STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495107	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY FOREST HEALTH AND REHABILITATION CENTER	450 PINEY FOREST RD DANVILLE, VA 24540

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 4/12/2022 through 4/15/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 4/12/22 through 4/15/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Five (5) complaints were investigated during the survey: 1. VA00050243 - substantiated 2. VA00051611 - unsubstantiated 3. VA00052015 - substantiated 4. VA00052608 - unsubstantiated 5. VA00053102 - unsubstantiated The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of 24 current Resident reviews and five (5) closed record reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		5/17/22

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

Electronically Signed | 05/04/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 607	Continued From page 1 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to implement their policy in regards to an allegation of abuse for 1 of 24 Residents, Resident #48. The facility staff failed to implement their policy in regards to reporting an alleged incident of abuse regarding Resident #48. The findings included: Section C (cognitive patterns) of Resident #48's significant change in status minimum data set (MDS) assessment with an assessment reference date (ARD) of 02/27/22 included a brief interview for mental status summary score of 5 out of a possible 15 points. Per the MDS manual, a score of 0-7 indicates severe impairment in cognitive skills. Diagnoses included, but were not limited to, Parkinson's disease, vascular dementia, unspecified mood disorder, and dementia with behavioral disturbances. Resident #48's comprehensive care plan included the areas of resistive to care, noncompliance with treatment regimen, verbally aggressive at times, impaired cognitive function, and impaired visual function.	F 607	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. F607 The Facility Reported Incident for Resident #48 was sent to the Office of Licensure and Certification on 4/15/22. Current residents in the center have the potential to be affected. The center Administrator will be educated by Regional Director of Clinical Services regarding policy for timely reporting of allegations of abuse and reporting allegations to the Office of Licensure and Certification. The Administrator/designee will notify the Regional Director of Clinical Services when an allegation of abuse has been	

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F 607	Continued From page 2 04/15/22, the surveyor was made aware of an allegation regarding Resident #48 being put in their room with the heat on and the door being shut. The alleged perpetrator was identified as Licensed Practical Nurse (LPN) #6. 04/15/22 10:22 a.m., the Administrator, Director of Nursing (DON), and Nurse Consultant were made aware of the allegation. The DON stated they were aware of the allegation an FRI has been completed and it has been investigated. 04/15/22 11:00 a.m., the survey team listened to a voicemail from a staff at the Department of Health Professions (DHP) to the administrator. This voicemail requested information regarding an alleged incident involving Resident #48. DHP had requested information regarding an investigation and facility reported incident (FRI) regarding Resident #48 allegedly being placed in their room with the heat on by a staff member of the facility, being yelled at by a staff person, and having a black eye. 04/15/22 12:47 p.m., phone call with the DHP intake analyst who had left the voicemail for the administrator. This staff stated they could only speak hypothetically. If there were an issue, it would go to the board of nursing. We cannot tell anyone not to do an FRI if I get asked that question I tell them they need to talk to the Office of Licensure and Certification (OLC) about that. If someone says something like do I need to report that I direct them to their corporate office, we only deal with the licensee. The surveyor was given 1 page of an investigation that read, on 03-21-22, the Administrator was made aware of potential abuse	F 607	received. Regional Director of Clinical Services will review allegations to ensure completion of reporting to required outside agencies include Office of Licensure and Certification. Results of review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the reviews will be conducted on a random basis. Cross Reference to 12 VAC 5-371-140 (A) Date of Compliance: 5-17-22	

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F 607	Continued From page 3	F 607		

regarding Resident #48. The administrator and HR spoke to this resident. The patient stated that no one here has been mean and when asked if they ever had a black eye they replied yes years ago. The administrator and HR personnel signed this document. No other documentation was provided.

04/15/22 1:20 p.m., Administrator stated they had spoken with Resident #48 with their Human Resource manager, talked to staff, talked to the nurse, and what I have written is what has been given to you. The administrator stated they did not complete an FRI after speaking with DHP it was kind of like case closed and I figured I was talking to a state entity. The administrator stated they were going to complete an FRI today and stated that I did not know of the clear separation of DHP and OLC. The administrator stated they felt like I was reporting when I spoke with the DHP staff and they did not think there was any risk to the patient.

04/15/22 2:27 p.m., call from DHP intake analyst who stated my usual verbage is we are not telling you to investigate something I was just calling to see if it had been investigated. I cannot tell anyone to or not to investigate. That is my usual verbage if I call someone it is because DHP has directed me to do so.

Facility policy titled, "Reporting Requirements/Investigations" effective date 01/23/20 read in part, "The Administrator will ensure the timely reporting, investigating, and follow up reporting of incidents of alleged/suspected patient abuse, neglect, mistreatment, exploitation, or crime against a patient to the State Agency and any other

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F 607	Continued From page 4 appropriate authorities. Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment...the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not results in serious bodily injury. Notify the Department of Health Office of Licensure and Certification by filing the initial report on the Virginia Department of Health Facility Reported Incident Form...Notify the Adult Protective Services Agency, the local Ombudsman, and the appropriate local law enforcement authorities for any incident of patient abuse, mistreatment, neglect. Notify within 24 hours the Department of Health Professions (DHP) for incidences involving...LPN's..." 04/15/22 2:40 p.m., Administrator, DON, and Nurse Consultant were made aware of the issue regarding not following their policy in regards to an allegation of abuse. Prior to the exit conference on 04/15/22 the administrator provided the surveyor with a copy of an FRI completed 04/15/22 regarding resident #48. No further information regarding this issue was provided to the survey team prior to the exit conference on 04/15/22.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609		5/17/22

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F 609	Continued From page 5 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to report an allegation of abuse to the appropriate state agencies. The administrator failed to notify the appropriate state agencies when they were made aware of an allegation of abuse from the Department of Health Professions (DHP) regarding Resident #48.	F 609	F609 The Facility Reported Incident for Resident #48 was sent to the Office of Licensure and Certification on 4/15/22. Current residents in the center have the potential to be affected. The center Administrator will be educated by Regional Director of Clinical Services regarding policy for timely reporting of	

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F 609	Continued From page 6 The findings included: Section C (cognitive patterns) of Resident #48's significant change in status minimum data set (MDS) assessment with an assessment reference date (ARD) of 02/27/22 included a brief interview for mental status summary score of 5 out of a possible 15 points. Per the MDS manual, a score of 0-7 indicates severe impairment in cognitive skills. Diagnoses included, but were not limited to, Parkinson's disease, vascular dementia, unspecified mood disorder, and dementia with behavioral disturbances. Resident #48's comprehensive care plan included the areas of resistive to care, noncompliance with treatment regimen, verbally aggressive at times, impaired cognitive function, and impaired visual function. 04/15/22, the surveyor was made aware of an allegation regarding Resident #48 being put in his room with the heat on and the door being shut. The alleged perpetrator was identified as Licensed Practical Nurse (LPN) #6. 04/15/22 10:22 a.m., the Administrator, Director of Nursing (DON), and Nurse Consultant were made aware of the allegation. The DON stated they were aware of the allegation an FRI has been completed and it has been investigated. 04/15/22 11:00 a.m., the survey team listened to a voicemail from a staff at the DHP to the administrator. This voicemail requested information regarding an alleged incident	F 609	allegations of abuse and reporting allegations to the Office of Licensure and Certification. The Administrator/designee will notify the Regional Director of Clinical Services when an allegation of abuse has been received. Regional Director of Clinical Services or designee will review allegations to ensure completion of reporting to required outside agencies including Office of Licensure and Certification. Results of review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the reviews will be conducted on a random basis. Date of Compliance: 5-17-22	

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F 609	Continued From page 7	F 609		

involving Resident #48. DHP had requested information regarding an investigation and facility reported incident (FRI) regarding Resident #48 allegedly being placed in their room with the heat on by a staff member of the facility, being yelled at by a staff person, and having a black eye.

04/15/22 12:47 p.m., phone call with DHP intake analyst who had left the voicemail for the administrator. This staff stated they could only speak hypothetically. If there were an issue, it would go to the board of nursing. We cannot tell anyone not to do an FRI if I get asked that question I tell them they need to talk to the Office of Licensure and Certification (OLC) about that. If someone says something like do I need to report that I direct them to their corporate office, we only deal with the licensee.

The surveyor was given 1 page of an investigation that read, on 03-21-22, the Administrator was made aware of potential abuse regarding Resident #48. The administrator and HR spoke to this resident. The patient stated that no one here has been mean and when asked if they ever had a black eye they replied yes years ago. The administrator and HR personnel signed this document. No other documentation was provided.

04/15/22 1:20 p.m., Administrator stated they had spoken with Resident #48 with their Human Resource manager, talked to staff, talked to the nurse, and what I have written is what has been given to you. The administrator stated they did not complete an FRI after speaking with DHP it was kind of like case closed and I figured I was talking to a state entity. The administrator stated they were going to complete an FRI today and

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F 609	Continued From page 8	F 609		

stated that I did not know of the clear separation of DHP and OLC. The administrator stated they felt like I was reporting when I spoke with the DHP staff and they did not think there was any risk to the patient.

04/15/22 2:27 p.m., call from DHP intake analyst who stated my usual verbage is we are not telling you to investigate something I was just calling to see if it had been investigated. I cannot tell anyone to or not to investigate. That is my usual verbage if I call someone it is because DHP has directed me to do so.

