices such as bedrails, PICC lines and CP followed per interventions for call bells within reach, activity preferences offer, double portions given, documentation of fluid restriction, ted hose on and dialysis fistula/graft to check bruit and thrill and has physician orders for residents with PICC lines and /or dialysis fistula/graft site to monitor for bruit and thrill. 4. The Unit Managers or designee will conduct audits on residents using bedrails to verify CP was initiated or update or discontinued for bedrails and conduct observation audits to verify care plan was followed for call bells in reach, fluid restrictions amounts documented, ted hose on per CP, PICC line and fistula/graft monitor bruit and thrill documentation complete to verify CP was followed and have physician orders for a dialysis fistula/graft site to monitor for bruit and thrill and/or PICC line. The Activities Director or designee will	

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F 656	Continued From page 32 Resident #144's most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an assessment reference date of 4/9/22, coded the resident as scoring a 9 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. MDS Section G- Functional Status: coded the resident as requiring extensive assistance for bed mobility, transfers, walking/locomotion, dressing and personal hygiene/bathing; the resident is independent for eating. A review of Resident #144's comprehensive care plan dated 5/4/22, documented in part, "FOCUS- Use of Right side 1/4 rails for enhancement of self-mobility and repositioning while in bed. INTERVENTIONS- Check side rails during safety check." The care plan was not updated at the time of the physician order and nor prior to the survey start date. A review of the physician orders dated 5/3/22, which revealed, "Right side 1/4 (one quarter) side rails while in bed to enable mobility." An interview was conducted on 5/3/22 at 4:45 PM with Resident #144. When asked if he used the side rail, Resident #144 stated, yes, I use it to turn over. An interview was conducted on 5/4/22 at 1:45 PM with LPN (licensed practical nurse) #5. When asked the purpose of the care plan, LPN #5 stated, the purpose of the care plan is to provide information about the goals for the resident. Bed rails should be on the care plan. I updated the care plan after the bed rail assessment was done	F 656	conduct audits to verify the CP activity preferences were followed and offered to resident□s that sit at the nursing station. The Dietary Manager or designee will verify, and the CP was followed for double portions and are on the meal tray per physician order and dietitian recommendation. Social Service will conduct audits on CP for antidepressants to verify initiated, and/or updated or discontinued. The MDS Director or designee will conduct audits on CHF, disease processes with interventions, ted hose, residents with contractures, dialysis fistula/graft sites to check for bruit and thrill, PICC line to verify care plan was initiated, update/revised, or discontinued. Audits will be conducted weekly x 4 weeks then monthly x 2 to verify care plans are initiated, updated, resolved, and followed. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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yesterday. The resident had bed rails before yesterday.

On 5/4/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator, ASM #3, the regional vice president of operations, ASM #4, the vice president of clinical services and ASM #6, the assistant administrator were made aware of the above concerns.

The facility's "Proper Use of Side Rails" policy dated 12/16, which reveals, "The use of side rails as an assistive device will be addressed in the resident care plan."

The facility's "Care Planning-Interdisciplinary Team" policy dated 9/13, which reveals, "Our facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. The care plan is based on the resident's comprehensive assessment."

No further information was provided prior to exit.

3. The facility staff failed to develop the comprehensive care plan for the use of bed rails for Resident #50.

Resident #50 was observed in bed with right side one quarter rails on 5/3/22 on initial resident observation at 1:30 PM, 5/3/22 at 5:00 PM and 5/4/22 at 8:30 AM.

Resident #50 was admitted to the facility on 3/9/22. Resident #50's diagnoses included but were not limited to: cervical, sternal and tibial fractures, spinal stenosis and urine retention.

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Resident #50's most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an assessment reference date of 3/16/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. MDS Section G- Functional Status: coded the resident as requiring extensive assistance for bed mobility, transfers, walking/locomotion, eating, dressing and personal hygiene/bathing.

A review of Resident #50's comprehensive care plan dated 5/4/22, documented in part, "FOCUS- Resident uses 1/4 rails for enhancement of self-mobility and repositioning. INTERVENTIONS- Check side rails during safety check." The care plan was not updated at the time of the physician order nor prior to the survey start date.

A review of the physician orders dated 5/3/22, which revealed, "Bilateral 1/4 side rails while in bed to enable mobility."

An interview was conducted on 5/3/22 at 1:30 PM with Resident #50. When asked if he used the side rail, Resident #50 stated, yes, they make me feel safe.

An interview was conducted on 5/4/22 at 1:35 PM with RN (registered nurse) #3. When asked the purpose of the care plan, RN #3 stated, the purpose of the care plan is to have the goals and interventions in one place for the team to see. When asked if bed rails should be on the care plan, RN #3 stated, yes, the bed rails should be on the care plan. I updated these resident's care plans yesterday.

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On 5/4/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator, ASM #3, the regional vice president of operations, ASM #4, the vice president of clinical services and ASM #6, the assistant administrator were made aware of the above concerns.

The facility's "Proper Use of Side Rails" policy dated 12/16, which reveals, "The use of side rails as an assistive device will be addressed in the resident care plan."

The facility's "Care Planning-Interdisciplinary Team" policy dated 9/13, which reveals, "Our facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. The care plan is based on the resident's comprehensive assessment."

No further information was provided prior to exit.

4. The facility staff failed to develop the comprehensive care plan for the use of bed rails for Resident #132.

Resident #132 was observed in bed with right side one quarter rails on 5/3/22 on initial resident observation at 1:10 PM, 5/3/22 at 4:30 PM and 5/4/22 at 8:20 AM.

Resident #132 was admitted to the facility on 4/13/22. Resident #50's diagnoses included but were not limited to: aortic valve insufficiency, sacral fracture post fall, left artificial hip and atherosclerotic cardiovascular disease.

Resident #132's most recent MDS (minimum

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data set) assessment, a Medicare 5 day assessment, with an assessment reference date of 4/20/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. MDS Section G- Functional Status: coded the resident as requiring extensive assistance for bed mobility, transfers, walking/locomotion, dressing and personal hygiene/bathing; supervision for eating.

A review of Resident #132's comprehensive care plan dated 5/4/22, documented in part, "FOCUS- Use Bilateral 1/4 rails for enhancement of self-mobility and repositioning while in bed as related to fracture on the sacrum. INTERVENTIONS- Check side rails during safety check." The care plan was not updated at the time of the physician order nor prior to the survey start date

A review of the physician orders dated 5/3/22, which revealed, "Bilateral 1/4 side rails while in bed to enable mobility."

An interview was conducted on 5/3/22 at 1:10 PM with Resident #132. When asked if he used the side rail, Resident #132 stated, yes, they make me feel safe.

An interview was conducted on 5/4/22 at 1:45 PM with LPN (licensed practical nurse) #5. When asked the purpose of the care plan, LPN #5 stated, the purpose of the care plan is to provide information about the goals for the resident. Bed rails should be on the care plan. I updated the care plan after the bed rail assessment was done yesterday. The resident had bed rails before yesterday.

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On 5/4/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator, ASM #3, the regional vice president of operations, ASM #4, the vice president of clinical services and ASM #6, the assistant administrator were made aware of the above concerns.

The facility's "Proper Use of Side Rails" policy dated 12/16, which reveals, "The use of side rails as an assistive device will be addressed in the resident care plan."

The facility's "Care Planning-Interdisciplinary Team" policy dated 9/13, which reveals, "Our facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. The care plan is based on the resident's comprehensive assessment."

No further information was provided prior to exit.
5. The facility staff failed to develop a comprehensive care plan for Resident #85 (R85) to include the use of bed rails.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/4/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is not cognitively impaired for making daily decisions. Section G documented R85 requiring extensive assistance of two or more persons for bed mobility and transfers.

On 5/3/2022 at 2:28 p.m., an interview was conducted with R85 in their room. R85 was observed lying in bed with bilateral upper bed rails

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in place on the bed. R85 stated that they used the rails to grab onto when turning and sitting up in bed.

Additional observations of R85 on 5/4/2022 at 8:30 a.m., revealed the findings above.

Review of R85's comprehensive care plan on 5/3/2022 failed to evidence documentation of use of bed rails.

The physician order's for R85 documented in part, "Order Date: 4/12/2022 9:22 (9:22 a.m.) ...Bilateral 1/4 side rails while in bed to enable mobility..."

The bed rail evaluation for R85 documented in part, "3/30/2022 17:57 (5:57 p.m.) ...Bed rail(s) is/are recommended at this time..."

On 5/5/22 at 9:10 a.m., an interview was conducted with RN #3, unit manager. RN #3 stated that nursing built the care plan on admission and it was revised when there were new orders or changes in condition. RN #3 stated that the care plan guided them on how to provide care to the resident. RN #3 stated that the care plan included interventions for particular problems and how to provide the care. RN #3 stated that it was a roadmap of care for the resident.

On 5/5/2022 at 11:06 a.m., an interview was conducted with RN #2, MDS director. RN #2 stated that new admissions had a baseline care plan created by the nursing staff. RN #2 stated that after the MDS assessment was completed there were triggers that they used to add focus areas to the care plan. RN #2 stated that they

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also reviewed the care plan to address any specific areas including psychotropic medications, diuretics and anticoagulants. RN #2 stated that they also included cardiac diagnoses like atrial fibrillation, CVA and CHF.

On 5/5/2022 at 12:32 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the vice president of operations, ASM #4, the vice president of clinical services and ASM #6 the assistant administrator were made aware of the findings.

No further information was provided prior to exit.

6. The facility staff failed to develop a comprehensive care plan for Resident #9 (R9) which included the use of (A) a antidepressant medication and (B) diagnosis of congestive heart failure/TED hose (compression stocking) use.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/29/2022, the resident scored 8 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is moderately impaired for making daily decisions. Section I documented R9 having an active diagnosis of heart failure. Section N documented R9 receiving an antidepressant during the assessment period.

(A) The physician order's for R9 documented in part, "Lexapro Tablet 20 MG (milligram) (Escitalopram Oxalate) Give 0.5 tablet by mouth one time a day related to Major Depressive Disorder, Single episode, unspecified. Order Date: 05/03/2022..."

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Review of R9's comprehensive care plan on 5/4/2022 failed to evidence documentation of use of an antidepressant.

On 5/5/2022 at 11:06 a.m., an interview was conducted with RN (registered nurse) #2, MDS director. RN #2 stated that new admissions had a baseline care plan created by the nursing staff. RN #2 stated that after the MDS assessment was completed there were triggers that they used to add focus areas to the care plan. RN #2 stated that they also reviewed the care plan to address any specific areas including psychotropic medications, diuretics and anticoagulants. RN #2 stated that antidepressants should be addressed on the care plan. RN #2 stated they would review R9's care plan for antidepressants.

On 5/5/2022 at 2:56 p.m., RN #2 stated that they had reviewed R9's care plan and antidepressants were not addressed on it. RN #2 stated that antidepressant side effect monitoring was being completed on the eMAR (electronic medication administration record).

(B) The admission record for R9 documented an admission diagnosis of heart failure, unspecified.

The physician order's for R9 documented in part, "Furosemide Tablet 20 MG (milligram), Give 2 tablet by mouth one time a day for CHF (congestive heart failure). Order Date: 04/22/2022..." The physician order's further documented, "TED hose: Knee High Ted hose 1 application miscellaneous every evening shift for BLE (bilateral lower extremity) edema with fluid retention Remove at HS (bedtime). Order Date: 02/03/2022..."

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Review of R9's comprehensive care plan on 5/4/2022 failed to evidence documentation for the use of TED hose or diagnosis of CHF.

On 5/5/22 at 9:10 a.m., an interview was conducted with RN #3, unit manager. RN #3 stated that nursing built the care plan on admission and it was revised when there were new orders or changes in condition. RN #3 stated that the care plan guided them on how to provide care to the resident. RN #3 stated that the care plan included interventions for particular problems and how to provide the care. RN #3 stated that it was a roadmap of care for the resident. RN #3 stated that R9 was non-compliant with wearing the TED hose and often refused to put them on. RN #3 stated that the TED hose should be an intervention on the care plan under the heart failure care plan. RN #3 stated that residents with heart failure diagnoses were monitored for weight gain, swelling and shortness of breath and these were all addressed on the care plan. RN #3 reviewed R9's care plan and stated that they did not see a care plan for the heart failure diagnosis or TED hose.

