STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495045	A. BUILDING ______ B. WING ______	C 05/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)	**2125 HILLIARD ROAD RICHMOND, VA 23228**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/17/22 through 5/20/22 and 5/23/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/17/22 through 5/20/22 and 5/23/22. Eight complaints were investigated during the survey (VA00054700 - unsubstantiated; VA00053964 - substantiated; VA00054943 - substantiated; VA00053584 - substantiated; VA00050966 - substantiated; VA00054353 - substantiated; VA00051025 - substantiated; VA00050806 - unsubstantiated). Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care - Requirements. The Life Safety Code survey/report will follow. The census in this 194 bed facility was 167 at the time of the survey. The survey sample consisted of 41 current resident reviews and 11 closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joe Catrambone	Administrator	6/10/2022

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 558	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide accommodations of resident needs by failing to ensure the call bell [a device with a button that can be pushed to alert staff when assistance is needed] was within reach for one of 52 current residents in the survey sample, Resident #317 (R317). The findings include: The facility staff failed to keep (R317's) call bell within their reach. (R317) was admitted to the facility with a diagnosis that included by not limited to: muscle weakness. The most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 05/23/2022, was "In progress" at the time of the survey. (R317's) "Admission Assessment" dated 05/16/2022 documented in part, "Clinical Evaluation Neurological. Orientation." Further review revealed checks mark for "Situation, Place, Person" indicating (R317) was oriented to those areas stated above. On 05/17/22 at approximately 1:15 p.m., an observation of (R317) revealed they were lying in bed and the call bell was observed hanging over the drawer pull on the bedside table on the left side of (R317) and out of their reach. On 05/17/22 at approximately 3:48 p.m., an	F 558	558 – Reasonable Accommodations Needs/Preferences 1. R317 no longer resides in the facility. 2. Utilizing the call light monitoring tool – a comprehensive review of current residents will be completed to validate call lights are within reach or the preference is care planned. 3. The director of nursing/ designee will educate the nursing department on "Focus on F-tag 558" and "call light" procedure on or before the date of compliance. 4. Utilizing the call light monitoring tool – the director of nursing/designee will audit 5 residents per week x 4 weeks to validate call light placement. Results of the audits will be reviewed with the QA&A committee.	6/30/2022

F 558 Continued From page 2 F 558

observation of (R317) revealed they were lying in bed and the call bell was observed hanging over the drawer pull on the bedside table on the left side of (R317) and out of their reach.

On 05/18/22 at approximately 11:00 a.m., an observation of (R317) revealed they were lying in bed and the call bell was observed hanging over the drawer pull on the bedside table on the left side of (R317) and out of their reach.

On 05/18/22 at approximately 3:00 p.m., an interview with (R317) and observation of (R317) revealed they were lying in bed and the call bell was observed hanging over the drawer pull on the bedside table on the left side of (R317). When asked if they knew where the call bell was (R317) stated that it was hanging on the bedside table. When asked if they could reach the call bell and activate it (R317) stated that they could not reach it. When asked how they call for assistance or help (R317) stated that they wait for someone to walk by their room and call out to them.

On 05/19/22 at approximately 8:47 a.m., an interview with CNA (certified nursing assistant) # 9. When asked where call bell should be placed CNA #9 stated that it should be within the resident's reach. When shown where the call bell was located and informed of the observations listed above CNA #9 stated the call bell was out of reach for the resident. When asked how often the placement of a resident's call bell is checked CNA #9 stated that it should be checked every time someone goes into the resident's room.