Facility policy titled, "Reporting Requirements/Investigations" effective date 01/23/20 read in part, "The Administrator will ensure the timely reporting, investigating, and follow up reporting of incidents of alleged/suspected patient abuse, neglect, mistreatment, exploitation, or crime against a patient to the State Agency and any other appropriate authorities. Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment...the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not results in serious bodily injury. Notify the Department of Health Office of Licensure and Certification by filing the initial report on the Virginia Department of Health Facility Reported Incident Form...Notify the Adult Protective Services Agency, the local Ombudsman, and the appropriate local law enforcement authorities for any incident of patient

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F 609	Continued From page 9 abuse, mistreatment, neglect. Notify within 24 hours the Department of Health Professions (DHP) for incidences involving...LPN's..." 04/15/22 2:40 p.m., Administrator, DON, and Nurse Consultant were made aware of the issue regarding not reporting an allegation of abuse to the appropriate state agencies. Prior to the exit conference on 04/15/22 the administrator provided the surveyor with a copy of an FRI completed 04/15/22 regarding resident #48. No further information regarding this issue was provided to the survey team prior to the exit conference on 04/15/22.	F 609		
F 655 SS=E	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 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.	F 655		5/17/22

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F 655	Continued From page 10 (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, family interview, and facility document review, the facility staff failed to provide the resident and/or their representatives a summary of the baseline care plans (CP). The facility staff were not providing the resident and/or family's summaries of the resident's baseline care plans. The findings included: 04/12/22 2:29 p.m., during an interview with a family member of Resident #70 the family	F 655	F655 Resident #70 no longer resides in the center. A review of new admissions in the last 30 days was conducted to ensure a summary of the baseline care plan was provided to the resident and/or resident representative. The MDS coordinator/Nursing Leadership will be educated by Regional Director of Clinical Services/designee regarding policy for providing baseline care plan	

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F 655	Continued From page 11 member expressed a concern to the surveyor that they had not been to a care plan meeting for this resident and that they were told the facility did a weekly report but they had never received one. 04/14/22 1:22 p.m., minimum data set (MDS) nurse stated they did not give baseline CP's to the family and that maybe the nurses on the floor do this. 04/14/22 1:23 p.m., Registered Nurse (RN) #4 stated they did jump start meetings but did not give baseline CP's to the families of the residents. 04/14/22 4:25 p.m., during a meeting with the Administrator, Director of Nursing, and Nurse Consultant (NC), the NC stated the facility was supposed to give the baseline CP's to the families and residents during the jump start meetings but they did not know who did this now. 04/14/22 04/15/22 9:27 a.m., NC stated they did not have any documentation that the baseline CP's were being given to anyone during the jump-start meetings. 04/15/22 10:34 a.m., RN #2 stated they did not give baseline CP's to anyone but were now aware they were supposed to be doing this. 04/15/22 11:53 a.m., the NC provided the surveyor with a copy of their policy titled, "Care Planning" effective date 11/01/19. This policy read in part, "...The Center will provide the patient and representative(s) with a summary of the baseline care plan...The RN MDS Coordinator or designee will be responsible for inviting the patient and the family to the conference...Notes will be kept for each patient's care plan discussed at the	F 655	summary to Resident and/or Representative. Education will include providing the baseline care plan summary during the initial care conference meeting with documentation in the medical record to reflect the meeting discussion. The DON/designee will review progress notes daily to ensure documentation in the medical record to reflect care plan meeting discussion to include that the baseline care plan summary was provided to Resident and/or Representative. Results of review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the reviews will be conducted on a random basis. Date of Compliance: 5-17-22	

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F 655	Continued From page 12 conference..." No further information regarding the baseline care plans was provided to the survey team prior to the exit conference on 04/15/22.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized 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.	F 656		5/17/22

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F 656	Continued From page 13 (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 family interview, staff interview, and clinical record review, the facility staff failed to develop a comprehensive care plan and failed to include the residents family in the CP process for 2 of 24 Residents, Resident #70 and #78. For Resident #70, the facility staff failed to develop a CCP when the resident developed pressure ulcers and failed to include the resident's representative in the care plan process. For Resident #78, the facility staff failed to develop a care plan to address depression. The findings included: 1. Section C (cognitive patterns) of Resident #70's admission minimum data set (MDS) assessment with an assessment reference (ARD) date of 03/13/22 included a brief interview for mental status (BIMS) summary score of 12 out of a possible 15 points. Section M (skin) was coded to indicate the resident did not have any pressure ulcers. Diagnoses included, but were not limited to, seizures, anemia, cerebral infarction, cognitive	F 656	F656 Resident #70 no longer resides in the center. Resident #78□s care plan was updated to include diagnosis of depression. A review of care plans for residents with diagnosis of depression and residents with pressure areas were reviewed to ensure the care plans have been updated/revised to reflect the diagnosis of depression and pressure ulcers. The DON/MDS coordinator/Nursing Leadership will be educated by Regional Director of Clinical Services/designee regarding policy for care planning to include updating care plans on an ongoing basis and reviewing quarterly. In addition, the MDS coordinator/designee will invite the Resident and Representative to the care plan conference utilizing the care plan invitation form. The DON/Unit Managers/MDS coordinator or designee will review progress notes and order listing report daily during clinical meeting 5x weekly to will ensure care plans are up to date with	

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F 656	Continued From page 14 communication deficit, urinary retention, benign prostatic hyperplasia, and abdominal aortic aneurysm. 04/12/22 2:29 p.m., during a family interview the family expressed a concern that this resident had not had a care plan meeting and they were told the facility did weekly reports but they had never received one. 04/13/22 3:04 p.m. the MDS coordinator reviewed the clinical record and stated they did not see where they had a CP meeting for this resident or where any invitation to the family had been sent to invite them to a CP meeting. The MDS coordinator stated they would send out an invitation and this resident should have had a CP meeting. 04/14/22 1:22 p.m., the MDS coordinator stated the family had been sent an invitation to a CP meeting that will be held on Tuesday. Resident #70's clinical record included the following documentation. "Skin Observation Tool" dated 03/22/22 Stage 2 Pressure ulcer to sacrum. 03/23/22 Family Nurse Practitioner (FNP) documented "...small open area of skin on...sacrum consistent with a stage 2 decubitus." Wound care notes from an outside company dated 03/24/22-initial encounter stage 2 gluteal fold pressure ulcer and stage 2 buttock pressure ulcer. During a review of Resident #70's CCP, the surveyor was unable to locate any documentation to indicate the resident had any current pressure ulcers. There was a focus area indicating the	F 656	new diagnoses and changes in skin. The MDS coordinator will invite Resident and/or Representative to the scheduled care plan meetings and will provide a copy of care plan conference invitations to the DON in clinical meeting. Invitations will be uploaded into clinical record. Results of review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the reviews will be conducted on a random basis. Cross Reference to 12 VAC 5-371-250 (G and (I) Date of Compliance: 5-17-22	

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F 656	Continued From page 15 resident was at risk for developing pressure ulcers. 04/13/22 10:14 a.m., the surveyor observed the facility nursing staff complete wound care to the resident's buttock pressure ulcer. The area on the gluteal fold was healed. No problems were identified. 04/13/22 12:47 p.m., the surveyor and MDS coordinator reviewed the residents CCP. The MDS coordinator stated they did not see any documentation in relation to the resident's pressure ulcers on the CCP. 04/13/22 5:30 p.m., during an end of the day meeting with the Administrator, Director of Nursing, and Nurse Consultant the missing information in regards to Resident #70's CP was reviewed. The facility provided the surveyor with a copy of a progress note transcribed by the business office manager on 04/14/22 in regards to a CP meeting and an invitation sent to the family indicating a CP meeting would be held on 04/19/22 between the hours of 11:00 a.m. and 12:00 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. Resident #78's minimum data set (MDS)	F 656		

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F 656	Continued From page 16	F 656		

assessment, with an assessment reference date (ARD) of 3/16/22, was signed as completed on 3/18/22. Resident #78 was assessed as able to make self understood and as usually able to understand others. Resident #78 Brief Interview for Mental Status (BIMS) summary score was a 13 out of 15; this indicated intact/borderline cognition. Resident #78 was assessed a requiring assistance with bed mobility, dressing, eating, toilet use, and personal hygiene. Resident #78's diagnoses included, but were not limited to: anemia, high blood pressure, kidney disease, and lung disease.

Resident #78's clinical record included an order for duloxetine 20mg capsule dated 3/24/22. This order included guidance to "give 1 capsule by mouth one time a day for depression".

A family nurse practitioner (FNP) note dated 3/30/22 indicated the plan for treating Resident #78's depression was the medication duloxetine.

The facility staff failed to develop a care plan addressing Resident #78 being provided a medication for depression. Resident #78's clinical documentation included a comprehensive care plan; the comprehensive care plan did not address depression.

