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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 04/27/2022 through 04/29/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint, VA00054966 substantiated with deficiency, was investigated during the survey. The census in this 120 certified bed facility was 99 at the time of the survey. The survey sample consisted of 4 resident reviews.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		5/31/22

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

Electronically Signed | 05/18/2022

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F 657	Continued From page 1 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the care plan for one Resident (Resident # 1) in survey sample of 4 residents. For Resident # 1, the facility staff failed to revise the care plan upon the discovery of open areas on the right buttocks. Findings included: Resident # 1 was admitted to the facility on 9/3/2019 and discharged from the facility on 4/8/2022. Diagnoses included but were not limited to: Diabetes, Gastroesophageal Reflux Disease, Dementia, Visual loss in left eye, History of Venous Thrombosis and embolism and Protein Calorie Malnutrition. The Most recent Minimum Data Set (MDS) with an Assessment Reference Date of 03/20/2022 was coded as an annual assessment. Resident # 1 was coded as requiring extensive assistance of one staff person for Activities of Daily Living. Review of the closed clinical record was conducted 4/27/2022-4/29/2022. Review of the care plan revealed no documentation of the open area observed on 4/6/2022. There were no new interventions documented on the care plan.	F 657	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F657 1- Resident #1 was discharged from the facility. 2- All residents are at risk for deficient practice related to care plan review and revision. The DON will review current residents with wounds to ensure that the care plan is updated appropriately with the wound status. 3-The DON, or designee will educate all Licensed Nurses on revising the care plans with residents that have wounds and to report any new open areas of residents appropriately to Nursing Leadership. 4-The DON or designee will complete weekly audits of the care plan of all	

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F 657	Continued From page 2 On 4/28/2022 at 3:40 p.m., an interview was conducted with the Unit Manager RN (Registered Nurse) on the North Unit who stated that when wounds were discovered, the expectation was for the care plan to be updated. On 4/28/2022 at 3:59 p.m., an interview was conducted with Licensed Practical Nurse (LPN-D) who stated when the Certified Nursing Assistants find open areas, the nurses should immediately assess the area, notify the physician, place a note in the nurses notes, shift report and update the care plan. On 4/28/2022 at 4:00 p.m., the Director of Nursing stated the facility staff should immediately document the discovery of any open areas on the care plan During the end of day debriefing on 4/29/2022, the facility Administrator, Corporate Nurse Consultant and Director of Nursing were informed of the findings. No further information was provided.	F 657	residents with wounds to ensure that the care plan is revised appropriately. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation 6- Completion date 5/31/22. The Admin/DON are responsible for implementation of the plan of correction.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to follow professional standards of practice	F 658	F658 1-Resident #1 was discharged from the facility. Resident #2 is receiving her	5/31/22

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F 658	Continued From page 3 for medication administration for 2 Residents (Residents # 1 and #2) in a survey sample of 4 Residents. 1. For Resident # 1, the facility staff failed to follow physicians orders to crush medications and failed to ensure the medication was swallowed after administration. 2. For Resident # 2, the facility staff failed to ensure medications were documented as having been administered. The findings included; 1. For Resident # 1, the facility staff failed to follow physicians orders to crush medications and failed to ensure the medication was swallowed after administration. Resident # 1, an 83 year old, was admitted to the facility on 9/3/2019. Diagnoses included but were not limited to: Diabetes, Gastroesophageal Reflux Disease, Dementia, Visual loss in left eye, History of Venous Thrombosis and embolism and Protein Calorie Malnutrition. Resident #1 was discharged from the facility on 4/8/2022 to the hospital for altered mental status. The most recent Minimum Data Set (MDS) assessment was an annual assessment with an assessment reference date of 3/20/2022. Resident #1 was coded to have severely impaired cognitive ability and required extensive assistance of one staff member to perform activities of daily living. Review of the clinical record was conducted 4/27/2022-4/29/2022.	F 658	medications as ordered. 2-The facility is at risk for deficient practice related to not receiving their medications as ordered. The DON or designee will review current residents Medication Administration Report to determine that the medications are administered and documented appropriately. The DON or designee will review current residents to determine who needs their medications crushed to ensure the orders are updated appropriately. 3-The DON, or designee will educate all Licensed Nurses on following the Rights of Medication Administration, following Physician orders with medication administration and documentation of medication administration appropriately. 4-The Unit Manager or designee will monitor the Medication Administration Report on a weekly basis to ensure that the medications and orders are followed correctly, medications are administered and documented appropriately. The Staff Development Coordinator or designee will complete Medication Pass Observation with 5 different nurses each week to ensure that the Rights of Medication Administration is being followed appropriately. 5-Results of the audits will be presented to the QAPI Committee for review and recommendation. 6-Completion date 5/31/22. The Admin/DON are responsible for implementation of the plan of correction.	