On 05/19/2022 at approximately 5:10 p.m., ASM (administrative staff member) # 1, administrator and ASM # 2, director of nursing were made

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F 558	Continued From page 3 aware of the findings. No further information was presented prior to exit.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580	580 – Notify of Change 1. RR 802 no longer resides in the facility. R 63 has been seen by the dietician and the plan of care was reviewed with the responsible party and MD. 2. Utilizing the "Change in condition" QAPI tool – a review of residents with x-rays or weight changes from 5.23.2022 will be completed and notifications of change will be validated by the Director of nursing/designee. 3. The director of nursing/designee will educate the licensed nursing staff on the "focus on f-tag 580" and "Change in condition" procedure on or before the date of compliance. 4. Utilizing the "change in condition" QAPI tool - the director of nursing/designee will audit 5 residents per week times four weeks with changes in condition related to weight change or x-ray diagnostic reports to validate notification of change. Results of the audits will be reviewed with QA&A committee.	6/30/2022

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(e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to notify the provider of changes in status for two of 52 residents in the survey sample, Residents #802 and #63.

The findings include:

1. For Resident #802 (R802), the facility staff failed to notify the provider of a delay in obtaining an X-ray for the resident's potentially fractured right hip.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/3/22, R802 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R802 was coded as requiring the extensive assistance of two staff members for bed mobility and

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transfers.

A review of the physician's orders for R802 revealed the following order, dated 4/8/22 at 11:27 p.m.: "X-ray to right hip and right knee...for pain to right hip and knee. D/c (discontinue) order once performed." The order was entered by LPN #7.

A review of R802's clinical record revealed the following progress note, dated 4/10/22 at 11:16 p.m. The note was written by LPN (licensed practical nurse) #7. "Patient's X-ray was positive for subcapital fracture of the right hip. MD (medical doctor) on call was [name of MD] was made aware and patient was sent to [name of local hospital] ER (emergency room) for evaluation and treatment."

Further review of R802's progress notes revealed no other documentation related to attempts to obtain urgent radiology services, or communication with providers regarding the potential delay in treatment for a fractured hip.

A review of R802's discharge summary from the local hospital dated 4/21/22 revealed R802 was admitted with a fractured right hip. During the hospital stay from 4/10/22 through 4/21/22, R802 underwent surgery on 4/11/22 to repair the right hip fracture.

A review of R802's comprehensive care plan dated 10/28/21 revealed no information related to a potential hip fracture.

On 5/19/22 at 1:05 p.m., LPN #7 was interviewed. She stated she remembered R802 very well. She stated on 4/8/22, she contacted the physician

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F 580	Continued From page 6 because R802 reported right hip pain, and R802's legs were swollen. The physician ordered an ultrasound of both legs and an X-ray of the hip. When asked if she documented any of these findings or conversations, she stated she thought she had. After reviewing R802's progress notes, LPN #7 stated she must have "just missed it." She stated she should have documented the assessment findings and the conversation with the provider in the progress notes. LPN #7 stated she worked 4/8/22, 4/9/22, and 4/10/22, and cared for R802 on each of these days. She stated the X-ray was ordered 4/8/22, but the X-ray company did not arrive at the facility to perform the X-ray until late in the evening on 4/10/22. When asked why the X-ray company did not arrive until nearly 48 hours after the order, she stated: "That's not unusual for them." When asked if she made any attempts to contact the X-ray company to determine when they would arrive or to ask if someone could arrive sooner than originally planned, she stated she did not. When asked if she contacted the physician/NP (nurse practitioner) to let them know the X-ray could not be performed immediately, she stated she did not. When asked if the delay in the X-ray resulted in a delay or treatment for R802's hip fracture, she stated: "Yes, absolutely." On 5/23/22 at 11:14 a.m., LPN #5 was interviewed. When asked about the process for obtaining mobile X-rays, she stated the nurse fills out a form, then calls the mobile X-ray company. She stated the X-ray company usually does not give a time when they anticipate someone will be there to perform the X-ray. She stated if she orders the X-ray at the beginning of her shift and she has not heard from the X-ray company by the end of the shift, she will call the company back to	F 580		

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determine a more exact time when the company will arrive to do the X-ray. She stated: "Sometimes they will tell you they will be here the next day because they are so backed up." She stated if a resident has a potential fracture, and the X-ray company cannot come immediately, she calls the provider to let them know that the X-ray is delayed, and will ask the provider what should be done next. She stated the provider will often say to send the resident out to the ER, and not to wait for the mobile X-ray.