The following information was found in a facility policy/procedure titled "Care Planning" (with an effective date of 11/1/19):
- "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical

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F 656	Continued From page 17 physical, mental, and psychosocial well-being of the patient." - "Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment." On 4/15/22 at 9:31 a.m., the facility's Corporate Nurse was interviewed about Resident #78's care plan not addressing the resident's depression; the Corporate Nurse acknowledged the care plan did not address the resident's depression. A survey team meeting was conducted with the facility's Administrator, Director of Nursing, and Corporate Nurse on 4/15/22 at 2:45 p.m. The failure of the facility staff to develop a care plan to address Resident #78's medication for depression was discussed. No addition information related to this issue was provided to the survey team.	F 656		
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	F 657		5/17/22

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F 657	Continued From page 18 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. (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 residents comprehensive care plans (CCP) for 2 of 24 Residents, Residents #53 and #70. The facility staff failed to review and revise Resident #53 CCP when the residents foley catheter was discontinued and failed to review and revise Resident #70's CCP when the residents aspirin was discontinued. The findings included: 1. Section C (cognitive patterns) of Resident #53's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/02/22 included a brief interview for mental status (BIMS) score of 9 out of a possible 15 points. Per the MDS manual a score of 8-12 indicated a resident was moderately impaired in cognitive skills for daily decision-making. Section H (bladder and bowel) had been coded to indicate the resident has a foley catheter.	F 657	F657 Resident #70 no longer resides in the center. Resident #53□s care plan was updated to remove use of Foley catheter. A review of care plans for the current residents in the center have been completed to ensure the care plan reflects the resident□s current status. The DON/MDS coordinator/Nursing Leadership will be educated by Regional Director of Clinical Services regarding policy for care planning to include updating care plans on an ongoing basis and reviewing quarterly to ensure care plan reflects the resident□s current status. The DON/designee will 10 care plans weekly to ensure care plans are up to date and reflect the resident□s current status. Results of review will be discussed at the monthly QAPI meeting. Once the QAPI	

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F 657	Continued From page 19 Diagnoses included, but were not limited to, autistic disorder, urinary tract infection, major depressive disorder, and benign prostatic hyperplasia. The CCP included the focus areas-resident has a urinary tract infection (UTI) related to chronic indwelling catheter and is at risk for more UTI's and has chronic indwelling foley catheter. Creation date for both areas was 03/03/22. 04/13/22 8:17 a.m., the surveyor did not observe a foley catheter in place. 04/13/22 9:04 a.m., MDS coordinator reviewed the CCP with the surveyor and stated they had meetings everyday regarding the residents and the staff were supposed to let them know of changes. The clinical record included a progress note documented by Licensed Practical Nurse (LPN) #7 on 03/17/22 "Foley catheter removed at 1800. No complications or discomfort...Will continue to monitor voiding for the next 6 hrs (hours). If no voiding in 6 hrs, foley will be reinserted." A physicians order was written to discontinue the foley catheter on 03/17/22. 04/13/22 5:30 p.m., during an end of the day meeting with the Administrator, Director of Nursing, and Nurse Consultant the issue with the foley catheter being on the CCP after it had been discontinued in March was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 657	committee determines the problem no longer exists the reviews will be conducted on a random basis. Cross Reference to 12 VAC 5-371-250 (C) and (F) Date of Compliance: 5-17-22	

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F 657	Continued From page 20 2. Section C (cognitive patterns) of Resident #70's admission minimum data set (MDS) assessment with an assessment reference (ARD) date of 03/13/22 included a brief interview for mental status (BIMS) summary score of 12 out of a possible 15 points. Section M (skin) was coded to indicate the resident did not have any pressure ulcers. Diagnoses included, but were not limited to, seizures, anemia, cerebral infarction, cognitive communication deficit, urinary retention, benign prostatic hyperplasia, and abdominal aortic aneurysm. Resident #70's clinical record included information indicating the anticoagulant medication aspirin was put on hold on 03/16/22 and discontinued on 03/21/22. On 03/21/22, the Family Nurse Practitioner transcribed a progress note that stated plavix and aspirin were contraindicated for this resident. Resident #70's CCP included the focus area resident is on anticoagulant therapy aspirin/plavix status post cerebral vascular accident (stroke). Interventions included administer anticoagulant medications as ordered by physician. Created and revision dates were documented as 03/14/22. 04/13/22 2:00 p.m., the MDS coordinator reviewed the CCP with the surveyor and confirmed that aspirin was still on the residents CCP. 04/13/22 5:30 p.m., during an end of the day meeting with the Administrator, Director of	F 657		

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F 657	Continued From page 21 Nursing, and Nurse consultant the issue with the anticoagulant medication being on the residents CCP after it had been discontinued was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 657		
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 observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide activities of daily living care (ADL) for dependent care residents for 3 of 24 residents, Residents #8, #53, and #95. Resident's #8 and #95 were observed to have long, jagged fingernails with debris present. Resident #53's fingernails and toenails were observed to be long, jagged, with debris present. The findings included: 1. Section C (cognitive patterns) of Resident #8's significant change in status minimum data set (MDS) assessment with an assessment reference date (ARD) of 01/10/22 included a brief interview for mental status (BIMS) summary score of 10 out of a possible 15 points. Per the MDS manual, a score of 8-12 indicated a resident was moderately impaired in cognitive skills for daily decision-making. Section G (functional	F 677	F677 Residents #8, #53, and #95 have had their fingernails/toenails cleaned and trimmed. Current Residents in the center have the potential to be affected. Current nursing staff will be educated by SDC/designee regarding nail care. Each Resident will be provided a nail brush to be used to clean fingernails and toenails during bath days and as needed. Fingernails will be trimmed on bath days as needed. Residents in need of toenail trimmings will be referred to Nurse Practitioner daily as needed. Residents that require further podiatry care will be placed on monthly podiatrist list. DON/Nursing Leadership will review 10 Residents per day per week to ensure fingernails and toenails are clean and trimmed.	5/17/22

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F 677	Continued From page 22 status) was coded 3/2 to indicate the resident required extensive assistance of one person for personal hygiene. Diagnoses included, but were not limited to, diabetes and muscle weakness. Resident #8's comprehensive care plan included the focus area ADL self-care performance deficit and resistant to care at times. 04/13/22 8:32 a.m., Resident #8's fingernails observed to be long and jagged with debris present under the nails. The resident stated they probably needed to be cut. Refused to allow the surveyor to see his toenails. 04/13/22 5:30 p.m., during an end of the day meeting with the Administrator, Director of Nursing, and Nurse Consultant the issue with the residents nails was reviewed. 04/15/22 8:18 a.m., certified nursing assistant (CNA) #4 stated they cut resident fingernails and the podiatrist would do the toenails. If we see someone who nails need to be trimmed, we tell the nurse. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. Section C (cognitive patterns) of Resident #53's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/02/22 included a brief interview for mental status (BIMS) score of nine out of a possible 15 points. Per the MDS manual a score of 8-12 indicated a resident was moderately	F 677	Results of review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the reviews will be conducted on a random basis. Cross Reference to 12 VAC 5-371-220 (D) Date of Compliance: 5-17-22	

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F 677	Continued From page 23	F 677		

impaired in cognitive skills for daily decision-making. Section G (functional status) was coded 3/2 to indicate the resident required extensive assistance of one person for personal hygiene.

Diagnoses included, but were not limited to, autistic disorder and major depressive disorder.

The residents comprehensive care plan included the focus area has ADL self-care performance deficit.

04/13/22 8:05 a.m., fingernails observed to be long and jagged. Resident #53 kept pointing to feet and saying "sore toe." Checked feet with staff development coordinator (SDC) toenails observed to be long, jagged, thick, and discolored. Resident #53's left great big toenail was observed with a brown substance at bottom of toenail bed. SDC stated they would let the Nurse Practitioner know and add this resident to the podiatry list.

04/13/22 8:14 a.m., unit manager stated the podiatrist was at the facility on March 24 but they did not think this resident had been seen and that the podiatrist generally cuts nails.

04/13/22 8:57 a.m., the Family Nurse Practitioner (FNP) stated the podiatrist will not go in to resident rooms and that the facility had bought instruments last week to cut nails. The FNP also stated that initially this resident was not able to get up.

04/13/22 5:30 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), and Nurse Consultant the issue

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F 677	Continued From page 24	F 677		

with the residents nails was reviewed. The DON stated the FNP had ordered something for Resident #53's toenails.

04/13/22 the FNP transcribed orders for Resident #53's left great toe to be painted with betadine everyday due to toe fungus and for the medication terbinafine HCL 250 mg one time a day for fungus.

04/15/22 8:18 a.m., certified nursing assistant (CNA) #4 stated they cut resident fingernails and the podiatrist would do the toenails. If we see someone who nails need to be trimmed, we tell the nurse.

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. Section C (cognitive patterns) of Resident #95's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/22/22 included a brief interview for mental status (BIMS) summary score of 15 out of a possible 15 points. Indicating the resident was cognitively intact. Section G (functional status) was coded 3/2 for personal hygiene indicating the resident required extensive assistance of one person for this task.

Diagnoses included, but were not limited to, diabetes, bipolar disorder, muscle weakness, and end stage renal disease.

Resident #95's comprehensive care plan included the focus area ADL self-care deficit.