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Review of the hospital records revealed documentation of pills being found in Resident # 1's mouth while in the Emergency Room. The assessment note stated: "Edentulous, dry, still has remnants of morning meds (medications) in her mouth"

On 4/29/2022 at 11:00 a.m., an interview was conducted with the Unit Manager who stated the hospital staff had called them on 4/8/2022 to report that pills had been found in Resident # 1's mouth. The Unit Manager stated she was involved in the transfer of Resident # 1 to the hospital that day but did not check the resident's mouth prior to transfer.

RN-C stated Resident # 1 was on a Pureed diet and "typically they cannot swallow pills. So, they (medications) would be crushed." RN-C reviewed the clinical record with the surveyor. There was an order written on 3/25/2022 to crush the medications. RN-C stated the medications should have been crushed.
RN-C stated that based on her review of the clinical record, she thought the blue stain on Resident # 1's clothes on the day of transfer "looked like it must have been the antibiotic, Valtrex, which had not been given that morning" due to Resident # 1 "being unresponsive and was going out to the ER (Emergency Room for evaluation." RN-C stated the last time that medication was given was on 3-11 the night before by LPN (Licensed Practical Nurse) D. RN-C stated the facility knew about the medication being found in Resident # 1's mouth because the ER (Emergency Room) called us."

The Director of Nursing stated she helped to

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assess Resident # 1 prior to transfer to the Emergency Room. The Director of Nursing stated she noticed a blue substance on the shoulder of the gown Resident # 1 was wearing. The Director of Nursing stated when she touched the blue area, it was a dried substance. The Director of Nursing stated Resident # 1 did not have any bulging of her mouth or cheeks or anything else that would indicate something was in her mouth. She continued with her assessment of the resident and helped to determine that the Resident needed to be transferred immediately to the Emergency Room for further evaluation. The Director of Nursing stated "in hindsight, I know that the blue substance was probably remnants of the medication that had been given the night before."

The Director of Nursing stated medications were not administered on the morning of 4/8/2022 because Resident # 1 was unresponsive. "So, the medications had to have been administered the night before" on 4/7/2022. The Director of Nursing stated the nurse should have made sure the pills were crushed as ordered and that they were swallowed.

The Director of Nursing stated the expectation was for nurses to administer medications as ordered by the physician and to make sure all pills were swallowed after administration.

Review of the Medication Administration Record revealed medications were administered on 4/7/2022 at 9:00 p.m.

Review of the care plan revealed documentation of the following statements : "The resident has a physician's order that states that medications may

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be crushed and administered together at one time r/t (related to) dysphasia.
Created on: 03/23/2021. Two of the interventions were: "Administer crushed medications as a single oral bolus and Monitor resident for any adverse effects of oral bolus administration of crushed medications."

During the end of day debriefing on 4/29/2022, the Facility Administrator, Corporate Nurse Consultant and Director of Nursing were informed of the findings that pills were found in Resident # 1's mouth upon admission to the Emergency Room on 4/8/2022. All stated that the nurses should have crushed the medications as per orders and should have made sure the medications were swallowed after administration.

No further information was provided.

2. For Resident # 2, the facility staff failed to document the administration of medications as ordered by the physician. There were numerous times medications were not documented as having been administered.

Resident # 2, a 71 year old, was admitted to the facility on 2/9/2022 and readmitted on 2/28/2022. Diagnoses included but were not limited to: Cerebral Infarction (stroke), Sepsis, Diabetes, Gastrostomy, Gastroesophageal Reflux Disease, Aphasia after Stroke, Hypertension.

The most recent Minimum Data Set (MDS) assessment was a Significant Change Assessment with an assessment reference date of 3/21/2022. Resident # 2 was coded to have

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moderately impaired cognitive ability and required total assistance of one staff member to perform activities of daily living.

Review of the clinical record was conducted 4/27/2022-4/29/2022.