On 5/23/22 at 12:44 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. ASM #2 stated the provider should be consulted if an X-ray of a potentially fractured hip cannot be obtained immediately.

On 5/23/22 at 1:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns.

A review of the facility policy, "Change in Condition," revealed, in part: "According to the American Medical Directors Association (AMDA) Clinical Practice Guidelines -
Acute Changes in Condition in the Long-Term Care Setting, - immediate notification is recommended for any symptom, sign or apparent discomfort that is acute or sudden in onset and a marked change in relation to usual symptoms and signs, or is unrelieved by measures already prescribed."

No further information was provided prior to exit.

Complaint deficiency

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2. For Resident #63 (R63), the facility staff failed to notify the physician of a significant weight loss in January 2022.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/14/22, R63 was coded as being severely cognitively impaired for making daily decisions, having scored zero out of 15 on the BIMS (brief interview for mental status). R63 was coded as having no significant weight loss during the look back period.

A review of R63's clinical record revealed the following weights on the following dates. On 12/7/21, the resident weighed 93 lbs. On 1/14/22, the resident weighed 87 pounds. The loss is a -6.45 % loss.

Further review of R63's clinical record revealed no evidence that the provider was notified of this significant weight loss.

On 5/19/22 at 9:29 a.m., OSM (other staff member) #12, the Registered Dietitian (RD) was interviewed. She stated she has only been working at the facility since March 2022, and was not responsible for reviewing weights for R63 in December 2021 or January 2022. She stated she pulls the weekly weights for at-risk residents and reviews them. She stated if she identifies a significant loss, she would contact the physician, and recommend interventions, if appropriate for the resident. She stated a 6.45% weight loss in 30 days is a significant weight loss, and should have been addressed by the RD at the time. She stated the RD should document in the clinical record regarding awareness of the significant weight loss and any interventions recommended

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to the physician.

A review of R63's care plan dated 10/8/19 and reviewed 3/15/22 revealed in part: "[R63] has the potential for nutrition/hydration imbalance...BMI (body mass index) is underweight...RD (registered dietician) to monitor and f/u (follow up) per protocol...review weights and notify physician and responsible party of significant weight change."

On 5/19/22 at 5:11 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

F 582 SS=D — Medicaid/Medicare Coverage/Liability Notice
CFR(s): 483.10(g)(17)(18)(i)-(v)

§483.10(g)(17) The facility must--
(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each

F 582 — Provider's Plan of Correction

582 – Medicaid/Medicare Coverage/Liability Notice
1. R 466 no longer resides in the facility.
2. Utilizing the "SNF beneficiary protection notification review" audit – a comprehensive review of residents receiving NOMNCs from 5.23.2022 to current will be completed by the Social Service department.
3. The Nursing Home Administrator/designee will educate the social service department on "Focus on F-tag 582" on or before the date of compliance.
4. Utilizing the "SNF beneficiary protection notification review" audit – the Social service team/designee will audit 5 NOMNCs per week times four weeks to validate compliance. Results will be reviewed with the QA&A committee.

Completion date: 6/30/2022

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resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, it was determined during the beneficiary notification facility task, the facility staff failed to provide beneficiary notification for one of three residents, Resident #466.

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The findings include:

During the facility task of beneficiary notification review on 5/18/22. The list of discharges for the last six months was provided on 5/18/22 at 7:30 AM.

Resident #466 was admitted to the facility on 10/20/21 with diagnoses that included but were not limited to:
fracture of right femur, schizophrenia, bipolar disease and chronic obstructive pulmonary disease. Resident #466 was discharged on 11/30/21.

The most recent MDS (minimum data set) assessment, a discharge return not anticipated assessment, with an ARD (assessment reference date) of 11/30/21, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired.