04/13/22 8:33 a.m., observed Resident #95 up in

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F 677	Continued From page 25 room stated their fingernails needed cutting and that they were told they cut them on shower days. 04/14/22 1:38 p.m., fingernails remain long with debris present under nails. 04/15/22 8:18 a.m., certified nursing assistant (CNA) #4 stated they cut resident fingernails and the podiatrist would do the toenails. If we see someone who nails need to be trimmed, we tell the nurse. 04/15/22 2:40 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), and Nurse Consultant the issue with the residents nail care was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 677		
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	F 686		5/17/22

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F 686	Continued From page 26 by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure residents with pressure ulcers receive necessary treatment and services to promote healing for 1 of 24 residents in the survey sample, Resident #107. For Resident #107, the facility staff failed to provide the correct physician's ordered treatment to a pressure area on the right trochanter on 4/14/22. The findings included: Resident #107's diagnosis list indicated diagnoses, which included, but not limited to Metabolic Encephalopathy, Protein-Calorie Malnutrition, Osteomyelitis, Major Depressive Disorder, Dementia, Adult Failure to Thrive, Functional Quadriplegia, and Essential Hypertension. The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 3/28/22 assigned the resident a brief interview for mental status (BIMS) summary score of 7 out of 15 indicating the resident was severely cognitively impaired. Resident #107 was coded as requiring extensive assistance with bed mobility, personal hygiene and being totally dependent on staff for eating, toileting, and bathing. Resident #107 was coded as having two (2) unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar that were present upon admission/entry or reentry. Resident #107's current comprehensive person-centered plan of care included a focus	F 686	F686 Resident #107 is currently receiving treatment as ordered by the physician. The Nurse Practitioner was notified that a wet to dry dressing was used on 4/14/22. No new orders received. Current Residents with pressure areas in the center have the potential to be affected. Current licensed nurses will be educated by SDC/designee regarding policy to provide wound care/dressing changes as ordered by the physician. In addition, education will be provided regarding process for ordering required dressing supplies and notification of physician as needed if a change in current treatment is necessary. DON/Nursing Leadership will review Residents with active wound care dressing orders weekly to ensure accuracy of treatment order and availability of supplies. DON/Nursing Leadership will review order listing report daily to ensure that the necessary supplies are available for new wound care dressing orders. Results of review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the reviews will be conducted on a random basis. Cross Reference to 12 VAC 5-371-220 (C)(1) Date of Compliance: 5-17-22	

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F 686	Continued From page 27	F 686		

area stating in part "The resident has a pressure ulcer to the right hip stage 4 and buttock stage 4. The resident has a risk for worsening pressure ulcers or the development of additional pressure ulcers related to: frequent incontinence, immobility, inability to turn and reposition independently".

Resident #107's current physician's orders included an order dated 3/24/22 to clean right trochanter with normal saline, pack with Iodoform and apply Mepilex foam border every night shift for wound. A review of the resident's April 2022 treatment administration record (TAR) revealed the treatment was documented with a "9" on 4/13/22. According to the TAR Chart Codes, a "9" indicated "Other/See Progress Notes". Resident's progress note dated 4/14/22 2:16 am read in part "cleaned with NS (normal saline) and packed with wet to dry until Iodoform is ordered". Surveyor reviewed the resident's current orders and did not locate an order to substitute Iodoform with a wet to dry dressing.

On 4/15/22 at 8:47 am, surveyor spoke with licensed practical nurse (LPN) #3 and asked if Resident #107 had Iodoform available. In the presence of the surveyor, LPN #3 checked the treatment cart and stated "no, I don't see it". At 9:05 am, surveyor spoke with the director of nursing (DON) regarding Resident #107's Iodoform not being available and the nurse on 4/14/22 substituting it with a wet to dry dressing without an order. DON stated they had ran out of the Iodoform. DON reviewed the resident's orders and acknowledged there was no order for the wet to dry dressing for the right trochanter pressure area. DON stated the administrator was in route to their sister facility to obtain Iodoform

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F 686	Continued From page 28 for the resident. At 9:14 am, the administrator returned to the facility with Iodoform for Resident #107. Surveyor requested and received the facility policy entitled "General Wound Care/Dressing Changes" which read in part "A licensed nurse will provide wound care/dressing change(s) as ordered by physician". On 4/15/22 at 2:39 pm, surveyor met with the administrator, DON, and regional nurse and discussed the concern of staff substituting the resident's physician ordered treatment to the right trochanter pressure wound without an order. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/15/22.	F 686		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756		5/17/22

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F 756	Continued From page 29 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to act on pharmacist reported irregularities for 4 of 24 residents, Resident #5, Resident #46, #41, and #86. For Resident #5 the facility staff failed to discontinue the medication, Dexilant per the pharmacist recommendation and family nurse practitioner (FNP) order. Dexilant is a proton pump inhibitor (PPI) used to reduce gastric acid production, and in the treatment of gastric reflux. For Resident #46 the facility staff failed to discontinue the medication, Voltaren (diclofenac sodium) gel per the pharmacist recommendation	F 756	F756 Resident #5□s Dexilant medication has been discontinued per physician order. Resident #46□s Voltaren gel has been discontinued per physician order. Resident #41□s pharmacist recommendations have been completed and are up to date. Resident #81□s pharmacist recommendations have been completed and are up to date. Current Residents in the center have the potential to be affected. DON/Nursing Leadership/Nurse Practitioner will be educated by Regional	

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F 756	Continued From page 30 and the FNP order. Voltaren gel is a nonsteroidal anti-inflammatory medication used to treat osteoarthritis. The findings included: 1. Resident #5's face sheet listed diagnoses which included but not limited to dysphagia, gastroesophageal reflux disease, diabetes mellitus, and depression. Resident #5's most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 01/07/22 assigned the resident a brief interview for mental status (BIMS) score of 5 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #5's clinical record was reviewed on 04/14/22 and contained a pharmacist drug regimen review form dated 12/31/21 which read in part, "See report for any noted irregularities and/or recommendations". The resident's clinical record also contained a "Consultant Pharmacist Recommendation to Physician" form dated 12/31/21, which read in part "This resident has been taking Dexilant 60 mg QD (every day) since 07/14/21 ...All PPI therapy requires a documented review for continued use after 12 weeks of routine use. Response: Discontinue PPI therapy." This form was signed by the consultant pharmacist. Under the "Physician/Provider Response" section of the form, the facility FNP had signed the form on 03/15/22. Resident #5's physician order summary for the month of April 2022 was reviewed and contained an order which read in part, "Dexilant Capsule	F 756	Director of Clinical Services regarding policy to timely act upon pharmacy recommendations. In addition, the process for retrieving and reviewing recommendations will be addressed to include documentation of completed reviews. DON/designee will access Senior Care pharmacy website 3x weekly to review interim pharmacy medication reviews and will access website monthly after pharmacy consultant visits to review recommendations. Reported irregularities will be addressed by Nursing leadership and/or physician/NP. DON will review each recommendation for completion and will then send to medical records to scan in clinical record. Results of review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the reviews will be conducted on a random basis. Cross Reference to 12 VAC 5-371-300 (I) Date of Compliance: 5-17-22	

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Delayed Release 60 mg (Dexlansoprazole) Give 1 capsule by mouth one time a day related to GASTROESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS (K21.9)"
Resident #5's electronic medication administration record (eMAR) for the month of April 2022 was reviewed and contained an entry, which read in part, "Dexilant Capsule Delayed Release 60 mg (Dexlansoprazole) Give 1 capsule by mouth one time a day related to GASTROESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS (K21.9)". This entry was initialed as being administered as per the order.

Surveyor spoke with the facility FNP on 04/14/22 at 11:05 am. Surveyor asked the FNP if the medication should have been discontinued, and FNP stated that it should have been. FNP also stated that the pharmacist sends the recommendation, the FNP then reviews, signs and faxes back to pharmacy. The pharmacy should then change the orders accordingly. FNP stated, "It is considered a pharmacy initiated order that I then sign".

Surveyor spoke with the facility director of nursing (DON) and regional nurse consultant (RNC) on 04/15/22 at 9:20 am. Surveyor asked the DON if they should have reviewed and signed the pharmacist recommendation form, and the RNC stated, "The DON runs the pharmacist report each month, distributes to the unit managers, who then gives it to the provider (FNP/physician) to decide what they want to do. The DON will then review again to ensure it gets done".

Surveyor requested and was provided with a facility policy entitled "Documentation and

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F 756	Continued From page 32 Communication of Consultant Pharmacist Recommendations", which read in part "The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist's observations and recommendation regarding residents' medication therapies are communicated to those with authority and /or responsibility to implement the recommendations and are responded to in an appropriate and timely fashion. 2. Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review ...3. Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to a recommendation directed to him/her within 30 days, the Director of Nursing and/or the consultant pharmacist may contact the Medical Director. If the prescriber that does not respond is also the Medical Director, the Director of Nursing and the Administrator will address the requirements with the Medical Director and/or pursue formal actions if necessary to facilitate compliance." The concern of acting upon the pharmacist recommendations was discussed with the administrative team on 04/15/22 at 11:50 am. Surveyor was provided with updated physician's order discontinuing the medication at this time. No further information was provided. 2. Resident #46's face sheet listed diagnoses which included but not limited to Parkinson's disease, peripheral vascular disease, fibromyalgia, chronic pain and polyosteoarthritis.	F 756		

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F 756	Continued From page 33 Resident #46's most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 02/25/22 assigned the resident a brief interview for mental status (BIMS) score of 5 out of 15. This indicates that the resident is severely cognitively impaired. Resident #46's clinical record was reviewed on 04/14/22 and contained a pharmacist drug regimen review form dated 01/26/22 which read in part, "See report for any noted irregularities and/or recommendations". The resident's clinical record also contained a "Consultant Pharmacist Recommendation to Physician" form dated 12/31/21, which read in part "Resident currently has the following order: Diclofenac Sodium (Voltaren) 1% Gel: apply to knees topically every night shift for pain. This medication is typically dosed in grams to the affected area. Per the manufacturer, upper extremities: Apply 2 grams Q (every) 6 hours-not to exceed 8 grams/day to any single joint. Lower extremities: Apply 4 grams Q 6 hours-not to exceed 16 grams/day to any single joint. Could you please specify the number of grams that should be applied? Thank you!" This form was signed by the consultant pharmacist. Under the "Physician/Provider Response" section of the form, the facility FNP had hand-written "d/c (discontinue) med" and signed the form on 03/15/22. Resident #46's clinical record contained a physician's order summary for the month of April 2022 which read in part, "Voltaren gel 1% (Diclofenac Sodium) Apply to knees topically every night shift for pain" Resident #46's electronic medication administration record (eMAR) for the month of	F 756		

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April 2022 was reviewed and contained an entry which read in part, "Voltaren gel 1% (Diclofenac Sodium) Apply to knees topically every night shift for pain" This entry was initialed as being administered per the physician's order.
Surveyor spoke with the facility FNP on 04/14/22 at 11:05 am. Surveyor asked the FNP if the medication should have been discontinued, and FNP stated that it should have been. FNP also stated that the pharmacist sends the recommendation, the FNP then reviews, signs and faxes back to pharmacy. The pharmacy should then change the orders accordingly. FNP stated, "It is considered a pharmacy initiated order that I then sign".