On 5/5/2022 at 11:06 a.m., an interview was conducted with RN #2, MDS director. RN #2 stated that new admissions had a baseline care plan created by the nursing staff. RN #2 stated that after the MDS assessment was completed there were triggers that they used to add focus areas to the care plan. RN #2 stated that they also included cardiac diagnoses like atrial fibrillation, CVA and CHF. RN #2 stated that they would review R9's care plan for antidepressants.

On 5/5/2022 at 2:56 p.m., RN #2 stated that they

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had reviewed R9's care plan and the heart failure diagnosis or TED hose were not addressed on it. RN #2 stated that they both should be included on the care plan and they were updating it.

On 5/5/2022 at 12:32 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the vice president of operations, ASM #4, the vice president of clinical services and ASM #6 the assistant administrator were made aware of the findings.

No further information was provided prior to exit.
7. The facility staff failed to implement the comprehensive care plan to check Resident # 97's (R97) bruit and thrill every day and every shift according to the physician's orders.

(R97) was admitted to the facility with diagnoses included but were not limited to: end stage renal disease [2], dependent on renal dialysis.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 04/05/2022, the resident scored 2 (two) out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately impaired of cognition intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded (R97) for "Dialysis" while a resident.

The physician's order sheet for (R97) documented in part, DIALYSIS: Hemodialysis Order set every shift Monitor AV (arterial/venous) fistula (3) to L (left) arm Monitor bruit and thrill (4). Order Date: 06/11/2021. Start Date: 06/11/2021." and "Hemodialysis Diagnosis: ESRD(end stage renal disease) Dialysis Days and Time: M/W/F

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(Monday/Wednesday/Friday) Pick up time: 0600 (6:00 a.m.). Date: 06/11/2021. Start Date: 06/11/2021."

The comprehensive care plan for (R97) with a revision date of 04/08/2022 documented in part, "Focus: The resident has hemodialysis r/t (related to) End stage renal disease. Dialysis Days and Time: M/W/F @ 0630 (6:30 a.m.) Pick up time: 0600. Date Initiated: 04/08/2022." Under "Interventions/Tasks" it documented in part, "Access fistula site for positive bruit /thrill as ordered. Date Initiated: 07/13/2021."

The facility's progress notes for (R97) dated 05/02/2022 through 05/05/2022 revealed documentation of (R97's) bruit and thrill being checked on 05/02/2022 at 3:01 p.m. and on 05/04/2022 at 2:21 p.m. Further review of the progress notes failed to evidence documentation of (R97's) bruit and thrill being checked on 05/02/2022 during the 7:00 a.m. to 3:00 p.m. and 11:00 p.m. to 7:00 a.m. shifts; 05/04/2022 during the 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. shifts; and on 05/03/2022 and 05/05/2022 during the 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. shifts.

The eTAR [electronic treatment record] for (R97) dated May 2022 failed to evidence documentation of (R97's) bruit and thrill being checked on the dates listed above.

On 05/05/22 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) # 7. After reviewing the physician's order, care plan, eTAR progress notes and for the date stated above LPN # 7 was asked if the care plan

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was being followed for the monitoring of (R97's) bruit and thrill every shift every day. LPN # 7 stated that the care plan was not being followed. When asked to describe the purpose of the care plan LPN # 7 stated that it was a road map on how to take care of the resident.

On 05/05/2022 at approximately 5:15 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, ASM # 3, the vice president of operations, ASM# 4, the vice president of clinical services and ASM # 6, the assistant administrator, were made aware of the findings.

No further information was presented prior to exit.

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

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

(3) An abnormal connection between two body parts, such as an organ or blood vessel and another structure. Fistulas are usually the result of an injury or surgery. This information was obtained from the website: https://medlineplus.gov/ency/article/002365.htm

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(4) When you slide your fingertips over the site you should feel a gentle vibration, which is called a "thrill." Another sign is when listening with a stethoscope a loud swishing noise will be heard called a "bruit." If both of these signs are present and normal, the graft is still in good condition. This information was obtained from the website: https://www.vascularhealthclinics.org/institutes-divisions/vascular-surgery-and-medicine/dialysis-access/#:~:text=When%20you%20slide%20your%20fingertips,is%20still%20in%20good%20condition.

8. Facility staff failed to develop a comprehensive care plan to address Resident 18's (R18) contractures of their legs.

(R18) was admitted to the facility with diagnoses included but were not limited to: multiple sclerosis (1), quadriplegic (2) and cerebral palsy (3).

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/10/2022, the resident scored 9 (nine) out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately impaired of cognition intact for making daily decisions. Section "G0400 Functional Limitations in Range of Motion" under "B. Lower extremity (hip, knee ankle, foot)" coded (R18) as "Impairment on both sides."

Review of the comprehensive care plan for (R18) dated 03/09/2021 documented in part, "Focus: the resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) Multiple Sclerosis, quadriplegia, upper extremity contractures, Dementia, generalized weakness,

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impaired mobility. Date Initiated: 03/09/2021. Under "Interventions/Tasks" it documented in part, "CONTRACTURES: The resident has contractures of the (upper extremities) Provide skin care to keep clean and prevent skin breakdown. Date Initiated: 09/22/2018." Further review of the comprehensive care plan failed to address the contractures of (R18's) bilateral lower extremities.

On 05/04/22 at 3:03 p.m., an interview was conducted with RN (registered nurse) # 2, MDS director. When asked about (R18's) comprehensive care plan not addressing (R18's) contractures of their bilateral lower extremities RN # 2 stated that it was not included on the care plan and that it should be addressed on the care plan.

On 05/05/2022 at approximately 12:35 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 3, vice president of operations, ASM# 4, vice president of clinical services and ASM # 6, assistant administrator, were made aware of the findings.

No further information was presented prior to exit.

References:
(1) A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html.

(2) The loss of muscle function in part of your

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body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

(3) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html.

9. The facility staff failed to implement the comprehensive care plan to keep Resident # 76's call bell within reach.

(R76) was admitted to the facility with a diagnosis that included by not limited to: slurred speech.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/24/2022, the resident scored 3 (three) out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. Section G "Functional Status" coded (R76) as no impairment of upper extremities (shoulder, elbow, wrist, hand).

On 05/03/22 at 1:54 p.m., an observation of (R76) in their room revealed they were sitting in wheelchair toward the foot of the bed. Observation of the call bell revealed it was lying in

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the middle of resident's bed and out of reach of the resident. Further observation of (R76) revealed they were vocalizing/yelling.

On 05/03/22 at 2:14 p.m., an observation of (R76) in their room revealed they were sitting in wheelchair toward the foot of the bed. Observation of the call bell revealed it was lying in the middle of resident's bed and out of reach of the resident. Further observation of (R76) revealed they were vocalizing/yelling.

The comprehensive care plan for (R76) dated 03/06/2020 documented in part, "Focus. Resident is a risk for fall as R/T (related to) Decreased Mobility. Date Initiated: 03/06/2020." Under "Interventions/Tasks" it documented in part, "Call Light within reach. Date Initiated: 03/06/2020."

On 05/04/22 at approximately 1:50 p.m., an observation of (R76) was conducted with LPN (licensed practical nurse) # 11. (R76) was observed lying in their bed with the call bell next to their right hand. When asked (R76) to press the call bell (R76) was able to press the button independently and activate the call bell system. When asked if (R76) was able to reach call bell when informed of observation of 5/3/22. LPN # 11 stated no. When asked why it was important to place call bell within reach for (R76) LPN stated so that they could call for help or assistance. After reviewing the comprehensive care plan for (R76) dated 03/06/2020 LPN # 11 was asked if the care plan was being implemented if (R76's) call bell was within reach. LPN # 11 stated no.

On 05/05/22 at approximately 12:35 p.m., ASM (administrative staff member) # 1, administrator,

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ASM # 2, director of nursing and ASM # 3, vice president of operations, ASM# 4, vice president of clinical services and ASM # 6, assistant administrator, were made aware of the findings.

No further information was presented prior to exit.
10. The facility staff failed to implement R419's activities care plan for individual activities.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/29/22, R419 was coded as having short term and long term memory problems, and as being severely impaired for making daily decisions. R419 was coded as requiring the extensive assistance of two staff members for transferring and moving around the unit.

On the following dates and times, R419 was sitting in a wheelchair outside the dining room, adjacent to the nurse station. The wheelchair was in full public view: 5/3/22 at 2:08 p.m., 4:35 p.m., 6:17 p.m.; 5/4/22 at 7:15 a.m. (head bowed to the front and asleep), 7:51 a.m. (head bowed and asleep); 9:23 a.m. (breakfast tray on overbed table, breakfast uneaten, head bowed and asleep); 9:51 a.m. (head bowed and asleep); 12:02 p.m. (nurse practitioner examining resident); 1:40 p.m.; 2:17 p.m.; 5:15 p.m.; 6:00 p.m. (eating dinner).

A review of R419's care plan dated 3/28/22 revealed, in part: "The resident is dependent on staff...for meeting emotional, intellectual, physical and social needs r/t (related to) cognitive deficits, physical limitations...The resident will maintain involvement in cognitive stimulation, social activities as desired through review date...The

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resident's preferred activities are watching game shows and the news on TV, listening to music."

On 5/4/22 at 4:34 p.m., CNA (certified nursing assistant) #2 was interviewed. When asked if she is made aware of a resident's preferred activities, she stated she usually is not, especially if a resident is unable to tell her what the resident prefers.

On 5/4/22 at 4:43 p.m., LPN (licensed practical nurse) #3 was interviewed. She stated she does not usually reference a resident's preferred activities to determine what a resident might like to do during the day.

On 5/4/22 at 5:17 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4 the vice president of clinical services, and ASM #6, the assistant administrator, were informed of these concerns.

On 5/5/22 at 10:16 a.m., OSM (other staff member) #17, an activities assistant, was interviewed. OSM #17 stated he hands out a daily flyer listing the activities on that unit for the day. He stated he goes around to residents to inform them of group activities. He stated R419 had attended BINGO on 5/3/22, but had refused any group activities on 5/4/22. When asked if he was aware of R419's preferences for individual activities as documented on the care plan, he stated he was not. He stated he does not see the residents' care plans. He stated, however, that he knew R419 enjoyed TV, the news, and music. When asked if TV, the news, or music had been provided to R419 during the times the resident

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was in the wheelchair outside the dining room, he stated: "No. Those things were not done."

On 5/5/22 at 10:39 a.m., OSM #18, the activities director, was interviewed. OSM #18 stated when a resident is first admitted, an initial assessment is completed, usually by the activities assistant. She stated if a resident is not able to express their interests in an interview, she interviews the family. She stated she then verbally communicates what the family has said to the activities assistants. She stated the staff determines the resident's interests, their likes, and their dislikes. She stated in R419's case, the family was interviewed because the resident was cognitively able to answer those questions. She stated R419's family stated the resident enjoyed watching game shows and the news on TV,and listening to music. She stated if a resident is unengaged in group activities, or is in their room, "we would make sure the TV is on either to their preferred channel or to a music station." When asked if R419's activities care plan had been implemented on 5/3/22 and 5/4/22, she stated it was not. She stated the staff was not offering R419 individual activates according to the resident's preference.

On 5/5/22 at 2:03 p.m., LPN #11 stated the purpose of a resident's care plan is to instruct the facility staff on how to give the best care for the resident. LPN #11 stated all of his nursing care is based on the care plan.

No further information was provided prior to exit.

11.a. The facility staff failed to follow Resident #52's (R52's) care plan for double portions as recommended by the dietician.

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On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/14/22, R52 was coded as having no cognitive impairment for making daily decisions. R 52 was coded as being on a therapeutic diet.

On 5/3/22 at 1:38 p.m., Resident #52 (R52) was interviewed. R52 had multiple complaints about food served to him. R52 stated the dietary staff consistently failed to provide double portions, as recommended by the dietician. R52 stated the food on the meal tray frequently did not match the published meal ticket.

On 5/3/22 at 5:55 p.m., R52's interview was completed. R52's dinner tray was delivered. R52 lifted the cover. The meal tray contained the following food: two small pieces of baked fish, each less than 1/4 inch thick, approximately 3 inches in length, approximately, two inches in width; approximately 1/3 cup of green peas with 4 pieces of small chopped onion, 1 boiled egg, a pack of saltines, fresh fruit salad, and a white roll. The meal ticket documented the tray should contain cranberry juice, but there was none on the tray. The meal ticket documented the tray should contain a wheat roll and double portions.