A review of the social services progress note dated 11/30/21 at 2:38 PM, revealed the following, "Discharge Summary: Resident is scheduled to discharge and return to her assisted living facility (ALF) with recommended home health (HH) and durable medical equipment (DME). Resident prescriptions were submitted to the pharmacy, her primary care physician (PCP) and the ALF were notified of her discharge last week and expecting her arrival."

On 5/18/22 at approximately 10:00 AM, the three beneficiary notices were returned. Resident #466's Beneficiary Protection Notification Review form revealed the following: "Under #2. Was a

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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 582	Continued From page 12 NOMNC (notice of Medicare non-coverage) provided to the resident the box was checked next to "*If NOT issues and should have been: F582." An interview was conducted on 5/18/22 at 10:25 AM with OSM (other staff member) #4, the social services worker. When asked if she was responsible for the beneficiary notices being performed, OSM #4 stated, "Yes, I did the beneficiary notice. On Resident #466, I did not do a notice. Usually I would email her RP (responsible party), but I have no evidence that I did that and I was covering our sister facility at the time. It was missed." On 5/20/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the director of human resources were made aware of the findings of the employee record review. No further information was provided prior to exit. A review of the facility's "Medicaid/Medicare Coverage/Liability Notice" policy, with no date, which revealed, "In cases where all Medicare covered services are ending, the beneficiary is being discharged and is not requesting an expedited review, only the NOMNC is required."	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		

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F 584	Continued From page 13 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility	F 584	584 – Safe/Clean/Homelike Environment 1. Resident 135's privacy curtain was removed and washed on 5-24-22. Resident #85 privacy curtain was removed and washed on 5-24-22. Resident #85 overbed light was repaired by the maintenance director on 5-18-22. Pantry #6 under the sink was cleaned and locked on 5-18-22. 2. The Administrator or designee has inspected the patient privacy curtains and overbed lights to validate that they are clean and functioning. Unit pantries/ nutrition rooms validated for cleanliness and function with corrections made (if any). 3. The Housekeeping Director or designee has re-educated the housekeeping staff on checking cleanliness of privacy curtains during daily cleaning and removing and cleaning as needed. The Administrator has re-educated the maintenance staff on inspecting and repairing overbed lights when needed. 4. The Housekeeping Director/Maintenance Director/or designee will audit resident rooms weekly times four weeks to validate clean privacy curtains and functioning overbed lights. The Administrator will submit audit findings to the QAPI committee for review and further recommendations.	6/30/2022

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document review, it was determined that the facility staff failed to maintain a clean, comfortable, homelike environment for two of 52 residents in the survey sample, Resident #135 and Resident #85; and in one of five pantries in the facility.

The findings include:

1. The facility staff failed to maintain a clean privacy curtain in Resident #135's (R135) room.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/19/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is not cognitively impaired for making daily decisions.

On 5/17/2022 at approximately 2:15 p.m., an interview was conducted with R135 in their room. Observation of R135's room revealed a privacy curtain hanging between their bed and their roommate's bed. Visible stains were observed from the bottom border of the curtain approximately six inches up onto the curtain surface. R135 stated that the stains were visible on the curtain when they first moved into the room. R135 stated that they had been in their room for about six months and had reported the privacy curtain being stained and dirty to the housekeepers and nursing staff multiple times and no one had ever taken it down to wash it. R135 stated that the curtain was "nasty" and it made the room appear dirty.

Additional observations of R135's privacy curtain on 5/17/2022 at 4:15 p.m., and 5/18/2022 at

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10:30 a.m. revealed the findings as described above.

On 5/18/2022 at 3:35 p.m., an interview was conducted with OSM (other staff member) #8, the director of housekeeping. OSM #8 stated that privacy curtains were washed in the laundry at the facility. OSM #8 stated that privacy curtains were cleaned and replaced when a room was empty or as needed when dirty. OSM #8 stated that housekeeping staff should be inspecting the privacy curtains daily when cleaning the rooms and that they expected other staff to report dirty privacy curtains or resident complaints to them to be cleaned and any stains should be cleaned off of the curtains. OSM #8 viewed the curtain in R135's room and stated that the curtain needed to be washed to remove the visible stains. OSM #8 informed R135 that the curtain would be washed and taken care of.