Surveyor spoke with the facility director of nursing (DON) and regional nurse consultant (RNC) on 04/15/22 at 9:20 am. Surveyor asked the DON if they should have reviewed and signed the pharmacist recommendation form, and the RNC stated, "The DON runs the pharmacist report each month, distributes to the unit managers, who then gives it to the provider (FNP/physician) to decide what they want to do. The DON will then review again to ensure it gets done".

Surveyor requested and was provided with a facility policy entitled "Documentation and Communication of Consultant Pharmacist Recommendations", which read in part "The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist's observations and recommendation regarding residents' medication therapies are communicated to those with authority and /or responsibility to implement the recommendations and are responded to in an appropriate and timely fashion. 2. Comments and recommendations

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concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review ...3. Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to a recommendation directed to him/her within 30 days, the Director of Nursing and/or the consultant pharmacist may contact the Medical Director. If the prescriber that does not respond is also the Medical Director, the Director of Nursing and the Administrator will address the requirements with the Medical Director and/or pursue formal actions if necessary to facilitate compliance."

The concern of acting upon the pharmacist recommendations was discussed with the administrative team during on 04/15/22 at 11:50 am. Surveyor was provided with updated physician's order discontinuing the medication at this time.

No further information was provided.

3. Resident #41's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 2/23/22, was dated as completed on 2/25/22. Resident #41 was assessed as able to make self understood and as able to understand others. Resident #41's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact or borderline cognitive impairment. Resident #41 was assessed as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #41's diagnoses included, but were not limited to: high blood pressure, kidney

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F 756	Continued From page 36 disease, diabetes, anxiety, and lung disease. Resident #41's clinical record included two (2) "Consultant Pharmacist Medication Regimen Review" documents one dated 10/24/21 and one dated 11/30/21. Both of these documents indicated: "See report for any noted irregularities and/or recommendations." No recommendations for these dates were found in Resident #41's clinical record. On 4/15/22 at 9:44 a.m., the facility's Corporate Nurse stated no recommendations for the aforementioned dates were sent by the pharmacist. The Corporate Nurse stated an email was sent, on the morning of 4/15/22, to obtain the recommendations for the aforementioned dates. Resident #41's clinical record included a "Consultant Pharmacist Recommendation to Physician" form dated 9/26/21. This document recommended a dose reduction for alprazolam from 0.5 mg to 0.25 mg at bedtime. The provider did not act on this recommendation until 11/5/21. On 4/15/21 at 9:49 a.m., the Corporate Nurse acknowledged a delay in the provider's response to the aforementioned alprazolam dose reduction recommendation. The Corporate Nurse stated the facility was working on improving the process to get pharmacist recommendations addressed in a timely manner. The following information was found in a facility pharmacy policy/procedure titled "Documentation and Communication of Consultant Pharmacist Recommendations" (with an effective date of August 2020): - "The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist's observations and	F 756		

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F 756	Continued From page 37	F 756		

recommendations regarding residents' medication therapies are communicated to those with authority and/or responsibility to implement the recommendations and are responded to in an appropriate and timely fashion."
- "The timing of these recommendations should enable a response prior to the next medication regimen review."

The failure of the facility staff to ensure Resident #41's pharmacist recommendation from medication regimen reviews were acted on by the provider in a timely manner was discussed with the facility's Administrator, Director of Nursing, and Corporate Nurse during survey team meeting on 4/15/22 at 2:45 p.m.

4. Resident #81's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 3/16/22, was dated as completed on 3/18/22. Resident #81 was assessed a usually able to make self understood and as usually able to understand others. Resident #81's Brief Interview for Mental Status (BIMS) summary score was documented as a 5 out of 15; this indicated severe cognitive impairment. Resident #81 was assessed as requiring assistance with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. Resident #81's diagnoses included, but were not limited to: high blood pressure, diabetes, arthritis, and dementia.

Resident #81's clinical record included a "Consultant Pharmacist Medication Regimen Review" document dated 12/31/21. This document indicated: "See report for any noted irregularities and/or recommendations." No recommendations for the 12/31/21 review date was found in Resident #81's clinical record. On

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F 756	Continued From page 38 4/15/22 at 9:51 a.m., the facility's Corporate Nurse stated no recommendations for the aforementioned date was sent by the pharmacist. The Corporate Nurse stated an email was sent, on the morning of 4/15/22, to obtain the 12/31/21 pharmacist recommendation. The following information was found in a facility pharmacy policy/procedure titled "Documentation and Communication of Consultant Pharmacist Recommendations" (with an effective date of August 2020): - "The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist's observations and recommendations regarding residents' medication therapies are communicated to those with authority and/or responsibility to implement the recommendations and are responded to in an appropriate and timely fashion." - "The timing of these recommendations should enable a response prior to the next medication regimen review." The failure of the facility staff to ensure Resident #81's pharmacist recommendation from the 12/31/21 medication regimen review was appropriately addressed was discussed with the facility's Administrator, Director of Nursing, and Corporate Nurse during survey team meeting on 4/15/22 at 2:45 p.m.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		5/17/22

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F 757	Continued From page 39 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure 2 of 24 residents were free from unnecessary medications, Resident #5 and Resident #46. For Resident #5, the facility staff failed to discontinue the medication, Dexilant per the family nurse practitioner's order. Dexilant is a proton pump inhibitor (PPI) used to reduce gastric acid production, and in the treatment of gastric reflux. For Resident #46, the facility staff failed to discontinue the medicaiton, Voltaren gel (diclofenac sodium) per the family nurse practitioner's order. Voltaren gel is a nonsteroidal anti-inflammatory medication used to treat osteoarthritis.	F 757	F757 Resident #5□s Dexilant medication has been discontinued. Resident #46□s Voltaren gel has been discontinued. Current Residents in the center have the potential to be affected. DON/Nursing Leadership/Nurse Practitioner will be educated by Regional Director of Clinical Services regarding policy to timely act upon pharmacy recommendations. In addition, the education will include ensuring that any physician orders received from the recommendations are noted in the clinical record. DON/designee will access Senior Care pharmacy website 3x weekly to review	

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F 757	Continued From page 40 The findings included: 1.Resident #5's face sheet listed diagnoses which included but not limited to dysphagia, gastroesophageal reflux disease, diabetes mellitus, and depression. Resident #5's most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 01/07/22 assigned the resident a brief interview for mental status (BIMS) score of 5 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #5's clinical record contained a "Consultant Pharmacist Recommendation to Physician" form dated 12/31/21, which read in part "This resident has been taking Dexilant 60 mg QD (every day) since 07/14/21 ...All PPI therapy requires a documented review for continued use after 12 weeks of routine use. Response: Discontinue PPI therapy." This form was signed by the consultant pharmacist. Under the "Physician/Provider Response" section of the form, the facility FNP had signed the form on 03/15/22. Resident #5's physician order summary for the month of April 2022 was reviewed and contained an order which read in part, "Dexilant Capsule Delayed Release 60 mg (Dexlansoprazole) Give 1 capsule by mouth one time a day related to GASTROESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS (K21.9)" Resident #5's electronic medication administration record (eMAR) for the month of April 2022 was reviewed and contained an entry, which read in part, "Dexilant Capsule Delayed	F 757	interim pharmacy medication reviews and will access website monthly after pharmacy consultant visits to review recommendations. Recommendations with physician orders will be completed by Nursing leadership. DON will review each recommendation for completion and will then send to medical records to scan in clinical record. Results of review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the reviews will be conducted on a random basis. Cross Reference to 12 VAC 5-371-220 (B) Date of Compliance: 5-17-22	

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Release 60 mg (Dexlansoprazole) Give 1 capsule by mouth one time a day related to GASTROESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS (K21.9)". This entry was initialed as being administered as per the order.

Surveyor spoke with the facility FNP on 04/14/22 at 11:05 am. Surveyor asked the FNP if the medication should have been discontinued, and FNP stated that it should have been. FNP also stated that the pharmacist sends the recommendation, the FNP then reviews, signs and faxes back to pharmacy. The pharmacy should then change the orders accordingly. FNP stated, "It is considered a pharmacy initiated order that I then sign".

The concern of the facility staff failing to ensure Resident #5 was free of unnecessary medications was discussed with the administrative team (administrator, director of nursing, regional nurse consultant) on 04/15/22 at 11:50 am. Surveyor was provided with updated physician's order discontinuing the medication at this time.

No further information was provided.

2. Resident #46's face sheet listed diagnoses which included but not limited to Parkinson's disease, peripheral vascular disease, fibromyalgia, chronic pain and polyosteoarthritis.