Review of Resident # 2's clinical record and MARs (Medication Administration Records) revealed no documentation that the following medications were administered on the days and times indicated to include but not limited to:

Clopidogrel 75 milligrams (mg) 1 tablet via PEG (percutaneous endoscopic gastrostomy) Tube one time per day at 9:00 a.m., omitted 2-12-22, and 2-13-22 at 9 AM and 2-21-22 at 9 AM and 2-28-22 at 9 AM

Hydrochlorithiazide 25 milligrams 1 tablet via PEG (percutaneous endoscopic gastrostomy) Tube one time per day at 9:00 a.m., omitted 2-12-22, and 2-13-22 at 9 AM and 2-21-22 at 9 AM and 2-28-22 at 9 AM

Insulin Lantus (units) u-100 subcutaneous 25 units every night at 9:00 p.m. omitted 2-23-22 and 2-27-22 at 9 PM..

Lisinopril 40 mg 1 tablet via PEG (percutaneous endoscopic gastrostomy) Tube one tine per day at 9:00 a.m., omitted 2-12-22, and 2-13-22 at 9 AM and 2-21-22 at 9 AM and 2-28-22 at 9 AM

Prevacid Solutab Delayed Release 30 milligrams 1 tablet via PEG (percutaneous endoscopic gastrostomy) Tube one time per day at 9:00 a.m., omitted 2-12-22, and 2-13-22 at 9 AM and 2-21-22 at 9 AM and 2-28-22 at 9 AM

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Sertraline 100 milligrams 1 tablet via PEG (percutaneous endoscopic gastrostomy) Tube one time per day at 9:00 a.m., omitted 2-12-22, and 2-13-22 at 9 AM and 2-21-22 at 9 AM and 2-28-22 at 9 AM

Metformin 500 milligrams Give 2 tablets via PEG (percutaneous endoscopic gastrostomy) Tube two times per day at 9:00 a.m. and 6 p.m., omitted 2-12-22, and 2-13-22 at 9 AM and 2-21-22 at 9 AM and 2-28-22 at 9 AM, 2-18-22 at 6 PM and 2-27-22 at 6 PM.

Baclofen 5 milligrams 1 tablet via PEG (percutaneous endoscopic gastrostomy) Tube three times per day at 9:00 a.m., 2:00 p.m., and 9:00 p.m.: omitted 2-12-22, and 2-13-22 at 9 AM and 2 PM and 2-21-22 at 9 AM and 2:PM and 2-28-22 at 9 AM and 2 PM, omitted 2-23-22 at 9 PM and 2-27-22 at 9 PM.

Valid physician's orders were evident for the medications and assessments not documented as having been administered.

On 4-29-22 at approximately 1:00 p.m., the director of nursing (DON) was asked about the medications and assessments that were not documented as having been administered. The DON said, "Medications should be documented at the time of administration." The DON stated she was made aware that the Agency nurses who worked those shifts on 2/12 and 2/13/2022 had not documented the administration of the medications and contacted them to come in to sign the records. The DON stated the nurses did not come in to sign the MARs, so they were place on a Do NOT Return list for the facility. The DON

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stated it was expected that all nurses should follow the rights of medication administration and document at the time of administration.

The Director of Nursing presented a statement regarding the missed medications included the excerpts: " Both nurses were contacted by myself ____(DON name redacted) in regards to the omissions on the MAR. Both nurses confirmed they had given the medications but refused to come back in to chart such. I contacted both of their agencies to make them aware of their insubordination and to ensure they were not to come back to our facility to work as they did not complete their job duties as licensed nurses."

Review of the care plan revealed the intervention "administer medications as ordered"

The Director of Nursing cited Lippincott as its Nursing professional guidance used by the facility.
"Fundamentals of Nursing by Lippincott", stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients."

Guidance is given from Lippincott Solutions, "Safe Medication Administration Practices, General" 10/02/2015. "Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions."

Additional Guidance from Lippincott's Nursing

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Center.com (www.nursingcenter.com)
Rights of Medication Administration excerpts:

"4. Right route
" Again, check the order and appropriateness of the route ordered.
" Confirm that the patient can take or receive the medication by the ordered route.
5. Right time
" Check the frequency of the ordered medication.
" Double-check that you are giving the ordered dose at the correct time.
" Confirm when the last dose was given.
6. Right documentation
" Document administration AFTER giving the ordered medication.
" Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug."