On 5/18/2022 at 3:55 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that housekeeping staff washed and laundered privacy curtains as needed. LPN #4 stated that they were not aware of any concerns regarding R135's privacy curtain being stained or dirty. LPN #4 stated that they would enter a work order for housekeeping to clean a privacy curtain identified as dirty or needing replacement or contact housekeeping directly to have this done.

The facility provided policy, "Focus on F Tag 584" documented in part, "...The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- ...(2) Housekeeping and

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maintenance services necessary to maintain a sanitary, orderly and comfortable interior...(5) Adequate and comfortable lighting levels in all areas..."

On 5/18/2022 at 4:49 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the human resource director were made aware of the above concern.

No further information was presented prior to exit.

2. The facility staff failed to maintain a clean privacy curtain and working overhead light in Resident #85's (R85) room.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/21/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was not cognitively impaired for making daily decisions.

On 5/18/2022 at approximately 11:45 a.m., an interview was conducted with R85. Observation of R85's privacy curtain revealed two dark brown stains approximately the size of a quarter. R85 stated that the spots were blood that had gotten on the curtain and had been on there for at least six months. R85 stated that housekeeping had changed one of the curtains but had never changed the other one. R85 stated that they had asked housekeeping and nursing to change the curtain multiple times and no one ever did. R85 stated that their light in the room only partially worked; that the light had a pull cord on it and the bottom light worked when you pulled it the first

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time but if you pulled it the second time the top light to make the room brighter did not work. R85 stated that it had not worked for over a month and the nurses had a hard time seeing when doing the wound care. Observation of the light in R85's room revealed the top light of the overhead light not working.

Additional observations of R85's room on 5/18/2022 at 2:30 p.m. revealed the findings as described above.

On 5/18/2022 at 3:35 p.m., an interview was conducted with OSM (other staff member) #8, the director of housekeeping. OSM #8 stated that privacy curtains were washed in the laundry at the facility. OSM #8 stated that privacy curtains were cleaned and replaced when a room was empty or as needed when dirty. OSM #8 stated that housekeeping staff should be inspecting the privacy curtains daily when cleaning the rooms and that they expected other staff to report dirty privacy curtains or resident complaints to them to be cleaned and any stains should be cleaned off of the curtains. OSM #8 viewed the two dark brown stains on the privacy curtain in R85's room and stated that the curtain needed to be washed to remove the visible stains. OSM #8 informed R85 that the curtain would be washed and taken care of.

On 5/18/2022 at 3:55 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that housekeeping staff washed and laundered privacy curtains as needed. LPN #4 stated that they were not aware of any concerns regarding R85's privacy curtain being stained or dirty or light being broken. LPN #4 stated that blood on the privacy curtain should be

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cleaned immediately. LPN #4 stated that staff should enter a work order for housekeeping to clean a privacy curtain identified as dirty or needing replacement or contact housekeeping directly to have this done. LPN #4 stated that any lights not working were repaired by maintenance and that staff either called maintenance directly or entered a work order into the computer to have the repairs done.

On 5/19/2022 at 12:17 p.m., an interview was conducted with OSM #9, the director of maintenance. OSM #9 stated that staff put work orders in the computer system for any repairs needed for the maintenance staff and that maintenance staff reviewed the work orders every morning. OSM #9 stated that all staff could put in work orders and residents could report maintenance issues to any staff. OSM #9 viewed the overhead light in R85's room and agreed that the top light was not working. OSM #9 stated that they would check the maintenance system to see if there was a work order in place. OSM #9 informed R85 that they would take care of the light repair.

On 5/19/2022 at approximately 12:55 p.m., OSM #9 stated that they checked the maintenance computer system and they did not have an active work order in place for the overhead light in R85's room.