Resident #46's most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 02/25/22 assigned the resident a brief interview for mental status (BIMS) score of 5 out of 15. This indicates that the resident is severely cognitively impaired.

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F 757	Continued From page 42 Resident #46's clinical record contained a "Consultant Pharmacist Recommendation to Physician" form dated 12/31/21, which read in part "Resident currently has the following order: Diclofenac Sodium (Voltaren) 1% Gel: apply to knees topically every night shift for pain. This medication is typically dosed in grams to the affected area. Per the manufacturer, upper extremities: Apply 2 grams Q (every) 6 hours-not to exceed 8 grams/day to any single joint. Lower extremities: Apply 4 grams Q 6 hours-not to exceed 16 grams/day to any single joint. Could you please specify the number of grams that should be applied? Thank you!" This form was signed by the consultant pharmacist. Under the "Physician/Provider Response" section of the form, the facility FNP had hand-written "d/c (discontinue) med" and signed the form on 03/15/22. Resident #46's clinical record contained a physician's order summary for the month of April 2022 which read in part, "Voltaren gel 1% (Diclofenac Sodium) Apply to knees topically every night shift for pain" Resident #46's electronic medication administration record (eMAR) for the month of April 2022 was reviewed and contained an entry which read in part, "Voltaren gel 1% (Diclofenac Sodium) Apply to knees topically every night shift for pain" This entry was initialed as being administered per the physician's order. Surveyor spoke with the facility FNP on 04/14/22 at 11:05 am. Surveyor asked the FNP if the medication should have been discontinued, and FNP stated that it should have been. FNP also stated that the pharmacist sends the	F 757		

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F 757	Continued From page 43 recommendation, the FNP then reviews, signs and faxes back to pharmacy. The pharmacy should then change the orders accordingly. FNP stated, "It is considered a pharmacy initiated order that I then sign". The concern of the facility staff failing to ensure Resident #46 was free of unnecessary medications was discussed with the administrative team (administrator, director of nursing, regional nurse consultant) on 04/15/22 at 11:50 am. Surveyor was provided with updated physician's order discontinuing the medication at this time. No further information was provided.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		5/17/22

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F 758	Continued From page 44 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, and facility document review, the facility staff failed to ensure residents were free of unnecessary psychotropic medications for 1 of 24 residents, Resident #78. Resident #78 was ordered and provided a medication, duloxetine, without monitoring for effectiveness or side effects. The findings include:	F 758	F758 Resident #78 currently has side effect and effectiveness monitoring for Duloxetine. Current Residents in the center receiving psychotropic medications have the potential to be affected. Current licensed nurses will be educated by SDC/designee regarding policy for behavioral assessment/behavior	

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F 758	Continued From page 45 Resident #78's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 3/16/22, was signed as completed on 3/18/22. Resident #78 was assessed as able to make self understood and as usually able to understand others. Resident #78 Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact/borderline cognition. Resident #78 was assessed a requiring assistance with bed mobility, dressing, eating, toilet use, and personal hygiene. Resident #78's diagnoses included, but were not limited to: anemia, high blood pressure, kidney disease, and lung disease. Resident #78's clinical record included an order for duloxetine 20mg capsule dated 3/24/22. This order included guidance to "give 1 capsule by mouth one time a day for depression". A family nurse practitioner (FNP) note dated 3/30/22 indicated the plan for Resident #78's depression was the medication duloxetine. The facility staff failed to develop a care plan addressing Resident #78 being provided a medication for depression. Resident #78's clinical documentation included a comprehensive care plan; this comprehensive care plan did not address depression. Resident #78's clinical record failed to include evidence of monitoring for the effectiveness of the duloxetine. During an interview with the facility's Corporate Nurse on 4/15/22 at 9:31 p.m., the Corporate Nurse confirmed there was no documentation to indicate monitoring of Resident #78 for signs and symptoms of depression; the	F 758	monitoring to include monitoring of side effects and effectiveness of medication. In addition, the nurses will be educated to include medication monitoring on the Medication Administration Record. Unit Managers/designees will review order listing report in clinical meeting 5x weekly to ensure psychotropic medications are being monitored for side effects/effectiveness and to ensure documentation of the monitoring is recorded on the medication administration record. Results of review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the reviews will be conducted on a random basis. Cross Reference to 12 VAC 5-371-220 (A) Date of Compliance: 5-17-22	

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F 758	Continued From page 46 Corporate Nurse stated there was no documentation of monitoring for side effects of the duloxetine. The following information was found in a facility pharmacy policy/procedure titled "General Guidelines for Medication Administration" (with a revision date of August 2020): "Monitoring of side effects or medication-related problems occurs continually, but particularly after medication administration and especially after the first few doses of a new medication." The following information was found in a facility policy/procedure titled "Behavioral Assessment/Behavior Monitor" (with an effective date of 11/1/19): "Problematic behavior shall be assessed and monitored. Factors influencing behaviors as well as management interventions shall be evaluated and care planned." On 4/14/22 at 4:25 p.m., the failure of the facility staff to monitor the effectiveness of Resident #78's medication, duloxetine, was discussed with the facility's Administrator, Director of Nursing, and Corporate Nurse. No additional information related to this issue was provided to the survey team prior to the conclusion of the survey.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) 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 staff interviews, clinical record reviews, facility document reviews, and in the course of a	F 760	F760	5/17/22

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F 760	Continued From page 47 complaint investigation, the facility staff failed to ensure 1 of 24 residents, Resident #164, was free of significant medication errors. Resident #164 did not receive their insulin per provider orders. The findings include: Resident #164's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 11/9/20, was signed as completed on 11/12/2020. Resident #164 was assessed as able to make self understood and as able to understand others. Resident #164's Brief Interview for Mental Status (BIMS) summary score was documented as a 9 out of 15; this indicated moderate cognitive impairment. Resident #164 was assessed as requiring assistance with bed mobility, transfers, and bathing. Resident #164 was assessed as requiring supervision with dressing, eating, toilet use, and personal hygiene. Resident #164's diagnoses included, but were not limited to: high blood pressure, diabetes, dementia, depression, and vision trouble. Review of Resident #164's provider orders for November 2020 included an order for insulin lispro 5 units subcutaneous injection to be administered before meals and at bed time. This order indicated the insulin should not be administered if the resident's blood sugar was 150 or less. Resident #164's medication administration records (MARs) for November 2020 was reviewed. The following doses of insulin were administered when they should have been held: 11/7/20 at 7:30 a.m.; 11/10/20 at 7:30 a.m.; 11/13/20 at 7:30 a.m.; 11/14/20 at 9:00 p.m.;	F 760	Resident #164 no longer resides in the center. Current Residents in the center receiving insulin have the potential to be affected. Current licensed nurses will be educated by SDC/designee regarding medication administration policy to include following physician orders. In addition, the nurses will be educated regarding accurate administration of insulin when order parameters are in place. DON/Nursing Leadership will review Medication Administration Records in clinical meeting 5x weekly to ensure residents receiving insulin with parameters is administered per physician orders. Results of review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the reviews will be conducted on a random basis. Cross Reference to 12 VAC 5-371-220 (A) Date of Compliance: 5-17-22	

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F 760	Continued From page 48 11/16/20 at 9:00 p.m.; 11/17/20 at 9:00 p.m.; 11/22/20 at 7:30 a.m.; 11/23/20 at 4:00 p.m.; 11/25/20 at 9:00 p.m.; 11/27/20 at 4:00 p.m.; 11/28/20 at 7:30 a.m.; and 11/28/20 at 9:00 p.m. The following information was found in facility pharmacy policy/procedure titled "General Guidelines for Medication Administration" (with a revision date of August 2020): - "Medications are administered in accordance with written orders of the prescriber." - "At a minimum, the 5 Rights - right resident, right drug, right dose, and right time - should be applied to all medication administration ..." Resident #164 being administered insulin when it was suppose to the held was discussed with the Administrator, Director of Nursing, and Corporate Nurse on 4/15/22 at 2:45 p.m. No additional information related to this issue was provided to the survey team. This is a complaint deficiency.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		5/17/22

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F 761	Continued From page 49 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to store drugs and biologicals in locked compartments on 1 of 2 facility units, North Wing. On North Wing, the facility staff left two (2) unopened saline flush syringes, a 500 ml IV bag of normal saline, and a blister pack card of Vitamin D2 tablets unattended on top of a medication cart. The findings included: On 4/14/22 at 4:07 pm, surveyor observed an unattended medication cart in the West Wing hall near the nurse's station. On top of the medication cart were two (2) unopened saline flush syringes, a 500 ml IV bag of normal saline, and a blister pack card of Vitamin D2 tablets. There were no staff within sight of the medication cart and one (1) resident was sitting in a wheelchair near the nurse's station. Surveyor remained beside the medication cart for approximately two (2) minutes until licensed	F 761	F761 Drugs and biologicals are currently stored in locked compartments on both nursing units. Current Residents in the center have the potential to be affected. Current licensed nurses will be educated by SDC/designee regarding policy for medication storage to include medication rooms and carts being locked. In addition, education will be provided regarding medications not being left unattended. Unit Managers/Nursing leadership will observe medication storage 5x weekly during routine rounding. Medication carts will be observed to ensure medications are not unattended and carts are locked. Results of observations will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the reviews will be conducted on a random basis. Cross Reference to 12 VAC 5-371-300 (B)	