Reference: Nursing2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania.
www.nursingcenter.com Accessed online 3/8/2018.

The Administrator, Corporate Nurse Consultant and DON were informed of the failure of the staff to document the above mentioned medications as having been administered, during the end of day debriefing on 4-29-22.

No further information was provided.

COMPLAINT DEFICIENCY

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F 677	Continued From page 11	F 677		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure one Resident (Resident # 1) of 4 in the survey sample, who were unable to independently carry out activities of daily (ADL), received necessary services to maintain good hygiene. For Resident # 1, the facility staff failed to provide showers and bed baths consistently. Findings included: Resident # 1 was admitted to the facility in 2019 and discharged from the facility on 4/8/2022. Diagnoses included but were not limited to Diabetes, Gastroesophageal Reflux Disease, Dementia, Visual loss in left eye, History of Venous Thrombosis and embolism and Protein Calorie Malnutrition. The Most recent Minimum Data Set (MDS) with an Assessment Reference Date of 03/20/2022 was coded as an annual assessment. Resident # 1 was coded as requiring extensive assistance of one staff person for performing Activities of Daily Living with dressing, personal hygiene and bathing. Section, E (Behavior) was not coded for rejection of care for ADL assistance. Review of the closed clinical record was	F 677	F677 1-Resident #1 was discharged from the facility. 2- The facility is at risk for deficient practice related to residents not receiving their showers or bed baths. The DON or designee will review current residents to ensure that showers and bed baths are provided and documented appropriately. 3-The Staff Development Coordinator, or designee will educate all Licensed Nurses and CNA□s on providing bed baths and showers to include documentation of refusals. 4-The Unit Manager or designee will review the ADL documentation on a weekly basis to ensure that a shower or bed bath was provided and documented appropriately. 5-Results of the audits will be presented to the QAPI Committee for review and recommendation. 6-Completion date 5/31/22. The Admin/DON are responsible for implementation of the plan of correction	5/31/22

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conducted 4/27/2022-4/29/2022.

Review of residents medical record did not reveal refusal of care for bathing.

On 4/29/2022 at 12:10 p.m., the Corporate Nurse Consultant presented a copy of the Activities of Daily Living-Showers documentation. Review revealed documentation of a shower on 3/27/2022 and bed baths being given on 3/30/2022, 4/2/2022 and 4/6/2022. There were only 4 times that any bathing activity was documented during the period of 3/27/2022-4/8/2022.

During an interview conducted during the survey, the Director of Nursing stated the facility staff should have provided a bed bath whenever a shower was not completed. The Director of Nursing stated that when Resident # 1 transferred to the other unit, the shower days changed to other scheduled days. The staff should have performed showers twice a week.

There was also only one shower documented given on 3/27/2022 and three bed baths given during the next period from 3/28/2022-4/8/2022 when discharged to the hospital. Review of residents medical record did not reveal refusal of care for bathing or grooming.

During the end of day debriefing, the facility Administrator, Corporate Nurse Consultant and Director of Nursing were informed of the issue.

No further information was provided.

COMPLAINT DEFICIENCY

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, the facility staff failed to identity the staging of a pressure area for one Resident (Resident # 1) in survey sample of 4 residents. For Resident # 1, the facility staff failed to describe in the documentation of the stage of open pressure areas observed on the right buttocks on 4/6/2022. Findings included: Resident # 1 was admitted to the facility in 2019 and discharged from the facility on 4/8/2022. Diagnoses included but were not limited to Diabetes, Gastroesophageal Reflux Disease, Dementia, Visual loss in left eye, History of Venous Thrombosis and embolism and Protein Calorie Malnutrition.	F 686	F686 1-Resident #1 was discharged from the facility. 2-The facility is at risk for deficient practice related to residents with wounds do not have proper documentation in place. The DON or designee will review current residents with wounds to ensure that there is proper documentation and staging of pressure areas. 3-The DON, or designee will educate all Licensed Nurses properly documenting the description, location, measurements of wounds and staging of pressure areas. 4-The DON, or designee will review the wound report and skin assessments of all residents with wounds to ensure that the areas are properly documented and that pressure ulcers are staged appropriately. 5-Results of the audits will be presented	5/31/22