On 5/19/2022 at 5:11 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the human resource director were made aware of the above concern.

No further information was provided prior to exit

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3. The facility staff failed to maintain a clean physical environment under the sink in the pantry of the Station 6 unit.

On 5/18/2022 at 3:20 p.m., an observation was conducted of the pantry of the Station 6 unit at the facility. Observation of the area underneath the sink revealed multiple loose paper towels which were water-stained stuck to the surface of the cabinet bottom. Four single serve bags of potato chips and two packages of peanut butter sandwich crackers were observed to be lying among the water-stained paper towels on the cabinet floor. A coffee maker was observed to be unplugged and laying on its side underneath the cabinet. The area around the sink piping was observed to be missing drywall with an open area exposing the wall behind it.

On 5/18/2022 at 3:35 p.m., an interview was conducted with OSM (other staff member) #8, the director of housekeeping. OSM #8 stated that housekeeping came into the pantry to clean the floors but did not clean inside the cabinets and stated that they did not think that the cabinets below the sink should be open. OSM #8 viewed the findings above and stated that the area needed to be cleaned out and closed. OSM #8 stated that there was potential for pests with the open area around the sink piping and food being left under the sink. OSM #8 stated that there should be no food under the sink and the dirty paper towels and other items should not be stored underneath the sink.

On 5/18/2022 at 3:55 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that nursing was responsible for

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F 584	Continued From page 20 the pantry and they assigned a CNA (certified nursing assistant) to clean the pantry every shift. LPN #4 observed the findings above and stated that it was "disgusting" and needed to be cleaned out. LPN #4 stated that there should be no food items stored underneath the sink with water-stained paper towels and everything needed to be cleaned out. LPN #4 stated that it did not look like the CNA's had been cleaning this area and would make sure the CNA assigned would take care of it. LPN #4 stated that the area was not a clean environment to store resident snacks. On 5/18/2022 at 4:49 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the human resource director were made aware of the above concern. No further information was provided prior to exit.	F 584		
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, §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:	F 607		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 607	Continued From page 21 Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to implement their policy to report and investigate an allegation of abuse for one of 52 residents in the survey sample, Resident #802 (R802). The facility staff failed to investigate and report R802's allegation that a TNA (temporary nursing assistant) was rough during care for the resident in April 2022. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/3/22, R802 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R802 was coded as requiring the extensive assistance of two staff members for bed mobility and transfers. A review of the facility policy, "Patient Protection: Abuse, Neglect, Mistreatment, and Misappropriation Prevention," revealed, in part: "Procedures for Reporting...Employees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse, neglect, exploitation, mistreatment...The administrator is responsible for the investigating, reporting, and coordinating of the investigation process of any alleged or suspected abuse regardless of the source of the concern...as necessary, taking immediate action to prevent further potential violation of any resident right while the alleged violation is being investigated...immediately reporting all alleged violations involving neglect,	F 607	607 – Develop/Implement Abuse/Neglect Policies 1. R 802 no longer resides in the facility. 2. Utilizing the "Investigations" QAPI tool – the director of nursing/designee will complete a review of any injury of unknown origin from 5.23.2022 to current to validate compliance of reporting. 3. The Regional Director of Operations will educate the Director of Nursing and Nursing Home Administrator on the "Focus on F-tag 607" and the "patient protection guideline" on or before the date of compliance. The Director of Nursing or Designee will re-educate the nursing staff on abuse reporting. 4. Utilizing the "Investigation" QAPI tool – the Nursing home administrator/designee will audit incidents of injuries of unknown origin weekly times four weeks to validate compliance with reporting. Results will be reviewed with the QA&A committee.	6/30/2022

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abuse...the facility must have evidence that all alleged violations are thoroughly investigated...key to investigating abuse allegations is an environment that facilitates the reporting of such allegations. Once reported, the center conducts a timely, thorough, and objective investigation of any allegations of abuse. Part of this investigation is the consideration of the indicators are possible abuse...Utilizing the investigation process, the center focuses on determining who, what, when, where, why and how for any occurrence to determine the root cause and appropriate course of action and response."