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F 761	Continued From page 50 practical nurse (LPN) #1 returned to the cart and stated they had just sat the items there. Surveyor requested and received the facility policy entitled "Storage of Medications" with the documented effective date of 9-2018. This policy read in part "2. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications. Medication room, carts, and medication supplies are locked when they are not attended by persons with authorized access". On 4/15/22 at 2:39 pm, survey team met with the administrator, director of nursing, and the regional nurse and discussed the concern of LPN #1 leaving two (2) unopened saline flush syringes, a 500 ml IV bag of normal saline, and a blister pack of Vitamin D2 tablets unattended on top of the medication cart. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/15/22.	F 761	Date of Compliance: 5-17-22	
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident 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. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility document reviews, the staff failed to ensure	F 800	F800	5/17/22

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F 800	Continued From page 51 residents were provided a nutritious diet that took into consideration resident preferences. The findings include: On 4/13/22 at approximately 9:18 a.m., Resident #28 and Resident #69 were observed to be provided their breakfast trays; the facility's Director of Nursing (DON) and Corporate Nurse were present for these observations. According to the menu and the residents' meal slips, both residents were to receive 4 fluid ounces of sausage gravy. Both Resident #28's and Resident #69's breakfast trays contained less than 4 fluid ounces of sausage gravy. Resident #69's sausage gravy appeared not to contain sausage. The DON and the Corporate Nurse were interviewed about the amount of sausage gravy provided to Resident #28 and Resident #69; they were in agreement it was approximately 1/3 of the amount the residents should have been provided. On 4/13/22 at 9:22 a.m., Resident #96's was observed to be provided their breakfast tray; the facility's DON and Corporate Nurse were present for this observation. Resident #96's breakfast plate contained a biscuit with no gravy and a container or grits or oatmeal. When provided their breakfast tray Resident #96 stated, "It's a joke." Resident #96's meal slip indicted the resident did not like eggs or sausage. On 4/13/22 at 9:30 a.m., the facility's Dietary Manager was interviewed about Resident #96's aforementioned breakfast tray; the Dietary Manager reported the resident should have been sent bacon due to the resident not liking eggs and sausage. On 4/13/22 at approximately 9:26 a.m., Resident	F 800	Residents #28, #69, #96, #80, #46 are currently receiving meals per diet order, portion requirements, and preferences. Current Residents in the center have the potential to be affected. Current dietary staff and Dietary Manager will be educated by Regional Dietary Director/designee regarding policy for meal distribution that includes all meals assembled in accordance with diet order, plan of care, and preferences. Dietary Manager/designee will observe meal trays during tray line assembly to ensure accuracy of items on tray compared to meal ticket. In addition, observation will include review for accurate portion sizes and preferences. Results of observations will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the reviews will be conducted on a random basis. Date of Compliance: 5-17-22	

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F 800	Continued From page 52 #80 and Resident #46 were observed to be provided their breakfast trays; the facility's Director of Nursing (DON) and Corporate Nurse were present for these observations. Both Resident #28's and Resident #69's breakfast trays contained a biscuit with sausage gravy; the amount of sausage gravy was less than 4 fluid ounces. (Dietary documentation indicted the serving size of the sausage gravy was 4 fluid ounces.) The DON and the Corporate Nurse were interviewed about the amount of sausage gravy provided to Resident #80 and Resident #46; they were in agreement it was approximately 1/2 of the amount of the 4 ounce serving size. Resident #46's breakfast meal slip for 4/13/22 indicated the resident was to receive a Cardiac diet. Resident #46 was observed to be provided a biscuit and sausage gravy as part of their 4/13/22 breakfast although a biscuit and sausage gravy was not listed on the resident's meal slip. On 4/13/22 at 3:00 p.m., CNA (certified nurse aide) #24 was interviewed about Resident #46's breakfast tray. CNA #24 reported they obtained different breakfast food items for the resident on 4/13/22. CNA #24 stated they obtained pureed foods including eggs, sausage, and grits. On 4/13/22 at 3:05 p.m, the facility's Dietary Manager was interviewed about the food items provided as part of Resident #46's breakfast on 4/13/22; the Dietary Manager reported the biscuit and sausage gravy should not have been sent as part of the resident's breakfast tray. On 4/13/22 at approximately 9:30 a.m., Dietary Staff Member (DSM) #24 was interviewed about serving the sausage gravy on the morning of 4/13/22. DSM #24 stated they were not intentionally providing smaller servings of	F 800		

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sausage gravy to residents on 4/13/22. DSM #24 reported that they were not limiting the amount of sausage gravy provided to residents. DSM #24 reported the sausage gravy pan still on the steam table contained all the sausage gravy that was left over after the morning meal. DSM #24 showed the surveyor (with the facility's DON and Corporate Nurse present) the 4 ounce serving tool used to plate the gravy. DSM #24 used the 4 ounce serving tool to show that the remaining sausage gravy was just slightly short of a 4 ounce serving.

The following information was found in a facility dietary policy titled "Therapeutic Diets" (dated October 2019):
- "It is the Center policy to insure that all residents have a diet order, including regular, therapeutic, and texture modified ..."
- ""Therapeutic diet" is defined as a diet ordered by a physician or delegated registered or licensed dietitian as part of the treatment for a disease or clinical condition, to eliminate or decrease specific nutrients in the diet (e.g. sodium), or to increase specific nutrients in the diet (e.g. potassium), or to provide food that a resident is able to eat (e.g. mechanically altered diet)."

The following information was found in a facility dietary policy titled "Menus" (dated October 2019): "Menus are served as written, unless changed in response to preference, unavailability of an item, or a special meal."

The following information was found in a facility dietary policy titled "Meal Distribution" (dated October 2019): "The Dining Service Director will ensure that all meals are assembled in accordance with the individualized diet order, plan

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F 800	Continued From page 54 of care, and preferences." The aforementioned observations of the small serving size of sausage gravy and incorrect food items on residents' 4/13/22 breakfast trays was discussed with the facility's Administrator, DON, and Corporate Nurse during a survey team meeting on 4/13/22 at 5:30 p.m.	F 800		
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;	F 842		5/17/22

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F 842	Continued From page 55 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and	F 842	F842	

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F 842	Continued From page 56 clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 2 of 24 residents in the survey sample, Residents #89 and #71. For Resident #89, the facility staff failed to accurately enter the correct code status order. The resident had active physician's orders for do not resuscitate (DNR) and full code status. For Resident #71, the facility staff failed to document the resident's current status, physician notification and response on one (1) occasion. The findings included: 1. Resident #89's diagnosis list indicated diagnoses, which included, but not limited to Cerebral Infarction, Aphasia, Rheumatoid Arthritis, Major Depressive Disorder, Type 2 Diabetes Mellitus, Essential Hypertension, and Encephalopathy. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 3/18/22 coded the resident as rarely/never understood and being severely impaired in cognitive skills for daily decision making. On 4/13/22, surveyor reviewed Resident #89's current physician's orders and noted the resident had active orders for "DNR" and "Full Code" each dated 3/30/22. Surveyor reviewed Resident #89's clinical record and was unable to locate a resident and/or resident representative signed durable do not resuscitate (DDNR) order form. On 4/13/22 at 5:31 pm, surveyor notified the director of nursing (DON) of Resident #89 having	F 842	Resident #89□s code status has been corrected and updated in clinical record. Resident #71□s clinical record has been updated to include notification of the Nurse Practitioner regarding the urine specimen not being collected. No new orders received. Current Residents in the center have the potential to be affected. Current licensed nurses will be educated by SDC/designee regarding clinical record documentation policies to include DNR and specimen orders. In addition, the nurses will be educated regarding documentation of lab test orders on the lab tracking log and ensuring that DNR orders have accompanying durable DNR order paperwork. Unit Managers/designees will review order listing report in clinical meeting 5x weekly. In addition, laboratory logs will be reviewed in clinical meeting 5x weekly ensure lab test orders are documented and completed. DNR orders will be reviewed to ensure durable DNR paperwork is in place and that code status is accurate in clinical record. Results of review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the reviews will be conducted on a random basis. Cross Reference to 12 VAC 5-371-360 (F) and 12-VAC 5-371-360 (E)(4) and (8) Date of Compliance: 5-17-22	

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F 842	Continued From page 57	F 842		

active orders for DNR and full code. The next morning at 8:58 am, the DON returned to the surveyor and stated the DNR order was discontinued because the resident did not have a DNR in the clinical record.

On 4/14/22 at 9:08 am, surveyor spoke with the social worker (SW) regarding Resident #89's code status. SW reviewed the resident's clinical record and stated they did not see a DNR order form in the record. SW stated they had spoken to the resident's spouse and offered information regarding advanced directives, however, the family had not asked to initiate a DNR. SW stated if a resident decides to initiate a DNR, they notify the SW and then the SW sets up a meeting with the nurse practitioner (NP).

On 4/14/22 at 9:17 am, surveyor spoke with the NP who stated Resident #89's code status was DNR when first admitted to the facility but recently while out to the hospital for a surgical procedure the DNR was revoked. NP stated since the resident's readmission, they have been trying to reach the resident's spouse to verify code status but had been unsuccessful. NP stated as of right now, Resident #89 was a full code.

On 4/15/22 at 2:39 pm, surveyor met with the administrator, DON, and regional nurse and discussed the concern of Resident #89 having active orders for DNR and full code status.

No further information regarding this concern was presented to the survey team prior to the exit conference on 4/15/22.