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F 686	Continued From page 14 The Most recent Minimum Data Set (MDS) with an Assessment Reference Date of 03/20/2022 was coded as an annual assessment. Resident # 1 was coded as requiring extensive assistance of one staff person for Activities of Daily Living. Review of the closed clinical record was conducted 4/27/2022-4/29/2022. Review of the Skin/Wound Progress notes revealed documentation of the following note dated 4/6/2022 at 8:16 a.m. "While performing ADL care on resident open areas noted to right buttocks notified medical doctor and responsible party. There was a "new order for Zinc paste every shift." There was no documentation in the clinical record that described the measurements or staging of Resident # 1's wound on the right buttock. The Director of Nursing was asked for a timeline of Resident # 1's wound along with copies of the weekly skin assessments for 4 weeks prior to discharge. The Director of Nursing presented a Timeline of the wound and four weekly skin assessment sheets as requested. On 4/29/2022 at 11:50 a.m., review of the Timeline documentation revealed the following: "4/6/22-The nurse noted an open areas (sic) during ADL (activities of daily living) care to the Right Buttock. The MD (medical doctor) and RP (responsible party) was notified. (Sic), the nurse then received an order for Zinc paste after speaking to the MD for the Right Buttock. 1. Treatment: Zinc Oxide 2. Interventions: Moisture Barrier Cream,	F 686	to the QAPI Committee for review and recommendation. 6-Completion date 5/31/22. The Admin/DON are responsible for implementation of the plan of correction	

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Pressure Reduction Mattress, float heels.
3. DX (diagnosis) of Protein Calorie Malnutrition/MVI (multivitamin) and Med Plus in place
4//8//22- Resident admitted to the hospital

Weekly Skin Assessment Sheets:
A "Skin Observation Tool" - type: Full Assessment sheet completed 4/4/2022 documented no noted open areas on the buttocks. The only issue noted was listed on page 2 as "blisters under arm, dx (diagnosis) and treatment in place." The form was signed by Licensed Practical Nurse on 4/5/2022.

There were no noted open pressure areas on the Weekly Skin assessments on 3/14/2022, 3/21/2022 and 3/28/2022. The Director of Nursing stated it was important to document measurements and staging of wounds in order to determine progression or regression in the healing process.

Regarding Wounds:
While it was documented on 4/6/2022 that the right buttock had an open area, there was no documentation that the area was staged. The exact location of the wound was not documented. A description of the wound was not documented.

A "Weekly Skin Review" sheet completed 4/4/2022 documented no noted open areas on the buttocks Full Assessment "Skin Observation Tool" The only issue noted was "blisters under arm, dx (diagnosis) and treatment in place." The form was signed by Licensed Practical Nurse on 4/5/2022.

Review of the skin review sheets from 3/14/2022

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and 3/21/2022 revealed documentation of no open areas. The skin review sheet dated 3/28/2022 on page 1 of 2 documented the observation of "left axilla" described as "infection."

There was no documentation in the clinical record that described the measurements or staging of Resident # 1's wound on the right buttock. There was a nursing note dated 4/6/2022 that documented the physician was notified. The nurse received an order for Zinc paste.

The skin review sheet dated 3/28/2022 on page 1 of 2 documented the observation of "left axilla" described as "infection."

Review of the Skilled Nursing Facility/Nursing Facility to Hospital Transfer Form revealed documentation on the second page under Skin/Wound Care two check marks were noted: Pressure ulcers/injuries (stage, location) was checked. In the blank was written "NA" for inapplicable.
Other wounds or bruises present-"yes" was checked. (Describe type, location) was written "NA" for inapplicable.

The Transfer form was completed by the Unit Manager/Charge Nurse (Registered Nurse-C) (RN-C).
On 4/29/2022 at 9:40 a.m., an interview was conducted with the Unit Manager, RN (Registered Nurse)-C who stated Resident # 1 was on the other (North) unit until Resident # 1 was diagnosed with Shingles and transferred to a private room on the South Unit. RN-C stated she completed the Transfer form and checked the boxes for skin issues based on review of the clinical record. RN-C stated she noted there was

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F 686	Continued From page 17	F 686		

documentation of an open area on the buttocks and an order had been written for a treatment. She stated she checked "other" because of documented "blisters and shingles" on the abdomen. RN-C stated due to the emergency transfer of Resident # 1, actual measurements were not obtained. RN-C stated she should have described more about the pressure ulcer on the form.