On 5/4/22 at 1:40 p.m., R52 was seated in the wheelchair beside the bed. R52's lunch tray was on the overbed table. R52 lifted the cover. The meal tray contained the following food: one medium chicken leg, approximately 1/3 cup of mixed vegetables, a boiled egg, a four inch square of cornbread, a bowl containing approximately 1/2 cup of lettuce, four slices of cucumbers, and eight pieces of diced tomatoes.

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The meal ticket stated the tray should contain angel food cake, but there was none on the tray. The resident's meal ticket documented: "Tossed Salad - NO tomatoes...Double Portions."

R52's clinical record contained the following order dated 3/30/22: "DIET: Liberal Renal (Avoid high K [potassium] foods) diet...Regular texture, Regular Thin Liquid consistency, NCS (no concentrated sweets); DOUBLE PORTIONS."

A review of R52's care plan dated 3/1/22 and revised on 3/11/22 revealed, in part: "Resident has nutritional problem or potential nutritional problem...Provide, serve diet as ordered."

A review of R52's clinical record revealed a Nutritional Evaluation dated 3/9/22, following R52's most recent readmission. This evaluation documented, in part: "Additional notes from interview...Resident is also a former LTC (long term care) director of foodservices. Reports that [R52] has not liked the facility's food thus far--referred to dietary department for follow up and assessment of more detailed meal preferences." Further review of the clinical record revealed no evidence of further follow up of R52's more detailed meal preferences.

Further review of R52's clinical record revealed the following Nutrition Note, written by OSM (other staff member) #12, the RD (registered dietician), dated 3/30/22: "Spoke with resident today with head of social work...RD reminded resident several times of the role of the RD and strategies to address perceived issues with meals...Given that resident reports that [R52] feels that [R52] does not get enough food, RD to request double portions from dietary department."

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On 5/5/22 at 9:53 a.m., OSM #13, dietary director, was interviewed. OSM #13 stated when a resident is admitted, she or a member of her staff goes to the resident's room and interviews the resident to determine the resident's food preferences. OSM #13 states the resident's preferences are documented on the meal ticket placed on each resident's meal tray at each meal. She stated the RD also interviews the resident about food preferences at the time of admission. When asked who is responsible for making sure the food on a resident's tray matches the meal ticket, OSM #13 stated a staff member "calls" the ticket to the staff member serving the plates on the kitchen line, and a supervisor double checks the tray for accuracy. OSM #13 stated each tray is checked to make sure double portions are present if that is what is ordered for the resident. She stated if a substitution needs to be made due to any food item being unavailable, she or a member of her staff attempts to speak to each resident about the changes, and the substitution is documented on each resident's meal ticket. OSM #13 stated she has spoken to R52 "a couple of times." She stated she had offered the resident to move from a renal diet to a regular diet, but the resident has refused.

On 5/5/22 at 10:25 a.m., OSM #12 was interviewed. She stated she tries to go visit a resident within 48 hours of admission. At this time, she interviews residents about strong food preferences, as well as other nutritional concerns. She stated she communicates information about a resident's food preferences by email to OSM #13. She stated she follows up monthly on residents who are on dialysis. She stated R52 has "a lot of food preferences, he has very high

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standards." She stated the resident can be preoccupied with food. She stated she does not have responsibilities for the accuracy of meals served to residents day to day.

On 5/5/22 at 12:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4 the vice president of clinical services, and ASM #6, the assistant administrator, were informed of these concerns.

On 5/5/22 at 2:03 p.m., LPN #11 stated the purpose of a resident's care plan is to instruct the facility staff on how to give the best care for the resident. LPN #11 stated all of his nursing care is based on the care plan.

11.b. The facility staff failed to follow R52's care plan regarding a fluid restriction.

On 5/3/22 at 1:38 p.m., an interview was conducted with R52. R52 stated that they were on a fluid restriction ordered by his physician. R52 also stated that sometimes they were not compliant with the restriction. When asked if staff members consistently asked how much fluids R52 had consumed in a shift, R52 stated: "No, almost never."

A review of R52's care plan dated 3/1/22 and updated 4/24/22 revealed, in part: "Resident is on fluid restrictions...monitor fluid intake per MD orders."

A review of R52's physician's orders revealed the following order with a start date of 3/8/22: "Fluid Restriction every shift...1500 ml (milliliters) Total

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Per Day; Nursing 660 ml total (240 ml day shift, 240 ml evening shift, 180 ml night shift); Dietary 840 ml total (360 ml breakfast, 240 ml lunch, 240 ml dinner)."

A review of R52's MARs (medication administration records), TARs (treatment administration records), and Point of Care records for April and May 2022 revealed no evidence of the exact amount of fluids R52 received on any shift, or for any 24 hour period in total.

On 5/4/22 at 4:34 p.m., CNA (certified nursing assistant) #2 was asked how she is informed if a resident is on a fluid restriction. She stated the nurse tells her. When asked if she records the amount of fluid a resident consumes during her shift, she stated she does not. She stated: "There is nowhere to record an amount." She stated she tells the nurse if she notices there is anything unusual about a resident's fluid consumption during her shift.

On 5/4/22 at 4:42 p.m., LPN (licensed practical nurse) #3 was interviewed. She stated a resident who is on a fluid restriction must have a doctor's order. She stated each resident on a fluid restriction has a block on the MAR (medication administration record) in which the nurse enters the total amount of fluid consumed by a resident during the shift. She stated she was not aware that anyone was calculating a total amount of fluid consumed in a 24 hour period for any resident. She stated the provider (nurse practitioner or physician) needed to be able to see the totals in order to make decisions about a resident's care. When shown R52's MARs for April and May 2022, she stated she did not see any fluid totals

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for any shifts. She stated the order must not have been entered correctly into the electronic medical record system. She stated usually a fluid restriction order automatically generates a place for the fluid amounts to be recorded on the MAR every shift.

On 5/5/22 at 12:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4 the vice president of clinical services, and ASM #6, the assistant administrator, were informed of these concerns.

On 5/5/22 at 2:03 p.m., LPN #11 stated the purpose of a resident's care plan is to instruct the facility staff on how to give the best care for the resident. LPN #11 stated all of his nursing care is based on the care plan.

A review of the facility policy, "Encouraging and Restricting Fluids," revealed, in part: "Follow specific instructions concerning fluid intake or restrictions...
Be accurate when recording fluid intake...Record fluid intake on the intake side of the intake and output record. Record fluid intake in mls."

No further information was provided prior to exit.

12. Facility staff failed to develop a comprehensive care plan for the use and care of a PICC line IV (intravenous) site; and for the use of side rails, for Resident #82.

Resident #82 was admitted to the facility on 3/31/22. On the most recent MDS (Minimum Data Set), an admission assessment with an

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ARD (Assessment Reference Date) of 4/2/22, Resident #82 scored 15 out of 15 on the BIMS (brief interview for mental status, indicating the resident was not cognitively impaired for making daily decisions). The resident was coded as requiring supervision for eating and extensive assistance for all other areas of activities of daily living.

On 5/03/22 at 2:44 PM and on 5/4/22 at 1:55 PM, Resident #82 was observed in bed with bilateral side rails up and an IV (intravenous) pole next to the bed for the administration of IV antibiotics.

A. IV care:

A review of the clinical record revealed the following physician's orders:

-An order dated 4/14/22 for Vancomycin (1) solution reconstituted 1.5 GM (gram), Use 1.5 gram intravenously in the morning for sacral and leg ulcer infections with MRSA (Methicillin-resistant Staphylococcus aureus); coccyx OM (osteomyelitis).

-An order dated 4/4/22 for Zosyn (2) solution reconstituted 3.375 (3-0.375) GM, Use 3.375 gram intravenously every 8 hours for sacral wound.

-Multiple orders dated 3/31/22 for the following: PICC (3) Line to right upper arm with double lumen every shift for facility protocol...monitor external catheter length...monitor insertion site for s/s (signs and symptoms) infections, infiltration, and complications...Change Primary IV tubing every 24 hours...Treatment for Right upper arm as needed for facility protocol change dressing

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using sterile central line dressing kit...change IV connection clave after blood draw...Treatment for Right upper arm every day shift every 2 day(s) change IV connection clave...Treatment for Right upper arm every day shift every 7 day(s) change dressing using sterile central line dressing kit, biopatch, and stat lock.

B. Side rails:

A review of the clinical record revealed a "Bed Rail Evaluation" dated 3/31/22 that documented the assessment for the use of side rails and that risk and benefits were explained and consent was provided. This assessment documented that the use of side rails was recommended.

A review of the comprehensive care plan revealed that neither of the above observed resident care needs and physician ordered interventions were care planned.

On 5/4/22 at 2:00 PM, an interview was conducted with LPN #8 (Licensed Practical Nurse). When asked what was the purpose of a care plan, they stated it was to guide the resident's care. When asked if a resident has a PICC line IV access, should the presence, care of, and medications related to the use of the PICC line be care planned, they stated that it should be. When asked if side rails should be care planned if a resident has them, they stated it should be.

On 5/5/22 at 12:59 PM an interview was conducted with ASM #6 (Administrative Staff Member), the Assistant Administrator. When asked what was the purpose of the care plan, they stated that it was so staff knows how to care

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for the resident. When asked who can develop or revise a care plan, they stated the MDS staff and nurses. When asked if the presence and care of a PICC line should be care planned, they stated it should be. When asked if the medications that are being administered via the PICC line should be care planned for side effects and adverse reactions, they stated they were not sure. When asked if the use of side rails should be care planned, they stated that side rails should be care planned.

On 5/5/22 at 9:10 a.m., an interview was conducted with RN #3 (Registered Nurse), the unit manager. RN #3 (Registered Nurse) stated that nursing built the care plan on admission and it was revised when there were new orders or changes in condition. RN #3 stated that the care plan guided them on how to provide care to the resident. RN #3 stated that the care plan included interventions for particular problems and how to provide the care. RN #3 stated that it was a roadmap of care for the resident.

On 5/5/2022 at 11:06 a.m., an interview was conducted with RN #2, the MDS director. RN #2 stated that new admissions had a baseline care plan created by the nursing staff. RN #2 stated that after the MDS assessment was completed there were triggers that they used to add focus areas to the care plan. RN #2 stated that they also reviewed the care plan to address any specific areas.

The facility policy, "Care Planning - Interdisciplinary Team" was reviewed. This policy documented, "Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized

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comprehensive care plan for each resident....A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS)...."

The facility policy, "Proper Use of Side Rails" was conducted. This policy documented, "...The use of side rails as an assistive device will be addressed in the resident care plan...."

On 5/4/22 at 5:18 PM, ASM #1 the Administrator, ASM #2 the Director of Nursing, ASM #3 the Vice President of Operations, ASM #4 Vice President of Clinical Services, and ASM #6 the Assistant Administrator, were made aware of the findings. No further information was provided.

References:

(1) Vancomycin is an antibiotic used to treat certain serious infections.
Information obtained from https://medlineplus.gov/druginfo/meds/a601167.html

(2) Zosyn is an antibiotic used to treat pneumonia and skin, gynecological, and abdominal infections.
Information obtained from https://medlineplus.gov/druginfo/meds/a694003.html

(3) PICC line is a peripherally inserted central catheter.
Information obtained from https://medlineplus.gov/ency/patientinstructions/000461.htm

13. Facility staff failed to develop a

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comprehensive care plan for the use of side rails for Resident #147.

Resident #147 was admitted to the facility on 6/11/22. On the most recent MDS (Minimum Data Set), a significant change assessment with an ARD (Assessment Reference Date) of 3/22/22, Resident #147 scored 8 out of 15 on the BIMS (brief interview for mental status, indicating the resident was cognitively impaired for making daily decisions. The resident was coded as requiring supervision for eating and extensive assistance for all other areas of activities of daily living.

On 5/03/22 at 2:59 PM and 5/4/22 at 1:55 PM, observations were made of Resident #147, who was in bed with bilateral side rails up.

A review of the clinical record revealed a "Bed Rail Evaluation" dated 6/11/21 that documented the assessment for the use of side rails and that risk and benefits were explained and consent was provided. This assessment documented that the use of side rails was recommended.

A review of the comprehensive care plan revealed that the use of side rails was not care planned.

On 5/04/22 at 2:00 PM, an interview was conducted with LPN (Licensed Practical Nurse) #8 . When asked what was the purpose of a care plan, they stated it was to guide the resident's care. When asked if side rails should be care planned if a resident has them, they stated it should be.