A review of R802's clinical record revealed the following progress note, dated 4/10/22 at 11:16 p.m. The note was written by LPN (licensed practical nurse) #7. "Patient's X-ray was positive for subcapital fracture of the right hip. MD (medical doctor) on call was [name of MD] was made aware and patient was sent to [name of local hospital] ER (emergency room) for evaluation and treatment."

Further review of R802's progress notes revealed no other documentation related to the circumstances surrounding R802's injury.

A review of the facility's FRIs (facility reported incidents) for April 2022 revealed nothing related to R802.

On 5/18/22 at 4:45 p.m., ASM (administrative staff member) #2 was asked if the facility had completed a FRI or any investigating regarding R802's right hip fracture in April 2022. ASM #2 stated when the resident originally complained of the hip pain, the resident was assessed. ASM #2

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stated she spoke with R802 and asked the resident what happened. R802 told ASM #2 an aide "gave [R802] a shove and felt she was rough." ASM #2 stated she asked R802 if the resident thought the aide intentionally was rough, and R802 stated they did not think the aide intentionally hurt the resident. ASM #2 stated the resident was sent to the emergency room after the fracture was diagnosed. She added: "We didn't have time to do some of the things we usually do." ASM #2 stated the facility staff associated the fracture with the "shove." She stated the cause of the fracture was a known event. When asked if she interviewed the TNA who handled the resident roughly, she stated she did not. When asked if she interviewed any other residents for whom the TNA cared, she stated she did not. When asked if the TNA was suspended pending any kind of investigation, she stated the TNA was from an agency and actually never worked in the facility again.

On 5/19/22 at 11:20 a.m., LPN (licensed practical nurse) #5 was interviewed. When asked what should happen if a resident reports that an aide was rough with them during care, she stated she would report it to the administrator because the administrator is the facility's abuse coordinator. She stated she would also make every effort to speak to the aide to find out what happened in the room, and ascertain why the resident felt the aide was rough during care.

On 5/19/22 at 11:55 a.m., CNA (certified nursing assistant) #10 was interviewed. She stated she learned about R802's report of being treated roughly "the day after it happened," but said she could not remember exactly what day this was. She stated the off going CNA told her the resident

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complained to her that a TNA had rolled her wrong in the bed and had hurt her leg. CNA #10 stated she believed it was approximately two days between when the injury happened and when R802 reported it to anyone.

On 5/19/22 at 1:05 p.m., LPN #7 was interviewed. She stated she remembered R802 very well. She stated on 4/8/22, she contacted the physician because R802 reported right hip pain, and R802's legs were swollen. The physician ordered an ultrasound of both legs and an X-ray of the hip. When asked if she asked R802 any questions regarding a possible cause of the pain and/or swelling, she stated she did not. LPN #7 stated that on 4/10/22 during the evening shift (3:00 p.m. - 11:00 p.m.), she learned that R802 had reported to another staff member that R802 was handled roughly by a TNA (temporary nursing assistant) earlier in the week, and R802 believed that the rough handling was the source of the hip pain. LPN #7 stated R802 had told another staff member that a TNA had turned her over and "mashed down on her hip" earlier in the week. LPN #7 stated she did not interview R802 to confirm this report, and stated she immediately reported this new information to ASM (administrative staff member) #2, the DON (director of nursing). When asked if ASM #2 or any other member of the facility staff followed up with her about R802's allegation, LPN #7 said no one followed up with her. She stated when she reported this to ASM #2, she was told the resident had reported this earlier in the week and an investigation had already been done. LPN #7 stated she could not remember exactly who told her an investigation had been done. When asked if R802's report of a staff member treating her roughly was an allegation of abuse, she stated,

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	495045	A. BUILDING ______ B. WING ______	C 05/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)	2125 HILLIARD ROAD RICHMOND, VA 23228

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

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"Yes. That's why I reported it." She stated she wanted "things to be taken care of."