RN-C stated the expectation was: "If nurses find open areas or skin issues, they should describe and get measurements, notify the MD of findings, get treatment orders, notify family, notify unit manager and document on the 24 hour report.

On 4/29/22 at 10:02 a.m., an interview was conducted with the Director of Nursing who stated she reviewed the Transfer form and regarding the documentation of the pressure ulcer and "probably would have put the location at least." The Director of Nursing stated that information about the pressure wound would have helped the ER know where a wound was located. The Director of Nursing stated not enough information was given on the form.

The Director of Nursing stated the facility would educate the nursing staff about the importance of thorough documentation of pressure ulcers. The Director of Nursing stated that even though the facility had a Wound Care Nurse Practitioner, the facility nurses needed to know the proper assessment and documentation of pressure ulcers.

The Administrator, Corporate Nurse Consultant and Director of Nursing were notified of the findings at the end of day meeting on 4/29/2022.

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F 686	Continued From page 18 There was a nursing note dated 4/6/2022 that documented the physician was notified. The nurse received an order for Zinc paste. There was no documentation of the size, exudate, Location and staging, pain, wound bed, color and description of wound edges. The Director of Nursing stated the staff would be educated. No further information was provided.	F 686		
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. §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	F 755		5/31/22

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F 755	Continued From page 19 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 staff interview and clinical record review, the facility staff failed for 1 resident (Resident # 3) of 4 residents in the survey sample to ensure medications were available for administration. For Resident # 3, the antibiotic medication Cipro (Ciprofloxacin) 500 milligrams was unavailable for administration. The findings included: Resident # 3, a 72 year old, was admitted to the facility on 1/18/2022 and readmitted 3/22/2022. Diagnoses included but were not limited to: Malignant neoplasm of the prostate, secondary malignant neoplasm of the bone, Anemia in Chronic Kidney Disease. The most recent Minimum Data Set assessment was a Significant Change assessment with an assessment reference date of 3/29/2022. Resident # 3 was coded with a Brief Interview of Mental Status score of 0 indicating severe cognitive impairment. Resident #3 required extensive to total assistance of one to two staff persons with activities of daily living. The following nursing notes were documented in the clinical record: 4/21/2022 at 2:46 p.m. " Cipro 500 mg (milligrams) unavailable." There was no	F 755	F755 1-Resident #3 was discharged from the facility. 2-The facility is at risk for deficient practice related to residents not receiving their medications as ordered. The DON or designee will review current residents receiving Antibiotics to ensure that they are receiving their medications appropriately. 3-The DON, or designee will educate all Licensed Nurses on following the Rights of Medication Administration, following Physician orders with medication administration, documentation of medication administration appropriately, proper procedures to follow to obtain medications from the STAT medication box and proper notification to the Physician. 4-The Unit Manager or designee will monitor the Medication Administration Report, along with residents all receiving Antibiotics on a weekly basis to ensure that the medications are available for administration and documented as administered appropriately. 5-Results of the audits will be presented to the QAPI Committee for review and recommendation. 6-Completion date 5/31/22.	

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F 755	Continued From page 20 documentation that the physician was notified. On 4/28/2022 during the end of day meeting, the Administrator, Corporate Nurse Consultant and Director of Nursing (DON) were informed of the fining that Cipro was not available for administration as ordered by the Physician. The following day,4/29/2022, the DON provided copies of the STAT box content which showed that the medication, Cipro was available in the facility. The DON stated, "The nurse failed to use our protocol. She should have gone to the Omnicell (Stat box) to determine if the medication was available, called the staff nurses to open the Omnicell if unable to open it to gain access to the medication." The DON stated the nurse should have notified the physician that the medication was not given, should have obtained any orders and should have notified the responsible party. There was no documentation that those things were done. Review of the STAT Omnicell Box contents showed Ciprofloxacin 250 milligrams Quantity 5 tablets and Ciprofloxacin 500 milligrams Quantity 5 tablets available in the box. The DON stated the medication was available in the facility but the nurse did not follow the protocol. Resident # 3 had a valid physician order for Cipro 500 milligrams by mouth BID (twice a day) for UTI (Urinary Tract Infection.) According to the April 2022 MAR, the Ciprofloxacin 500 milligrams was not administered on 4/21/2022 at 9 A.M. The Administrator and DON were notified of the	F 755	The Admin/DON are responsible for implementation of the plan of correction	