On 5/5/22 at 12:59 PM an interview was

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conducted with ASM #6 (Administrative Staff Member), the Assistant Administrator. When asked what was the purpose of the care plan, they stated that it was so staff knows how to care for the resident. When asked who can develop or revise a care plan, they stated the MDS staff and nurses. When asked if the use of side rails should be care planned, they stated that side rails should be care planned.

On 5/5/22 at 9:10 a.m., an interview was conducted with RN #3 (Registered Nurse), the unit manager. RN #3 stated that nursing built the care plan on admission and it was revised when there were new orders or changes in condition. RN #3 stated that the care plan guided them on how to provide care to the resident. RN #3 stated that the care plan included interventions for particular problems and how to provide the care. RN #3 stated that it was a roadmap of care for the resident.

On 5/5/2022 at 11:06 a.m., an interview was conducted with RN (Registered Nurse) #2, the MDS director. RN #2 stated that new admissions had a baseline care plan created by the nursing staff. RN #2 stated that after the MDS assessment was completed there were triggers that they used to add focus areas to the care plan. RN #2 stated that they also reviewed the care plan to address any specific areas.

The facility policy, "Care Planning - Interdisciplinary Team" was reviewed. This policy documented, "Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident.... A comprehensive care plan for each resident is

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developed within seven (7) days of completion of the resident assessment (MDS)...."

The facility policy, "Proper Use of Side Rails" was conducted. This policy documented, "...The use of side rails as an assistive device will be addressed in the resident care plan...."

On 5/4/22 at 5:18 PM, ASM #1 the Administrator, ASM #2 the Director of Nursing, ASM #3 the Vice President of Operations, ASM #4 Vice President of Clinical Services, and ASM #6 the Assistant Administrator, were made aware of the findings. No further information was provided.

14. Facility staff failed to develop a comprehensive care plan for the use of side rails for Resident #4.

Resident #4 was admitted to the facility on 6/3/16. On the most recent MDS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Date) of 4/30/22, Resident #4 was not able to be interviewed and was coded as being moderately cognitively impaired for making daily decisions on the staff interview. The resident was coded as requiring extensive to total assistance for all areas of activities of daily living.

On 5/03/22 at 2:51 PM and 5/4/22 at 1:55 PM, Resident #4 was observed in bed, with bilateral side rails up.

A review of the comprehensive care plan revealed that the use of side rails was not care planned.

Further review of the clinical record failed to reveal any evidence that an assessment and

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consent had been completed for the use of the side rails.

On 5/04/22 at 2:00 PM, an interview was conducted with LPN (Licensed Practical Nurse) #8. When asked what was the purpose of a care plan, they stated it was to guide the resident's care. When asked if side rails should be care planned if a resident has them, they stated it should be.

On 5/5/22 at 12:59 PM an interview was conducted with ASM (Administrative Staff Member) #6, the Assistant Administrator. When asked what was the purpose of the care plan, they stated that it was so staff knows how to care for the resident. When asked who can develop or revise a care plan, they stated the MDS staff and nurses. When asked if the use of side rails should be care planned, they stated that side rails should be care planned.

On 5/5/22 at 9:10 a.m., an interview was conducted with RN (Registered Nurse) #3, the unit manager. RN #3 stated that nursing built the care plan on admission and it was revised when there were new orders or changes in condition. RN #3 stated that the care plan guided them on how to provide care to the resident. RN #3 stated that the care plan included interventions for particular problems and how to provide the care. RN #3 stated that it was a roadmap of care for the resident.

On 5/5/2022 at 11:06 a.m., an interview was conducted with RN (Registered Nurse) #2, the MDS director. RN #2 stated that new admissions had a baseline care plan created by the nursing staff. RN #2 stated that after the MDS

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F 656	Continued From page 66 assessment was completed there were triggers that they used to add focus areas to the care plan. RN #2 stated that they also reviewed the care plan to address any specific areas. The facility policy, "Care Planning - Interdisciplinary Team" was reviewed. This policy documented, "Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident....A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS)...." The facility policy, "Proper Use of Side Rails" was conducted. This policy documented, "...The use of side rails as an assistive device will be addressed in the resident care plan...." On 5/5/22 at 12:33 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Vice President of Operations, ASM #4 Vice President of Clinical Services, and ASM #6 the Assistant Administrator, were made aware of the findings. No further information was provided.	F 656		
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 resident interview, staff interview,	F 658	1. Resident #52 order for Eliquis was	6/15/22

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F 658	Continued From page 67 facility document review, and clinical record review, it was determined that the facility staff failed to correctly transcribe an order according to professional standards of practice for one of 55 residents in the survey sample, Resident #52 (R52). The facility staff failed to accurately transcribe R52's order for Eliquis (1), which was held on 3/28/22. The findings include: On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/14/22, R52 was coded as having no cognitive impairment for making daily decisions. R52 was coded as receiving and anticoagulant on all seven days of the look back period. On 5/3/22 at 1:38 p.m., an interview was conducted with R52. R52 stated they had been diagnosed with atrial fibrillation (2) during a recent hospitalization. R52 stated the physician ordered Eliquis for the atrial fibrillation. R52 stated they underwent an outpatient skin graft procedure on 3/29/22. R52 stated the physician wanted the Eliquis held the day of the procedure, then restarted on 3/30/22. R52 stated the facility did not restart the Eliquis until "several days later." R52 stated they repeatedly asked for the Eliquis, but the nursing staff stated there was no order. A review of R52's physician's orders revealed the following: "Eliquis Tablet 5 MG (milligrams). Give 1 tablet by mouth two times a day...Monitor for bleeding, bruising, and black tarry stools. Start date 3/8/22. End date 3/28/22." A second physician's order for Eliquis was dated 4/5/22: "Eliquis Tablet 5 MG. Give 1 tablet by mouth two	F 658	corrected on 4/5/2022 by the Nurse Practitioner and had no adverse reactions from the delay in the order. 2. An audit will be conducted on residents receiving Eliquis by the Unit Manager or designee to verify if Eliquis medication ordered to hold the medication and a resume date to administer and were resumed and administered per physician order. 3. The Facility Educator or designee will in-service the Licensed Nursing staff with 1:1 education completed to LPN #3 on medication administration policy, 5 rights of medication administration, , accurately receiving medication orders, clarification of orders, and transcribing orders as received, the process for physician orders to hold medications -date to hold and a resume date to administer per physician order. 4. The Unit Manager or designee will conduct audits to verify new medication orders to ensure that orders are received, clarified, and transcribed accurately, physician orders for medications on hold, have a hold date and a resume date and administered per physician order. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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times a day for A Fib. Monitor for bleeding, bruising, and black tarry stools. Start date 4/5/22."

A review of R52's progress notes revealed the following nurse's note: "3/28/22 Note Text: Eliquis Tablet 5 MG. Give 1 tablet by mouth two times a day...Monitor for bleeding, bruising, and black tarry stools. On hold prior to an upcoming procedure on 3/29/22."

Further review of R52's clinical record revealed the following provider progress note dated 3/29/22: "Patient examined in the hall, returning from skin graft procedure...A fib (atrial fibrillation), stable, cont (continue)...Apixaban."

A review of R52's care plan dated 4/28/22 revealed, in part, the following: "Resident is on anticoagulant therapy r/t (related to) atrial fibrillation...Administer anticoagulant medications as ordered by physician."

On 5/3/2022 at 12:20 p.m., ASM (administrative staff member) #2, the director of nursing stated that the nursing standard of practice was Lippincott.

On 5/5/22 at 11:10 a.m., LPN (licensed practical nurse) #3 was interviewed. LPN #3 was the unit manager for R52's unit. LPN #3 stated R52 had independently scheduled the skin graft procedure, and the facility staff did not know about it until 3/28/22. She stated she contacted the NP (nurse practitioner) and obtained an order to hold the Eliquis on 3/28/22 in preparation for the procedure. She stated she did not enter the order correctly into the electronic medical record. She stated the provider gave instructions for the Eliquis to re-start on 3/30/22. She stated: "We

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should have started it right back." She stated she generally does a chart audit for all new orders on the unit, but she did not catch the error.

On 5/5/22 at 12:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4 the vice president of clinical services, and ASM #6, the assistant administrator, were informed of these concerns.

No further information was provided prior to exit.

According to "Fundamentals of Nursing- Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. Be sure to look for order duplications that could cause your patient to receive a medication in error...."

REFERENCES
(1) "Apixaban (Eliquis) is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease. Apixaban is also used to prevent deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in people who are having hip replacement or knee replacement surgery. Apixaban is also used to treat DVT and PE and may be continued to prevent DVT and PE from happening again after the initial treatment is completed. Apixaban is in a

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F 658	Continued From page 70 class of medications called factor Xa inhibitors. It works by blocking the action of a certain natural substance that helps blood clots to form." This information was taken from the website https://medlineplus.gov/druginfo/meds/a613032.html. (2) "Atrial fibrillation is one of the most common types of arrhythmias, which are irregular heart rhythms. Atrial fibrillation causes your heart to beat much faster than normal. Also, your heart's upper and lower chambers do not work together as they should. When this happens, the lower chambers do not fill completely or pump enough blood to your lungs and body. This can make you feel tired or dizzy, or you may notice heart palpitations or chest pain. Blood also pools in your heart, which increases your risk of forming clots and can leads to strokes or other complications. Atrial fibrillation can also occur without any signs or symptoms. Untreated fibrillation can lead to serious and even life-threatening complications." This information is taken from the website https://www.nhlbi.nih.gov/health-topics/atrial-fibrillation.	F 658		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of	F 679		6/15/22

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F 679	Continued From page 71 each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide activities per a resident's assessed interest for one of 55 residents in the survey sample, Resident #419 (R419). The facility staff failed to provide R419 with preferred activities of watching television or listening to music by leaving the resident seated in a wheelchair at the entrance to the dining room, adjacent to the nurses' station, sleeping and eating in public view, during the day and evening on 5/3/22 and 5/4/22. The findings include: On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/29/22, R419 was coded as having short term and long term memory problems, and as being severely impaired for making daily decisions. R419 was coded as requiring the extensive assistance of two staff members for transferring and moving around the unit. On the following dates and times, R419 was sitting in a wheelchair outside the dining room, adjacent to the nurse station. The wheelchair was in full public view: 5/3/22 at 2:08 p.m., 4:35 p.m., 6:17 p.m.; 5/4/22 at 7:15 a.m. (head bowed to the front and asleep), 7:51 a.m. (head bowed and asleep); 9:23 a.m. (breakfast tray on overbed table, breakfast uneaten, head bowed and asleep); 9:51 a.m. (head bowed and asleep);	F 679	1. Resident #419 activities preferences were updated on 5/15/2022. 2. An audit will be conducted by the Activities Director for current residents to ensure activity preferences are up to date. 1:1 Education provided to CNA# 2, OSM#17, and LPN #3 by the Activities Director on how to access the care plan for resident activity preferences. 3. The Facility Educator or designee will in-service the Activity staff, Licensed Nurses, CNAs on how to access resident care plans to find residents activity preferences and offering activity preferences if the residents is interested and/or willing. 4. The Activity Director will conduct observation audits on residents sitting at the nursing station to ensure residents activity preferences are being offered and documenting if resident preferences are being met or declines weekly x 4 then monthly x 2. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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12:02 p.m. (nurse practitioner examining resident); 1:40 p.m.; 2:17 p.m.; 5:15 p.m.; 6:00 p.m. (eating dinner).

A review of R419's care plan dated 3/28/22 revealed, in part: "The resident is dependent on staff...for meeting emotional, intellectual, physical and social needs r/t (related to) cognitive deficits, physical limitations...The resident will maintain involvement in cognitive stimulation, social activities as desired through review date...The resident's preferred activities are watching game shows and the news on TV, listening to music."

On 5/4/22 at 4:34 p.m., CNA (certified nursing assistant) #2 was interviewed. When asked if she is made aware of a resident's preferred activities, she stated she usually is not, especially if a resident is unable to tell her what the resident prefers.

On 5/4/22 at 4:43 p.m., LPN (licensed practical nurse) #3 was interviewed. She stated she does not usually reference a resident's preferred activities to determine what a resident might like to do during the day.

On 5/4/22 at 5:17 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4 the vice president of clinical services, and ASM #6, the assistant administrator, were informed of these concerns.