2. Resident #71's diagnosis list indicated diagnoses, which included, but not limited to

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Gastroparesis, Gastro-Esophageal Reflux Disease, Essential Hypertension, Osteoarthritis of Knee, Primary Bilateral Open-Angle Glaucoma, Bilateral Ocular Hypertension, and Diaphragmatic Hernia.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 3/14/22 assigned the resident a brief interview for mental status (BIMS) summary score of 5 out of 15 indicating the resident was severely cognitively impaired. Resident #71 was coded as requiring extensive assistance with personal hygiene and being totally dependent on staff for toileting. The resident was coded as being frequently incontinent of urine.

On 4/13/22 at 8:28 am, Resident #71 stated to the surveyor they think they may have a "bladder infection". On 4/13/22 at 5:31 pm, surveyor notified the administrator, director of nursing (DON), and regional nurse of the resident's statement.

Resident #71 was seen by the nurse practitioner (NP) on 3/30/22, the progress note stated in part "The patient is seen today at the request of nursing for evaluation of dysuria. Nursing staff reports that the patient has had some very slimy foul-smelling urine when being changed. The patient denies any complaints today other than some burning with urination." A provider order dated 3/30/22 stated in part "collect UA (urinalysis) C&S (culture and sensitivity) one time only for dysuria". A nursing progress note dated 3/30/22 at 1:51 pm stated in part "UA C&S for dysuria ordered by NP (name omitted), EC (emergency contact) (name omitted) made aware. Order placed in (name omitted) book and

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printed".

Surveyor reviewed Resident #71's clinical record and was unable to locate results of the UA C&S ordered on 3/30/22. On 4/14/22 at 1:25 pm, surveyor spoke with licensed practical nurse (LPN) #1 regarding the UA C&S results. LPN #1 reviewed the resident's clinical record and acknowledged they also could not find the results. LPN #1 then checked the daily lab tracking documentation and not could locate documentation of the UA C&S ordered on 3/30/22.

On 4/14/22 at 1:34 pm, surveyor spoke with Resident #71 and asked if they were having any burning with urination and they stated "not today" but "yesterday it did".

On 4/14/22 at 2:40 pm, surveyor spoke with LPN #2 who wrote the nursing progress note above dated 3/30/22 at 1:51 pm. LPN #2 stated they put the order in to populate on the medication administration record (MAR) to be done on the next shift and put it in the lab book. LPN #2 looked on the resident's March 2022 MAR and stated it was "clicked off" that it was done.

On 4/14/22 at 4:11 pm, surveyor again spoke with LPN #1 who stated they now remember the UA order and when they went to the resident on that morning to obtain the urine, the resident had vomited. Resident #71 denied any burning with urination and stated it was their stomach that was the problem. LPN #1 stated they then contacted the NP and the NP said not to worry about the UA since it was (his/her) stomach and they were no longer having symptoms and discontinued the order. LPN #1 stated they "clicked off" on the

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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 842	Continued From page 60 MAR that they did the UA in error and also failed to document the conversation with the NP. On 4/14/22 at 4:23 pm, surveyor met with the administrator, DON, and regional nurse and discussed the concern of LPN #1 signing the MAR indicating the UA C&S was obtained when it was not and failing to document the conversation with the NP regarding Resident #71. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/15/22.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		5/17/22

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	495107	A. BUILDING _____ B. WING _____	C 04/15/2022

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F 880	Continued From page 61 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 62 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to implement infection control programs and processes including actions to decrease the transmission of COVID-19 and/or other infectious organisms for 1 of 24 residents. The facility staff were observed working directly with Resident #83 with their mask pulled down below their nose and/or chin. The findings included: Section C (cognitive patterns) of Resident #83's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/17/22 included a brief interview for mental status (BIMS) summary score of 11 out of a possible 15 points. Diagnoses included, but were not limited to, kidney failure and diabetes. Under the immunization tab in the electronic health record (EHR) the facility staff had documented consent refused for the COVID-19 vaccine. 04/12/22 1:46 p.m., the staff development coordinator (SDC) stated they had no residents and/or staff with COVID-19 at the present time and surgical mask were being worn by the staff. The exception would be when working with new admits or someone on quarantine for COVID-19	F 880	F880 LPN #2 and TNA #1 were educated immediately on the infection control practice for proper facial mask wearing when providing direct resident. Resident #83 no longer resides in the center. Current Residents in the center have the potential to be affected. Current facility staff will be educated by SDC/designee regarding infection control practices specific to use of personal protective equipment. In addition, facility staff will be educated on proper wearing of facial masks when providing direct resident care. Infection Preventionist/designee will observe staff daily during routine infection rounds for appropriate wearing of surgical masks. In addition, facility department managers/designees will observe staff daily during routine rounds to ensure appropriate wearing of surgical masks. Results of observations will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the reviews will be conducted on a random basis. Cross Reference to 12 VAC 5-371-180 (C)(6) Date of Compliance: 5-17-22	

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F 880	Continued From page 63	F 880		

and then an N95 mask, goggles or face shield was required.

04/14/22 4:50 a.m., observed Licensed Practical Nurse (LPN) #2 and Temporary Nursing Assistant (TNA) #1 in Resident #83's room standing directly over Resident #83. One staff member was observed on one side of the bed and the other staff member was observed standing on the other side of the residents bed. LPN #2 and TNA #1 were observed to pull their surgical masks up when the surveyor entered the resident's room.

04/14/22 5:09 a.m., LPN #2 stated they should have had their mask above their nose and covering their nose.

04/14/22 5:43 a.m., TNA #1 stated they had needed to change their mask because they had sneezed in it.

The facility staff provided the survey team with a copy of their policy titled, "COVID-19" effective date 02/11/22. This policy read in part, "...Educate employees...on signs and symptoms of COVID-19 and recommended infection prevention and control practices. Review the appropriate use of Personal Protective Equipment...Review with all employees...the core principles of COVID-19 of infection control...Face cover or mask (covering mouth and nose), when indicated..."

The facility policy titled, "COVID-19 Vaccination Policy" effective date 01/25/22 read in part, "...The center requires all health care personnel be fully vaccinated against COVID-19...This mandatory COVID-19 vaccination policy applies to all facility staff, regardless of clinical

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F 880	Continued From page 64 responsibility or resident contact..." A review of the COVID-19 staff vaccination list revealed both of these staff had been vaccinated. 04/14/22 4:25 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), and Nurse Consultant, the issue with staff being working directly with Resident #83 with face covering not being worn appropriately was reviewed as well as the resident's vaccine status. 04/15/22, The facility provided the surveyor with a copy of a history and physical regarding Resident #83 that read in part, "...I interviewed and examined the patient at 1pm on February 22, 2022...patient was diagnosed with COVID-19 3 weeks ago...As relates to COVID patient has received both vaccinations as well as a booster..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 880		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not	F 886		5/17/22

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F 886	Continued From page 65 limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing	F 886		

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F 886	Continued From page 66 residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to maintain an infection control program designed to help prevent the development and transmission of COVID-19 and other communicable diseases and infections. The facility staff failed to follow the manufacturer guidelines when obtaining a rapid COVID-19 test for 1 of 1 staff members (SM) #1. The Infection Preventionist (IP) swabbed SM #1's nares for less than 15 seconds and only rotated the swab 3 times. The manufacture instruction read to rotate the swab for 5 times or more for a total of 15 seconds. The findings included: 04/13/22 11:27 a.m., the surveyor observed the IP obtain a COVID-19 sample from SM #1. The IP was observed to insert a nasal swab into SM #1's right nare and rotate the swab 3 times. The IP removed the swab, inserted the swab into SM #1's left nare and rotated the swab 3 times. The IP swabbed both nostrils for less than 10 seconds. The following information was found in the	F 886	F886 The Infection Preventionist referred to the manufacturer guidelines for the test being used and repeated the test on the staff member per the guidelines. Results of test remained negative. Current staff and Residents in the center have the potential to be affected. Infection Preventionist/SDC/DON will be educated by Regional Director of Clinical Services regarding COVID-19 rapid testing procedure consistent with standard of practice and manufacturer guidelines for the specific test being used. DON/designee will observe one staff per week receiving a rapid COVID-19 test to ensure accuracy of test procedure. Results of observations will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the reviews will be conducted on a random basis. Cross Reference to 12 VAC 5-371-180 (C)(6) Date of Compliance: 5-17-22	

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F 886	Continued From page 67 manufacturer's instructions currently being used by the facility in regards to COVID-19 testing instructions. "...Anterior Nasal (Nares) Swab...Only the swab provided in the kit is to be used for nasal swab collection. To collect a nasal swab sample, carefully insert the entire absorbent tip of the swab (usually ½ to ¾ of an inch (1 to 1.5 cm) into the nostril. Firmly sample the nasal wall by rotating the swab in a circular path against the nasal wall 5 times or more for a total of 15 seconds, then slowly remove from the nostril. Using the same swab, repeat sample collection in the other nostril..." After reviewing this information with the surveyor the IP stated they had swabbed both nares 3 times for about 10 seconds and stated she would now always do five times for a total of at least 15 seconds. 04/14/22 4:25 p.m., the Administrator, Director of Nursing, and Nurse Consultant (NC) were made aware of the issue regarding the IP obtaining a COVID-19 sample. The NC stated the IP was instructed to retest the staff and they had no positive cases of COVID-19 from testing. 04/14/22 2:05 p.m., the IP stated she re-swabbed SM #1, she did the swab in both nostrils for 5 times and 15 seconds and this staff was negative for COVID-19. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 886		