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F 755	Continued From page 21 issue at the end of day meeting on 4-29-2022 No further information was provided.	F 755		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 842		5/31/22

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F 842	Continued From page 22 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and in the course of a complaint investigation the facility staff failed to ensure a complete and accurate clinical record for 2 residents (Resident # 1, and #2) of 4 residents in the survey sample.	F 842	F842 1-Resident #1 was discharged from the facility. The age discrepancy in the medical record for Resident #2 was corrected by the Physician group. 2-The facility is at risk for deficient	

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F 842	Continued From page 23 1. For Resident #1, the clinical record did not include all wound related documentation. 2. For Resident # 2, the facility staff failed to ensure a complete and accurate clinical record, there was a discrepancy in the resident's age. The findings included: 1. For Resident #1, the clinical record did not include all wound related documentation . Resident # 1, an 83 year old, was admitted to the facility on 9/3/2019. Diagnoses included but were not limited to: Diabetes, Gastroesophageal Reflux Disease, Dementia, Visual loss in left eye, History of Venous Thrombosis and embolism and Protein Calorie Malnutrition. Resident #1 was discharged from the facility on 4/8/2022 to the hospital for altered mental status. The most recent Minimum Data Set (MDS) assessment was an annual assessment with an assessment reference date of 3/20/2022. Resident #1 was coded to have severely impaired cognitive ability and required extensive assistance of one staff person to perform activities of daily living. In section M300 -Skin Conditions, Resident # 1 was coded as at risk for pressure injuries. There were no unhealed wounds coded. While it was documented on 4/6/2022 that the right buttock had an open area, there was no documentation that the area was staged. The exact location of the wound was not documented. A description of the wound was not documented.	F 842	practice related to inaccurate and incomplete clinical records. The DON, or designee will review current residents with wounds to ensure that the wound documentation is accurate and completed appropriately in the clinical record. The DON, or designee will review current residents to ensure that the Physician group notes reflect the resident information accurately. 3-The DON, or designee will educate all Licensed Nurses on Nurses properly documenting the description, location, measurements of wounds and staging of pressure areas. The DON, or designee will educate the Physician groups on accurately documenting resident information in their progress notes. 4-The DON, or designee will review the wound report and skin assessments of all residents with wounds to ensure that the areas are properly documented and that pressure ulcers are staged appropriately. The DON, or designee will review three Physician group progress notes on a weekly basis to ensure that the resident information is documented correctly. 5-Results of the audits will be presented to the QAPI Committee for review and recommendation. 6-Completion date 5/31/22. The Admin/DON are responsible for implementation of the plan of correction	

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F 842	Continued From page 24	F 842		

A "Weekly Skin Review" sheet completed 4/4/2022 documented no noted open areas on the buttocks Full Assessment "Skin Observation Tool" The only issue noted was "blisters under arm, dx (diagnosis) and treatment in place." The form was signed by Licensed Practical Nurse on 4/5/2022.

Review of the skin review sheets from 3/14/2022 and 3/21/2022 revealed documentation of no open areas. The skin review sheet dated 3/28/2022 on page 1 of 2 documented the observation of "left axilla" described as "infection."

There was no documentation in the clinical record that described the measurements or staging of Resident # 1's wound on the right buttock. There was a nursing note dated 4/6/2022 that documented the physician was notified. The nurse received an order for Zinc paste.

The Director of Nursing was asked for a timeline of Resident # 1's wound along with copies of the weekly skin assessments for 4 weeks prior to discharge. The Director of Nursing presented a Timeline of the wound and four weekly skin assessment sheets as requested.

On 4/29/2022 at 11:50 a.m., review of the Timeline documentation revealed the following:

"4/6/22-The nurse noted an open areas (sic) during ADL (activities of daily living) care to the Right Buttock. The MD (medical doctor) and RP (responsible party) was notified. (sic), The nurse then received an order for Zinc paste after speaking to the MD for the Right Buttock.

1. Treatment: Zinc Oxide
2. Interventions: Moisture Barrier Cream,

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	495193	A. BUILDING _____ B. WING _____	C 04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENRICO HEALTH & REHABILITATION CENTER	561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Pressure Reduction Mattress, float heels.
3. DX (diagnosis) of Protein Calorie Malnutrition/MVI (multivitamin) and Med Plus in place
4//8//22- Resident admitted to the hospital
4/21/22 -Resident admitted to a sister facility from the hospital with Hospice."