On 5/5/22 at 10:16 a.m., OSM (other staff member) #17, an activities assistant, was interviewed. OSM #17 he hands out a daily flyer listing the activities on that unit for the day. He

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stated he goes around to residents to inform them of group activities. He stated R419 had attended BINGO on 5/3/22, but had refused any group activities on 5/4/22. When asked if he was aware of R419's preferences for individual activities as documented on the care plan, he stated he was not. He stated he does not see the residents' care plans. He stated, however, that he knew R419 enjoyed TV, the news, and music. When asked if TV, the news, or music had been provided to R419 during the times the resident was in the wheelchair outside the dining room, he stated: "No. Those things were not done."

On 5/5/22 at 10:39 a.m., OSM #18, the activities director, was interviewed. OSM #18 stated when a resident is first admitted, an initial assessment is completed, usually by the activities assistant. She stated if a resident is not able to express their interests in an interview, she interviews the family. She stated she then verbally communicates what the family has said to the activities assistants. She stated the staff determines the resident's interests, their likes, and their dislikes. She stated in R419's case, the family was interviewed because the resident was cognitively able to answer those questions. She stated R419's family stated the resident enjoyed watching game shows and the news on TV, and listening to music. She stated if a resident is unengaged in group activities, or is in their room, "we would make sure the TV is on either to their preferred channel or to a music station." When asked if R419's activities care plan had been implemented on 5/3/22 and 5/4/22, she stated it was not. She stated the staff was not offering R419 individual activates according to the resident's preference.

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F 679	Continued From page 74 A review of the facility policy, "Individual Activities and Room Visit Program," revealed, in part: "Individual activities will be provided for those residents whose situation or condition prevents participation in other types of activities, and for those residents who do not wish to attend group activities...For those residents whose condition or situation prevents participation in group activities, and for those who do not wish to participate in group activities, the activities program provides individualized activities consistent with the overall goals of an effective activities program. Individualized activities offered are reflective of the resident's activity interests, as identified in the Activity Assessment, progress notes and the resident's Comprehensive Care Plan." No further information was provided prior to exit.	F 679		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to monitor a resident's fluid intake while on a fluid restriction for one of 55 residents in the survey sample, Resident #52 (R52). The facility	F 684	1. Resident #52 physician order was updated to include the ability for nurses to document fluid intake amount every shift on 5/4/2022. 2. An audit of residents on fluid	6/15/22

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F 684	Continued From page 75 staff failed to record in April and May 2022, the amount of fluid consumed each shift by R52, who was on a physician ordered fluid restriction . The findings include: On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/14/22, R52 was coded as having no cognitive impairment for making daily decisions. R52 was coded as receiving dialysis services during the look back period. On 5/3/22 at 1:38 p.m., an interview was conducted with R52. R52 stated that the resident was on a fluid restriction ordered by his physician. R52 also stated that sometimes they were not compliant with the restriction. When asked if staff members consistently asked how much fluids R52 had consumed in a shift, R52 stated: "No, almost never." A review of R52's physician's orders revealed the following order with a start date of 3/8/22: "Fluid Restriction every shift...1500 ml (milliliters) Total Per Day; Nursing 660 ml total (240 ml day shift, 240 ml evening shift, 180 ml night shift); Dietary 840 ml total (360 ml breakfast, 240 ml lunch, 240 ml dinner)." A review of R52's MARs (medication administration records), TARs (treatment administration records), and Point of Care records for April and May 2022 revealed no evidence of the exact amount of fluids R52 received on any shift, or for any 24 hour period in total. A review of R52's care plan dated 3/1/22 and	F 684	restriction will be conducted by the Unit Manager or designee to verify residents on a fluid restriction have documentation of fluid intake amounts on each shift. 3. The Facility Educator or designee will in-service the Licensed Nurses and CNA□s on accurately reporting fluid intake amounts every shift with documentation in the clinical record. Documentation of additional fluid intake amounts each shift when the resident is observed or verbalizes drinking more and not adhering to the fluid restriction. Residents that choose not to adhere to fluid restriction will have CP initiated, and/or updated, documented resident/RP education with understanding risk for fluid overload and complications etc. and MD/NP and dialysis unit will have documented notification by the Licensed Nurses of the resident not adhering to the fluid restriction. 4. Audits will be conducted by Unit Manager or designee to verify residents on fluid restrictions have fluid intake amounts documented each shift and residents that choose not to adhere to the fluid restriction have the additional amount of fluid intake documented on their clinical record weekly x 4 then monthly x 2. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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updated 4/24/22 revealed, in part: "Resident is on fluid restrictions...monitor fluid intake per MD orders."

On 5/4/22 at 4:34 p.m., CNA (certified nursing assistant) #2 was asked how she is informed if a resident is on a fluid restriction. She stated the nurse tells her. When asked if she records the amount of fluid a resident consumes during her shift, she stated she does not. She stated: "There is nowhere to record an amount." She stated she tells the nurse if she notices there is anything unusual about a resident's fluid consumption during her shift.

On 5/4/22 at 4:42 p.m., LPN (licensed practical nurse) #3 was interviewed. She stated a resident who is on a fluid restriction must have a doctor's order. She stated each resident on a fluid restriction has a block on the MAR (medication administration record) in which the nurse enters the total amount of fluid consumed by a resident during the shift. She stated she was not aware that anyone was calculating a total amount of fluid consumed in a 24 hour period for any resident. She stated the provider (nurse practitioner or physician) needed to be able to see the totals in order to make decisions about a resident's care. When shown R52's MARs for April and May 2022, she stated she did not see any fluid totals for any shifts. She stated the order must not have been entered correctly into the electronic medical record system. She stated usually a fluid restriction order automatically generates a place for the fluid amounts to be recorded on the MAR every shift.

On 5/5/22 at 12:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the

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F 684	Continued From page 77 director of nursing, ASM #3, the regional vice president of operations, ASM #4 the vice president of clinical services, and ASM #6, the assistant administrator, were informed of these concerns. A review of the facility policy, "Encouraging and Restricting Fluids," revealed, in part: "Follow specific instructions concerning fluid intake or restrictions... Be accurate when recording fluid intake...Record fluid intake on the intake side of the intake and output record. Record fluid intake in mls." No further information was provided prior to exit.	F 684		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and service for a complete dialysis [1] program for one of 55 residents in the survey sample, Residents #97 (R97). The facility staff failed to assess R97's dialysis access site for bruit and thrill per physician order. The findings include: (R97) was admitted to the facility with diagnoses	F 698	1. Resident #97 electronic treatment record was updated on 5/10/2022 to reflect evidence of documentation of resident #97 bruit and thrill being monitored every shift. 2. An Audit will be completed by the Unit Manager or designee on hemodialysis residents with dialysis fistula/graft sites to verify the resident has a physician order to monitor for bruit and thrill each shift and documented every	6/15/22

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F 698	Continued From page 78 included but were not limited to: end stage renal disease [2], dependent on renal dialysis. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 04/05/2022, the resident scored 2 (two) out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately impaired of cognition intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded (R97) for "Dialysis" while a resident. The physician's order sheet for (R97) documented in part, DIALYSIS: Hemodialysis Order set every shift Monitor AV (arterial/venous) fistula (3) to L (left) arm Monitor bruit and thrill (4). Order Date: 06/11/2021. Start Date: 06/11/2021." and "Hemodialysis Diagnosis: ESRD(end stage renal disease) Dialysis Days and Time: M/W/F (Monday/Wednesday/Friday) Pick up time: 0600 (6:00 a.m.). Date: 06/11/2021. Start Date: 06/11/2021." The comprehensive care plan for (R97) with a revision date of 04/08/2022 documented in part, "Focus: The resident has hemodialysis r/t (related to) End stage renal disease. Dialysis Days and Time: M/W/F @ 0630 (6:30 a.m.) Pick up time: 0600. Date Initiated: 04/08/2022." Under "Interventions/Tasks" it documented in part, "Access fistula site for positive bruit /thrill as ordered. Date Initiated: 07/13/2021." The facility's progress notes for (R97) dated 05/02/2022 through 05/05/05/2022 revealed documentation of (R97's) bruit and thrill being checked on 05/02/2022 at 3:01 p.m. and on 05/04/2022 at 2:21 p.m. Further review of the	F 698	shift the bruit and thrill is functional. 3. The Facility Educator or designee will in-service the Licensed Nurses on the process for transcribing a physician order for monitoring the dialysis fistula/graft site for bruit and thrill with documentation to verify the dialysis fistula/graft site was monitored for bruit and thrill and is functional each shift. 4. The Unit Managers or designee will conduct audits on residents with a dialysis fistula/graft site to verify has a physician order for monitoring bruit and thrill each shift with documentation completed weekly audit x4 weeks and monthly x2 months. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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progress notes failed to evidence documentation of (R97's) bruit and thrill being checked on 05/02/2022 during the 7:00 a.m. to 3:00 p.m. and 11:00 p.m. to 7:00 a.m. shifts; 05/04/2022 during the 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. shifts; and on 05/03/2022 and 05/05/2022 during the 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. shifts.

The eTAR [electronic treatment record] for (R97) dated May 2022 failed to evidence documentation of (R97's) bruit and thrill being checked on the dates listed above.

On 05/04/2022 at approximately 4:00 p.m., an interview was conducted with LPN (licensed practical nurse) # 12. When asked about documenting that (R97's) bruit and thrill was being checked according to the physician's orders LPN # 12 stated that it is checked but they do not document it anywhere. When asked how it could be evidenced that (R97's) bruit and thrill was being checked LPN # 12 stated that if it was not documented they could not say it was done.

On 05/04/2022 at approximately 5:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 3, vice president of operations, ASM# 4, vice president of clinical services and ASM # 6, assistant administrator, were made aware of the findings.

No further information was presented prior to exit.

References:
(1) Dialysis treats end-stage kidney failure. It removes waste from your blood when your

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F 698	Continued From page 80 kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000707.htm. (2) The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm. (3) An abnormal connection between two body parts, such as an organ or blood vessel and another structure. Fistulas are usually the result of an injury or surgery. This information was obtained from the website: https://medlineplus.gov/ency/article/002365.htm (4) When you slide your fingertips over the site you should feel a gentle vibration, which is called a "thrill." Another sign is when listening with a stethoscope a loud swishing noise will be heard called a "bruit." If both of these signs are present and normal, the graft is still in good condition. This information was obtained from the website: https://www.vascularhealthclinics.org/institutes-divisions/vascular-surgery-and-medicine/dialysis-access/#:~:text=When%20you%20slide%20your%20fingertips,is%20still%20in%20good%20condition.	F 698		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If	F 700		6/15/22

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F 700	Continued From page 81 a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement bed rail requirements for 6 of 55 residents in the survey sample, Residents #368, #144, #50, #132, #4 and #147. The findings include: 1. The facility staff implemented bed rails for Resident #368 (R368) without a recommended need and failed to obtain informed consent for the use of bed rails. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/26/22, the resident scored 14 out of 15 on the BIMS (brief interview for mental	F 700	1. Resident #368 has been discharged from the facility. Resident #144 did not have any negative outcome from the bedrail evaluation not being completed. Resident # 144 bed rail evaluation was completed on 05/12/2022. Based on bedrail evaluation, resident #144 is a candidate for left side ¿ bedrail as an enabler. Risk/benefits of bedrail including entrapment reviewed with resident #144 and RP. Consent collected, MD orders were obtained for use of bed rail and bedrail care plan updated to reflect use of left side ¿ bedrail to act as an enabler to maintain independence with bed mobility.	

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F 700	Continued From page 82 status), indicating the resident is not cognitively impaired for making daily decisions. A review of R368's clinical record revealed a bed rail evaluation dated 4/19/22. The evaluation documented, "20. Is the use of bed rail(s) likely to increase the risk of an accident or pose as a barrier for this patient? (i.e. Is it likely that the resident might attempt to climb over, around or between the rails, exit the bed in an unsafe manner or be at risk of getting caught in between the rails or the rails and the mattress etc.) Yes...23. Recommendations: Based on the above evaluation, determination is as follows: b. Bed rails are not indicated or recommended at this time..." A review of R368's May 2022 physician's orders failed to reveal an order for bed rails. R368's baseline care plan dated 4/19/22 failed to reveal documentation regarding bed rails. Further review of R368's clinical record failed to reveal documentation that informed consent for the use of bed rails was obtained. On 5/3/22 at 2:20 p.m. and 5/4/22 at 9:38 a.m., R368 was observed lying in bed with bilateral quarter bed rails in the upright position. On 5/4/22 at 3:58 p.m., OSM (other staff member) #3 (the director of rehab) stated she could not find any therapy evaluations or consents for R368's bed rails. On 5/4/22 at 4:43 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (the nurse who completed R368's bed rail evaluation). LPN #3 stated a bed rail assessment is included on a form that is completed upon a	F 700	Resident #50 did not have any negative outcome. Resident #50 bed rail evaluation was completed on 05/12/2022. Risks/benefits of bedrail including entrapment reviewed with resident #50. Resident is own RP. Care plan updated to reflect use of bed rail.Resident #132 did not any negative outcome. Resident #132 bed rail evaluation was completed on 05/12/2022 and care plan updated. Risks/benefits of bedrail including entrapment reviewed with resident #132. Resident is her own RP. Resident #4 did not have any negative outcome. Resident #4 bed rail evaluation/assessment was completed on 05/12/2022. Resident #4 does not meet criteria for use of bedrail.Risks/benefits of bedrail including entrapment reviewed with resident #4 and RP. Bed rail order was discontinued. Resident #147 did not have any negative outcome. Bedrail assessment/evaluation was completed on 5/12/2022 for resident #147. Assessment indicates resident requires the use of bedrail as an enabler. Risks/benefits of bedrail including entrapment reviewed with resident #147 and RP. 2. The Unit Managers/Designee will conduct an audit of current residents to verify documentation was complete and accurate on the bedrail assessment to determine continue need for bedrail, request for bedrails with education of risk and benefits, consent with documentation	

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resident's admission. LPN #3 stated the nurses assess if bed rails would benefit a resident or deter and restrict a resident. LPN #3 stated informed consent is obtained if bed rails are deemed a benefit for a resident. LPN #3 stated that although the nurses complete a bed rail assessment upon admission, the therapy staff usually completes a secondary assessment. In regards to R368's bed rail assessment, LPN #3 stated that after she completed her assessment and after speaking with R368, LPN #3 believed R368 did not need bed rails and therefore, she did not obtain informed consent.

On 5/4/22 at 5:20 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Proper Use of Side Rails" documented, "3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails...9. Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks..."

No further information was presented prior to exit.
2. The facility staff failed to evidence that Resident #144 had the risks / benefits reviewed for use of side rails.

Resident #144 was observed in bed with right side one quarter bed rails on 5/3/22 on initial resident observation at 1:00 PM, 5/3/22 at 4:45 PM and 5/4/22 at 8:15 AM.

Resident #144 was admitted to the facility on 4/7/22. Resident #144's diagnoses included but

obtained from the resident (as able) and RP, a physician order obtained for use of bedrails and the care plan was initiated or updated for bedrail use or discontinuation of bedrails.

3. The Facility Educator or designee will in-service the Licensed Nurses on the facility bed rail policy and on the process for documentation ,completion of the bedrail assessment in the resident evaluation form or bedrail assessment form, conducted on new admits , as needed for changes and quarterly the bedrail assessment includes education for the resident (as able) and RP with risks and benefits of bedrail use for bed mobility, not used as a restraint and including risk for entrapment ,the consent for bedrails will be obtained from the resident (as able) and the RP and completed on the bedrail assessment to verify the resident (as able) and the RP agreed to the plan of care for bedrails for application and discontinuation , obtain a physician order for use of bedrails and care plan initiated, updated or discontinued for bedrail use.

4. The Unit Managers or designee will conduct audits on residents with new orders or request for bed rails to verify a bed rail assessment, consent obtained from resident (as able)/RP with education for risk and benefits documented and completed, and a physician order for bedrails obtained, care plan for bedrails initiated, updated, or discontinued weekly x 4 then monthly x 2. The audit findings

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were not limited to: metabolic encephalopathy, diabetes, dementia, retention of urine and urinary tract infection.

Resident #144's most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an assessment reference date of 4/9/22, coded the resident as scoring a 9 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. MDS Section G- Functional Status: coded the resident as requiring extensive assistance for bed mobility, transfers, walking/locomotion, dressing and personal hygiene/bathing; the resident is independent for eating.

A review of Resident #144's comprehensive care plan dated 5/4/22, documents in part, "FOCUS- Use of Right side 1/4 rails for enhancement of self-mobility and repositioning while in bed. INTERVENTIONS- Check side rails during safety check"

A review of the physician orders dated 5/3/22, which revealed, "Right side 1/4 (one quarter) side rails while in bed to enable mobility."

A request was made on 5/3/22 at approximately 4:41 PM for the bed rail assessment and consent for Resident #144.

Bed rail assessments and consent were provided on 5/4/22 at 9:15 AM.

A review of the "Bed Rail Evaluation" for Resident #144 was dated 5/3/22 at 6:38 PM and revealed "Bed rail(s) is/are recommended at this time." The care plan and bed rail assessment were not

will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months

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updated at the time of the physician order nor prior to the survey start date

An interview was conducted on 5/3/22 at 4:45 PM with Resident #144. When asked if he used the side rail, Resident #144 stated, yes, I use it to turn over.

On 5/4/22 at 1:35 PM, an interview was conducted with RN (registered nurse) #3. When asked who assesses the resident and obtains consent for use of bed rails, RN #3 stated, nursing does the initial assessment and obtains consent. Therapy comes after that and does another assessment.

An interview was conducted on 5/4/22 at 4:44 PM with LPN (licensed practical nurse) #3. When asked who conducts the bed rail assessment, LPN #3 stated, we do the assessment on admission, to see if the bed rails benefit them or would be a restraint. We provide information and get consent, this is reviewed by the therapy department and they do a second assessment. Therapy has the final say on whether the patient can benefit from bed rails. We also obtain informed consent and educate. We are the first line of defense and we educate and get consent. We make sure the education and consent are done.

On 5/4/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator, ASM #3, the regional vice president of operations, ASM #4, the vice president of clinical services and ASM #6, the assistant administrator were made aware of the above concerns

The facility's "Proper Use of Side Rails" policy

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dated 12/16, which reveals, "The risks and benefits of side rails will be considered for each resident. Consent for the side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks."

No further information was provided prior to exit.

3. The facility staff failed to evidence that Resident #50 had the risks / benefits reviewed for the use of side rails.

Resident #50 was observed in bed with right side one quarter rails on 5/3/22 on initial resident observation at 1:30 PM, 5/3/22 at 5:00 PM and 5/4/22 at 8:30 AM.

Resident #50 was admitted to the facility on 3/9/22. Resident #50's diagnoses included but were not limited to: cervical, sternal and tibial fractures, spinal stenosis and urine retention.

Resident #50's most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an assessment reference date of 3/16/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. MDS Section G- Functional Status: coded the resident as requiring extensive assistance for bed mobility, transfers, walking/locomotion, eating, dressing and personal hygiene/bathing.

A review of Resident #50's comprehensive care plan dated 5/4/22, documents in part, "FOCUS- Resident uses 1/4 rails for enhancement of self-mobility and repositioning.
INTERVENTIONS- Check side rails during safety

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check"

A review of the physician orders dated 5/3/22, which revealed, "Bilateral 1/4 side rails while in bed to enable mobility."

A request was made on 5/3/22 at approximately 4:41 PM for the bed rail assessment and consent for Resident #50.

Bed rail assessments and consent were provided on 5/4/22 at 9:15 AM. The care plan, consent and bed rail assessment were not updated at the time of the physician order nor prior to the survey start date

A review of the "Bed Rail Evaluation" for Resident #50 was dated 5/3/22 at 7:43 PM and revealed "Bed rail(s) is/are recommended at this time."

An interview was conducted on 5/3/22 at 1:30 PM with Resident #50. When asked if he used the side rail, Resident #50 stated, yes, they make me feel safe.

On 5/4/22 at 1:35 PM, an interview was conducted with LPN (licensed practical nurse) #5. When asked who assesses the resident and obtains consent for use of bed rails, LPN #5 stated, nursing does the initial assessment and obtains consent. Then therapy comes after that and does another assessment.

An interview was conducted on 5/4/22 at 4:44 PM with LPN (licensed practical nurse) #3. When asks who conducts the bed rail assessment, LPN #3 stated, we do the assessment on admission, to see if the bed rails benefit them or would be a restraint. We provide information and get

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consent, this is reviewed by the therapy department and they do a second assessment. Therapy has the final say on whether the patient can benefit from bed rails. We also obtain informed consent and educate. We are the first line of defense and we educate and get consent. We make sure the education and consent are done.

On 5/4/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator, ASM #3, the regional vice president of operations, ASM #4, the vice president of clinical services and ASM #6, the assistant administrator were made aware of the above concerns

The facility's "Proper Use of Side Rails" policy dated 12/16, which reveals, "The risks and benefits of side rails will be considered for each resident. Consent for the side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks."

No further information was provided prior to exit.

4. The facility staff failed to evidence that Resident #132 had the risks / benefits reviewed for the use of side rails.

Resident #132 was observed in bed with right side one quarter rails on 5/3/22 on initial resident observation at 1:10 PM, 5/3/22 at 4:30 PM and 5/4/22 at 8:20 AM.

Resident #132 was admitted to the facility on 4/13/22. Resident #50's diagnoses included but were not limited to: aortic valve insufficiency, sacral fracture post fall, left artificial hip and atherosclerotic cardiovascular disease.

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Resident #132's most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an assessment reference date of 4/20/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. MDS Section G- Functional Status: coded the resident as requiring extensive assistance for bed mobility, transfers, walking/locomotion, dressing and personal hygiene/bathing; supervision for eating.

A review of Resident #132's comprehensive care plan dated 5/4/22, documents in part, "FOCUS- Use Bilateral 1/4 rails for enhancement of self-mobility and repositioning while in bed as related to fracture on the sacrum. INTERVENTIONS- Check side rails during safety check"

A review of the physician orders dated 5/3/22, which revealed, "Bilateral 1/4 side rails while in bed to enable mobility."

A request was made on 5/3/22 at approximately 4:41 PM for the bed rail assessment and consent for Resident #50.

Bed rail assessments and consent were provided on 5/4/22 at 9:15 AM. The care plan, consent, and bed rail assessment were not updated at the time of the physician order nor prior to the survey start date

A review of the "Bed Rail Evaluation" for Resident #132 was dated 5/3/22 at 6:33 PM and revealed "Bed rail(s) is/are recommended at this time."

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An interview was conducted on 5/3/22 at 1:10 PM with Resident #132. When asked if he used the side rail, Resident #132 stated, yes, they make me feel safe.

On 5/4/22 at 1:35 PM, an interview was conducted with RN (registered nurse) #3. When asked who assesses the resident and obtains consent for use of bed rails, RN #3 stated, nursing does the initial assessment and obtains consent. Therapy comes after that and does another assessment.

An interview was conducted on 5/4/22 at 4:44 PM with LPN (licensed practical nurse) #3. When asks who conducts the bed rail assessment, LPN #3 stated, we do the assessment on admission, to see if the bed rails benefit them or would be a restraint. We provide information and get consent, this is reviewed by the therapy department and they do a second assessment. Therapy has the final say on whether the patient can benefit from bed rails. We also obtain informed consent and educate. We are the first line of defense and we educate and get consent. We make sure the education and consent are done.

On 5/4/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator, ASM #3, the regional vice president of operations, ASM #4, the vice president of clinical services and ASM #6, the assistant administrator were made aware of the above concerns

The facility's "Proper Use of Side Rails" policy dated 12/16, which reveals, "The risks and benefits of side rails will be considered for each resident. Consent for the side rail use will be

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obtained from the resident or legal representative, after presenting potential benefits and risks."

No further information was provided prior to exit.

5. Facility staff failed to conduct an assessment and evaluation and obtain a consent for the use of side rails for Resident #4.

Resident #4 was admitted to the facility on 6/3/16. On the most recent MDS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Date) of 4/30/22, Resident #4 was not able to be interviewed and was coded as being moderately cognitively impaired for making daily decisions on the staff interview. The resident was coded as requiring extensive to total assistance for all areas of activities of daily living.

On 5/03/22 at 2:51 PM and 5/4/22 at 1:55 PM, Resident #4 was observed in bed, with bilateral 1/2 side rails up.

A review of the clinical record failed to reveal any evidence of an assessment and evaluation, and consent for the use of side rails.