Weekly Skin Assessment Sheets:
A "Skin Observation Tool" - type: Full Assessment sheet completed 4/4/2022 documented no noted open areas on the buttocks. The only issue noted was listed on page 2 as "blisters under arm, dx (diagnosis) and treatment in place." The form was signed by Licensed Practical Nurse on 4/5/2022.

The skin review sheet dated 3/28/2022 on page 1 of 2 documented the observation of "left axilla" described as "infection."

Review of the skin review sheets from 3/14/2022 and 3/21/2022 revealed documentation of no open areas.

Review of the Skilled Nursing Facility/Nursing Facility to Hospital Transfer Form revealed documentation on the second page under Skin/Wound Care two check marks were noted:
Pressure ulcers/injuries (stage, location) was checked. In the blank was written "NA" for inapplicable.
Other wounds or bruises present-"yes" was checked. (describe type, location) was written "NA" for inapplicable.

The Transfer form was completed by the Unit Manager/Charge Nurse (Registered Nurse-C) (RN-C).

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On 4/29/2022 at 9:40 a.m., an interview was conducted with the Unit Manager, RN (Registered Nurse)-C who stated Resident # 1 was on the other (North) unit until Resident # 1 was diagnosed with Shingles and transferred to a private room on the South Unit. RN-C stated she completed the Transfer form and checked the boxes for skin issues based on review of the clinical record. RN-C stated she noted there was documentation of an open area on the buttocks and an order had been written for a treatment. She stated she checked "other" because of documented "blisters and shingles" on the abdomen. RN-C stated due to the emergency transfer of Resident # 1, actual measurements were not obtained. RN-C stated she should have described more about the pressure ulcer on the form.

RN-C stated the expectation was: "If nurses find open areas or skin issues, they should describe and get measurements, notify the MD of findings, get treatment orders, notify family, notify unit manager and document on the 24 hour report.

On 4/29/22 at 10:02 a.m., an interview was conducted with the Director of Nursing who stated she reviewed the Transfer form and regarding the documentation of the pressure ulcer and "probably would have put the location at least." The Director of Nursing stated that information about the pressure wound would have helped the ER know where a wound was located. The Director of Nursing stated not enough information was given on the form.

The Administrator, Corporate Nurse Consultant and Director of Nursing were notified of the incomplete clinical record at the end of day

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meeting on 4/29/2022.

No further information was provided.

2. For Resident # 2, the facility staff failed to ensure a complete and accurate clinical record, there was a discrepancy in the resident's age. The incorrect age was listed in the progress notes on several dates and another person's medical information was included in the record.

Resident # 2, a 71 year old, was admitted to the facility on 2/9/2022 and readmitted on 2/28/2022. Diagnoses included but were not limited to: Cerebral Infarction (stroke), Sepsis, Diabetes, Gastrostomy, Gastroesophageal Reflux Disease, Aphasia after Stroke, Hypertension.

The most recent Minimum Data Set (MDS) assessment was a Significant Change Assessment with an assessment reference date of 3/21/2022. Resident # 2 was coded to have moderately impaired cognitive ability and required total assistance of one staff member to perform activities of daily living.

Review of the clinical record was conducted 4/27/2022-4/29/2022.

Review of the Progress notes revealed Resident's # 2's age was listed several times as 65 years old. The Resident's age was listed as 71 years old in other progress notes. Resident # 2 was born in 1950, therefore, the correct age was 71 years old.

On 2/22/2022, 3/1/2022, 3/15/2022, the

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F 842	Continued From page 28 progress notes stated a" 65 year old..." During the end of day debriefing on 4/29/2022, the Administrator, Corporate consultant and Director of Nursing were informed of the findings. All stated the clinical record should be accurate. The Director of Nursing reviewed the documents and determined the attending physician was the provider who wrote the wrong age in the progress notes. Further review of the clinical record, revealed documentation in the progress notes that a Progress note was written on 2/3/2022 at 13:05 for another person's name. This person was hospitalized at _____ (name of hospital redacted) was from 01/17/2022 to 02/02/2020 (Sic) due to Acute ischemic stroke." No further information was provided. COMPLAINT DEFICIENCY	F 842		