On 5/5/22 at 3:33 PM, ASM #6 (Administrative Staff Member) the Assistant Administrator, stated that there was no evidence of an assessment and evaluation and consent for the use of side rails.

On 5/04/22 at 2:00 PM, an interview was conducted with LPN #8 (Licensed Practical Nurse). When asked if a resident should have an assessment/evaluation and consent for the use of side rails before implementing them, they stated that it should be completed prior to using side rails.

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The facility policy, "Proper Use of Side Rails" was conducted. This policy documented, "...An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails...Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks..."

On 5/5/22 at 12:33 PM, ASM #1 the Administrator, ASM #2 the Director of Nursing, ASM #3 the Vice President of Operations, ASM #4 Vice President of Clinical Services, and ASM #6 the Assistant Administrator, were made aware of the findings. No further information was provided.

6. Facility staff failed to remove side rails after the most recent assessment and evaluation documented that side rails were not recommended for Resident #147.

Resident #147 was admitted to the facility on 6/11/22. On the most recent MDS (Minimum Data Set), a significant change assessment with an ARD (Assessment Reference Date) of 3/22/22, Resident #147 scored 8 out of 15 on the BIMS (brief interview for mental status, indicating the resident was cognitively impaired for making daily decisions. The resident was coded as requiring supervision for eating and extensive assistance for all other areas of activities of daily living.

On 5/03/22 at 2:59 PM and 5/4/22 at 1:55 PM, observations were made of Resident #147, who was in bed with bilateral side rails up.

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F 700	Continued From page 93 A review of the clinical record revealed a "Bed Rail Evaluation" dated 6/11/21 that documented the assessment for the use of side rails and that risk and benefits were explained and consent was provided. This assessment documented that the use of side rails was recommended. However, further review of the clinical record revealed the most recent "Bed Rail Evaluation" dated 3/11/22 which documented that the use of side rails was not recommended. The resident was observed to be still using them. On 5/04/22 at 2:00 PM, an interview was conducted with LPN #8 (Licensed Practical Nurse). When asked if a side rail assessment revealed that side rails were not recommended, should the resident have them, they stated the side rails should not be used. On 5/4/22 at 5:18 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Vice President of Operations, ASM #4 Vice President of Clinical Services, and ASM #6 the Assistant Administrator, were made aware of the findings. No further information was provided.	F 700		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		6/15/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 94 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to have medications available for administration to the resident in a timely manner for one of 55 residents in the survey sample, Resident #52 (R52). The facility staff failed to have R52's scheduled medications available for administration on 4/14/22, 4/24/22, and 4/26/22. The findings include: On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment	F 755	1. Resident #52 medications have been ordered and are available in the medication cart for administration per scheduled time. 2. An Audit conducted by the Unit Manager on current resident□s medications to verify medications are available in the medication cart and administered per scheduled times and if unavailable the MD/NP notified with the request for alternative medication if appropriate and Resident/RP notified of medication changes with documentation.	

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F 755	Continued From page 95 reference date) of 3/14/22, R52 was coded as having no cognitive impairment for making daily decisions. R52 was coded as receiving dialysis services and as receiving insulin injections during the look back period. On 5/3/22 at 1:38 p.m., an interview was conducted with R52. R52 stated that during the previous few weeks, the resident did not receive medications related to diabetes and to dialysis because they were not in the medication cart for the nurse to administer. A review of R52's clinical record revealed the following order with a start date of 3/26/22: "Liraglutide (Victoza) (1) Solution Pen Injector...Inject 1.8 mg (milligrams) subcutaneously one time a day for dm2 (diabetes mellitus type 2)." A review of R52's MARs (medication administration records) revealed the medication was not available for administration on 4/24/22 and 4/26/22. On 4/25/22 the resident was at dialysis, and was not in the facility at the time the medication was due. A progress note dated 4/24/22 documented: "4/24/2022 6:11 p.m. Orders - Administration Note Text: Liraglutide Solution Pen-injector 18 MG/3ML...pending." A progress note dated 4/26/22 documented: "4/26/2022 9:19 p.m. Orders - Administration Note Text: Liraglutide Solution Pen-injector 18 MG/3ML...Call placed to [name of pharmacy], spoke to [name of pharmacist], stated medicine will be delivered this in the morning." Further review of R52's clinical record revealed the following order with a start date of 3/15/22: "Auryxia (2) Tablet 1 GM (gram) 210 mg Fe (Iron)...Give 2 tablets by mouth three times a day for hyperphosphatemia (too much phosphorus in	F 755	3. The Facility Educator or designee will in-service the Licensed Nurses on the process for re-ordering medications to ensure residents have medication available for administration at the scheduled times, if not available the MD/NP notified of unavailable medication and request for an alternative medication to administer if appropriate. Any new medication changes the resident/Rp will be notified with documentation. 4. Audits will be conducted by the Unit Manager to verify medication has been re-ordered and are available, if medication unavailable the MD/RP notified with request for an alternative medication to administer if appropriate weekly x 4 weeks, then monthly x 2. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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the blood), dialysis pt (patient)." A review of R52's MARs revealed the medication was not available for administration on 4/14/22 at 12:00 p.m. and 5:00 p.m. A progress note dated 4/14/22 documented: "4/14/2022 12:11 p.m. Orders - Administration Note Text: Auryxia Tablet 1 GM 210 MG (Fe)...all placed to [name of pharmacy], spoke to [name of pharmacist], stated 'medication will be delivered this evening.'"

Further review of R52's clinical record revealed the following order with a start date of 4/26/22: "Trulicity (3) Solution Pen Injector...Inject 0.5 ml (milliliters) subcutaneously one time a day every Tue (Tuesday) for DM2." A review of R52's MAR and progress notes revealed the medication was not available for administration on 4/26/22. A progress note dated 4/26/2022 at 11:08 a.m. documented: "Orders - Administration Note Text: Trulicity Solution Pen-injector 3 MG/0.5ML...Pending, call placed to [name of pharmacy], spoke to [name of pharmacist] stated 'medicine will be delivered this evening.'" There was no progress note MAR entry indicating the Trulicity was administered at all on 4/26/22.

A review of R52's care plan dated 3/11/22 revealed, in part: "Diabetes medication as ordered by the doctor."

A review of the facility's list of medications available at all times from a mechanized dispenser for administration to residents revealed none of the three medications listed above was available on site for administration by nurses to R52.

On 5/4/22 at 4:43 p.m., LPN (licensed practical nurse) #3 was interviewed. She stated if a

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medication is not available in the medication cart, she would check the mechanical medication dispenser to see if the medication is available there. She stated if the medication is not there, she would call the pharmacy and ask for an immediate delivery. She stated if the medication was for a diabetic, the physician should be contacted, and new orders requested. She stated: "A diabetic needs their medication. Period." She stated she would document the physician notification in the progress notes.

Attempts to interview the pharmacists who processed these medication/refill requests were unsuccessful during the survey.

On 5/5/22 at 12:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4 the vice president of clinical services, and ASM #6, the assistant administrator, were informed of these concerns.

A review of the facility policy, "Unavailable Medications," revealed, in part: "Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure that medications are available to meet the needs of each resident...B.Nursing staff shall...Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that

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F 755	Continued From page 98 are available." No further information was provided prior to exit. REFERENCES (1) "Liraglutide injection (Victoza) is used with a diet and exercise program to control blood sugar levels in adults and children 10 years of age and older with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) when other medications did not control levels well enough." This information was taken from the website https://medlineplus.gov/druginfo/meds/a611003.html. (2) "Ferric citrate (Auryxia) is used to control high blood levels of phosphorus in people with chronic kidney disease who are on dialysis (medical treatment to clean the blood when the kidneys are not working properly)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a622004.html. (3) "Dulaglutide (Trulicity) injection is used with a diet and exercise program to control blood sugar levels in adults with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a614047.html.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		6/15/22

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F 760	Continued From page 99 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure one of 55 residents in the survey sample Resident #52 (R52) was free from a significant medication error. The facility staff failed to administer Eliquis (1) as ordered after the "hold" period related to a procedure ended. The findings include: On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/14/22, R52 was coded as having no cognitive impairment for making daily decisions. R52 was coded as receiving and anticoagulant on all seven days of the look back period. On 5/3/22 at 1:38 p.m., an interview was conducted with R52. R52 stated they had been diagnosed with atrial fibrillation (2) during a recent hospitalization. R52 stated the physician ordered Eliquis for the atrial fibrillation. R52 stated they underwent an outpatient skin graft procedure on 3/29/22. R52 stated the physician wanted the Eliquis held the day of the procedure, then restarted on 3/30/22. R52 stated the facility did not restart the Eliquis until "several days later." R52 stated they repeatedly asked for the Eliquis, but the nursing staff stated there was no order. A review of R52's physician's orders revealed the	F 760	1. Resident #52 medication reconciliation was completed and is receiving his Eliquis per Physician□s order. 2. Audit conducted by the Unit Manager for residents on anticoagulants to verify physician orders to hold anticoagulant medications are held and/or resumed and administered per physician order. 3. The Facility Educator or designee will in-service the Licensed Nurses on the process for transcription of physician orders to hold medication such as anticoagulants etc. and when to resume the medication have dates on the EMAR to administer the medication per physician□s order and the order is transcribed accurately. 4. Audits will be conducted by Unit Manager or designee to verify residents with orders for Eliquis are transcribed accurately and resumed per physician order if placed on hold. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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following: "Eliquis Tablet 5 MG (milligrams). Give 1 tablet by mouth two times a day...Monitor for bleeding, bruising, and black tarry stools. Start date 3/8/22. End date 3/28/22." A second physician's order for Eliquis was dated 4/5/22: "Eliquis Tablet 5 MG. Give 1 tablet by mouth two times a day for A Fib. Monitor for bleeding, bruising, and black tarry stools. Start date 4/5/22."

A review of R52's progress notes revealed the following nurse's note: "3/28/22 Note Text: Eliquis Tablet 5 MG. Give 1 tablet by mouth two times a day...Monitor for bleeding, bruising, and black tarry stools. On hold prior to an upcoming procedure on 3/29/22."

Further review of R52's clinical record revealed the following provider progress note dated 3/29/22: "Patient examined in the hall, returning from skin graft procedure...A fib (atrial fibrillation), stable, cont (continue)...Apixaban."

A review of R52's care plan dated 4/28/22 revealed, in part, the following: "Resident is on anticoagulant therapy r/t (related to) atrial fibrillation...Administer anticoagulant medications as ordered by physician."

On 5/3/2022 at 12:20 p.m., ASM (administrative staff member) #2, the director of nursing stated that the nursing standard of practice was Lippincott.

On 5/5/22 at 11:10 a.m., LPN (licensed practical nurse) #3 was interviewed. LPN #3 was the unit manager for R52's unit. LPN #3 stated R52 had independently scheduled the skin graft procedure, and the facility staff did not know about it until 3/28/22. She stated she contacted

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the NP (nurse practitioner) and obtained an order to hold the Eliquis on 3/28/22 in preparation for the procedure. She stated she did not enter the order correctly into the electronic medical record. She stated the provider gave instructions for the Eliquis to re-start on 3/30/22. She stated: "We should have started it right back." She stated she generally does a chart audit for all new orders on the unit, but she did not catch the error.

On 5/5/22 at 12:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4 the vice president of clinical services, and ASM #6, the assistant administrator, were informed of these concerns.

No further information was provided prior to exit.

According to "Fundamentals of Nursing- Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. Be sure to look for order duplications that could cause your patient to receive a medication in error...."

REFERENCES
(1) "Apixaban (Eliquis) is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease. Apixaban is also used to prevent deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary

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F 760	Continued From page 102 embolism (PE; a blood clot in the lung) in people who are having hip replacement or knee replacement surgery. Apixaban is also used to treat DVT and PE and may be continued to prevent DVT and PE from happening again after the initial treatment is completed. Apixaban is in a class of medications called factor Xa inhibitors. It works by blocking the action of a certain natural substance that helps blood clots to form." This information was taken from the website https://medlineplus.gov/druginfo/meds/a613032.html. (2) "Atrial fibrillation is one of the most common types of arrhythmias, which are irregular heart rhythms. Atrial fibrillation causes your heart to beat much faster than normal. Also, your heart's upper and lower chambers do not work together as they should. When this happens, the lower chambers do not fill completely or pump enough blood to your lungs and body. This can make you feel tired or dizzy, or you may notice heart palpitations or chest pain. Blood also pools in your heart, which increases your risk of forming clots and can leads to strokes or other complications. Atrial fibrillation can also occur without any signs or symptoms. Untreated fibrillation can lead to serious and even life-threatening complications." This information is taken from the website https://www.nhlbi.nih.gov/health-topics/atrial-fibrillation.	F 760		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must-	F 803		6/15/22

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F 803	Continued From page 103 §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide food per the dietician's recommendation, and failed to serve food that matched the published menu for one of 55 residents in the survey sample, Resident #52 (R52). At lunch on 5/3/22 and 5/4/22, R52 did not receive double portions per the dietician's recommendation; R52's food items did not match the published menu and meal ticket. The findings include:	F 803	1. Resident #52 is receiving meals that match the therapeutic diet menu, diet order, patient preference and meal ticket. 2. All residents with have the potential to be affected. An audit conducted by the Dietary Director on current residents to verify they are receiving meals that match the therapeutic menu, patient preference, diet order and meal ticket. 3. The Dietary Director will in-service the Dietary Staff on the process to ensure residents are receiving meals that match	

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F 803	Continued From page 104 On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/14/22, R52 was coded as having no cognitive impairment for making daily decisions. R52 was coded as being on a therapeutic diet, and as receiving dialysis services during the look back period. On 5/3/22 at 1:38 p.m., Resident #52 (R52) was interviewed. R52 had multiple complaints about food served to him. R52 stated the dietary staff consistently failed to provide double portions, as recommended by the dietician. R52 stated the food on the meal tray frequently did not match the published meal ticket. On 5/3/22 at 5:55 p.m., R52's interview was completed. R52's dinner tray was delivered. R52 lifted the cover. The meal tray contained the following food: two small pieces of baked fish, each less than 1/4 inch thick, approximately 3 inches in length, approximately, two inches in width; approximately 1/3 cup of green peas with 4 pieces of small chopped onion, 1 boiled egg, a pack of saltines, fresh fruit salad, and a white roll. The meal ticket documented the tray should contain cranberry juice, but there was none on the tray. The meal ticket documented the tray should contain a wheat roll and double portions. On 5/4/22 at 1:40 p.m., R52 was seated in the wheelchair beside the bed. R52's lunch tray was on the overbed table. R52 lifted the cover. The meal tray contained the following food: one medium chicken leg, approximately 1/3 cup of mixed vegetables, a boiled egg, a four inch square of cornbread, a bowl containing approximately 1/2 cup of lettuce, four slices of cucumbers, and eight pieces of diced tomatoes.	F 803	the therapeutic diets, resident food preferences, likes and dislikes, diet order and meal ticket match the tray and double portions servings. Residents who request foods that not on their diet and request foods that are their dislike preferences will inform the Dietary Manager or Dietitian or Nursing management regarding request that are not consistent to diet per physician order or dietitian recommendations and/or request food on resident□s dislikes preferences to update care plan for these request that are not consistent to diet and prior dislike preferences. 4. Audits will be conducted by the Dietary Director or designee for t residents to verify therapeutic diet menu, resident likes and dislike preferences, diet order and meal tickets match the tray when served and accurate serving size of double portion on meal tray weekly x 4 weeks then monthly x 2. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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The meal ticket stated the tray should contain angel food cake, but there was none on the tray. The resident's meal ticket documented: "Tossed Salad - NO tomatoes...Double Portions."

A review of R52's clinical record revealed a Nutritional Evaluation dated 3/9/22, following R52's most recent readmission. This evaluation documented, in part: "Additional notes from interview...Resident is also a former LTC (long term care) director of food services. Reports that [R52] has not liked the facility's food thus far--referred to dietary department for follow up and assessment of more detailed meal preferences." Further review of the clinical record revealed no evidence of further follow up of R52's more detailed meal preferences.

Further review of R52's clinical record revealed the following Nutrition Note, written by OSM (other staff member) #12, the RD (registered dietician), dated 3/30/22: "Spoke with resident today with head of social work...RD reminded resident several times of the role of the RD and strategies to address perceived issues with meals...Given that resident reports that [R52] feels that [R52] does not get enough food, RD to request double portions from dietary department."

R52's clinical record contained the following order dated 3/30/22: "DIET: Liberal Renal (Avoid high K [potassium] foods) diet...Regular texture, Regular Thin Liquid consistency, NCS (no concentrated sweets); DOUBLE PORTIONS."

A review of R52's care plan dated 3/1/22 and revised on 3/11/22 revealed, in part: "Resident has nutritional problem or potential nutritional problem...Provide, serve diet as ordered."

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On 5/5/22 at 9:53 a.m., OSM (other staff member) #13, dietary director, was interviewed. OSM #13 stated when a resident is admitted, she or a member of her staff goes to the resident's room and interviews the resident to determine the resident's food preferences. OSM #13 states the resident's preferences are documented on the meal ticket placed on each resident's meal tray at each meal. She stated the RD also interviews the resident about food preferences at the time of admission. When asked who is responsible for making sure the food on a resident's tray matches the meal ticket, OSM #13 stated a staff member "calls" the ticket to the staff member serving the plates on the kitchen line, and a supervisor double checks the tray for accuracy. OSM #13 stated each tray is checked to make sure double portions are present if that is what is ordered for the resident. She stated if a substitution needs to be made due to any food item being unavailable, she or a member of her staff attempts to speak to each resident about the changes, and the substitution is documented on each resident's meal ticket. OSM #13 stated she has spoken to R52 "a couple of times." She stated she had offered the resident to move from a renal diet to a regular diet, but the resident has refused.

On 5/5/22 at 10:25 a.m., OSM #12 was interviewed. She stated she tries to go visit a resident within 48 hours of admission. At this time, she interviews residents about strong food preferences, as well as other nutritional concerns. She stated she communicates information about a resident's food preferences by email to OSM #13. She stated she follows up monthly on residents who are on dialysis. She stated R52

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has "a lot of food preferences, he has very high standards." She stated the resident can be preoccupied with food. She stated she does not have responsibilities for the accuracy of meals served to residents day to day.

On 5/5/22 at 12:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4 the vice president of clinical services, and ASM #6, the assistant administrator, were informed of these concerns.

A review of the facility policy, "Food and Nutrition Services," revealed, in part: "Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident...The multidisciplinary staff, including nursing staff, the attending physician and the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization...A resident-centered diet and nutrition plan will be based on this assessment. Meals and/or nutritional supplements will be provided within 45 minutes of either resident request or scheduled meal time, and in accordance with the resident's medication requirements...Reasonable efforts will be made to accommodate resident choices and preferences...Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature."

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F 803	Continued From page 108 No further information was provided prior to exit.	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility document review, the facility staff failed to provide food at a palatable temperature during dinner service on 05/03/2022 with potential to affect 46 of 46 residents on the fourth floor receiving a meal tray. The findings include: On 5/3/22 at 1:38 p.m., Resident #52 (R52) was interviewed. (R52) had multiple complaints about the temperature of food that is delivered to the room. (R52) stated the meals rarely arrive at the meal times posted on the unit, and that the food is consistently "on the cold side." (R52) stated staff are too busy helping feed dependent residents to heat the food to a more palatable temperature. (R52) stated they did not want to bother staff to reheat the food, and that reheated food just is not as appealing. On 05/03/2022 at approximately 4:15 p.m., the	F 804	1. Residents on the 4th floor are receiving food at a palatable temperature. 2. An audit conducted by the Dietary Director to verify residents on the 4th floor are receiving food at a palatable temperature. 3. The Facility Educator or designee will in-service the Dietary and Nursing Staff on the process to maintain food temperatures when serving meals. Meal trays delivered on the 4th floor staff are to begin process of passing meal trays to maintain palatable temperatures with closing the door when not passing the meal trays to maintain temperatures. 4. Audits will be conducted by the Dietary Director or designee on the 4th floor to validate the resident□s meal serving temperature is maintained and	6/15/22

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F 804	Continued From page 109 holding temperatures of dinner meal, obtained from the service line in the kitchen were: Whole crab cakes - 171 degrees Fahrenheit Chopped crab cakes - 169 degrees Fahrenheit Pureed crab cakes - 181 degrees Fahrenheit Vegetables- 180 degrees Fahrenheit Pureed bread - 174 degrees Fahrenheit Pureed vegetables - 179 degrees Fahrenheit After the holding temperatures were obtained, plates were prepared, covered with a lid, placed in food carts and taken to the floors. On 05/03/2022 at approximately 6:20 p.m., a test tray was plated and sent to the fourth floor in the food cart with resident trays. On 05/03/2022 at 6:44 p.m. (when the final meal was served on the fourth floor), the temperatures of the food on the test tray were obtained by OSM # 13, the dietary manager. The temperatures were: Whole crab cakes - 136 degrees Fahrenheit Chopped crab cakes - 134 degrees Fahrenheit Pureed crab cakes - 120 degrees Fahrenheit Regular consistency vegetables- 125 degrees Fahrenheit Pureed bread - 113 degrees Fahrenheit Pureed vegetables - 121 degrees Fahrenheit The food on the test tray was sampled by two surveyors who determined the whole, chopped and pureed crab cakes, regular consistency and pureed vegetables and the pureed bread were not warm enough to be palatable. OSM # 13 confirmed this and stated these food items could be warmer. The facility policy, "Food Quality and Palatability" documented in part, "It is the center policy that, food is prepared by methods that conserve nutritive value, flavor and appearance. Food is	F 804	palatable by performing a food temperature test on the last meal served on the 4th floor and documented for verification. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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F 804	Continued From page 110 palatable, attractive and served at a safe and appetizing temperature." The facility's policy "Food and Nutrition Services" documented in part, "Policy Statement. Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident." On 05/04/2022 at approximately 5:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 3, vice president of operations, ASM# 4, vice president of clinical services and ASM # 6, assistant administrator, were made aware of the findings. No further information was presented prior to exit. Complaint deficiency.	F 804		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to maintain five of five dumpsters in a sanitary manner. Two outside dumpsters were observed with their door open and approximately eight pairs of used plastic gloves and numerous pieces of debris, including several pieces of cardboard and trash were found lying on the ground around and behind the facility's dumpsters.	F 814	1. The facility dumpster doors were closed, trash was cleaned, and dumpsters power washed by the maintenance department on 5/3/2022. Dumpsters are being maintained to ensure no trash or debris are around the dumpsters and trash is disposed of properly. 2. Audit will be conducted by Director of Environmental Services Manager or designee to verify the facility dumpsters	6/15/22

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F 814	Continued From page 111 The findings include: On 05/03/2022 at approximately 12:20 p.m., an observation of the facility's dumpsters was conducted with OSM (other staff member) # 6, director of maintenance. When asked who was responsible for maintaining the dumpsters and the immediate area around the dumpsters in a clean and sanitary manner OSM # 6 stated that it was the maintenance department. The observation revealed that the facility had five trash dumpsters located toward the rear of the facility. An observation of the dumpsters revealed the sliding side doors on two of the dumpsters were fully open. Observations of the area between and behind the five dumpsters revealed a broken mop handle next to the dumpsters, approximately eight pairs of used plastic gloves, numerous pieces of trash, including several pieces of cardboard behind and in-between dumpsters mixed in and lying on top of decaying leaves and pine needles. When asked who was responsible for ensuring the dumpster were kept closed and the area was kept free of trash and debris OSM # 6 stated that it was the responsibility of the maintenance department. When asked how often the dumpster area was cleaned and checked OSM # 6 stated that is checked every morning. When asked why it was important to keep the dumpsters closed and the area clean and free from debris and trash, OSM # 6 stated that it prevented contamination and prevented animals from from coming around. The facility's policy "Food-Related Garbage and Refuse Disposal" documented in part, "7.	F 814	doors are properly closed, no trash or debris is near, around or under the dumpsters. 3. The Maintenance, Housekeeping and Dietary staff will be in-serviced by Administrator or designee on the process for dumpster doors are kept closed and no trash or debris is near, around or under the dumpsters to prevent rodents and other pests. 4. Audits will be conducted by the Director of Environmental Services Manager or designee to verify dumpster doors are closed and no trash or debris is near, around or under the dumpsters weekly x 4 weeks then monthly x 2. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months.	

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F 814	Continued From page 112 Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter." On 05/04/2022 at approximately 5:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 3, vice president of operations, ASM# 4, vice president of clinical services and ASM # 6, assistant administrator, were made aware of the findings. No further information was provided prior to exit.	F 814		