On 5/23/22 at 12:44 p.m., ASM #2 was interviewed. When asked why the facility never followed their policy to report and investigate an allegation of abuse, she stated: "It certainly was not intentional. We have investigated plenty of other allegations."

On 5/23/22 at 12:57 p.m., ASM #1, the administrator, was interviewed. He stated that if he is aware of an allegation of abuse, he submits an initial FRI, and reports the allegation to the physician and the RR (resident representative), as well as to other agencies required by the regulations. He stated the allegation is thoroughly investigated. He stated a thorough investigation should include staff interviews and resident interviews. He stated he submits a final FRI to the state agency. When asked why R802's allegation of abuse was never reported or investigated per the policy, he stated he could not answer that.

On 5/23/22 at 1:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns.

No further information was provided prior to exit.

Complaint deficiency

F 609 SS=D — Reporting of Alleged Violations — F 609

CFR(s): 483.12(c)(1)(4)

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495045	A. BUILDING ______ B. WING ______	C 05/23/2022

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F 609	Continued From page 26 §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, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to report an allegation of abuse to the State Agency, for one of 52 residents in the survey sample, Resident #802 (R802). The facility staff failed to report R802's allegation that a TNA (temporary nursing assistant) was rough during care for the resident in April 2022. The findings include:	F 609	609 – Reporting of Alleged Violations 1. R802 no longer resides in the facility. 2. Utilizing the "Investigations" QAPI tool – the director of nursing/designee will complete a review of any injury of unknown origin from 5.23.2022 to current to validate compliance of reporting. 3. The Regional Director of Operations will educate the Director of Nursing and Nursing Home Administrator on the "Focus on F-tag 607" and the "patient protection guideline" on or before the date of compliance. 4. Utilizing the "Investigation" QAPI tool – the Nursing home administrator/designee will audit incidents of injuries of unknown origin weekly times four weeks to validate compliance with reporting. Results will be reviewed with the QA&A committee.	6/30/2022

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F 609	Continued From page 27	F 609		

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/3/22, R802 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R802 was coded as requiring the extensive assistance of two staff members for bed mobility and transfers.

A review of R802's clinical record revealed the following progress note, dated 4/10/22 at 11:16 p.m. The note was written by LPN (licensed practical nurse) #7. "Patient's X-ray was positive for subcapital fracture of the right hip. MD (medical doctor) on call was [name of MD] was made aware and patient was sent to [name of local hospital] ER (emergency room) for evaluation and treatment."

Further review of R802's progress notes revealed no other documentation related to the circumstances surrounding R802's injury.

A review of the facility's FRIs (facility reported incidents), sent to the State Agency, for April 2022 did not reveal a report related to R802.

On 5/18/22 at 4:45 p.m., ASM (administrative staff member) #2 was asked if the facility had completed a FRI or any investigating regarding R802's right hip fracture in April 2022. ASM #2 stated when the resident originally complained of the hip pain, the resident was assessed. ASM #2 stated she spoke with R802 and asked the resident what happened. R802 told ASM #2 an aide "gave [R802] a shove and felt she was rough." ASM #2 stated she asked R802 if the

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PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)	2125 HILLIARD ROAD RICHMOND, VA 23228

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F 609	Continued From page 28	F 609		

resident thought the aide intentionally was rough, and R802 stated they did not think the aide intentionally hurt the resident. ASM #2 stated the resident was sent to the emergency room after the fracture was diagnosed. She added: "We didn't have time to do some of the things we usually do." ASM #2 stated the facility staff associated the fracture with the "shove." She stated the cause of the fracture was a known event.

On 5/19/22 at 11:20 a.m., LPN (licensed practical nurse) #5 was interviewed. When asked what should happen if a resident reports that an aide was rough with them during care, she stated she would report it to the administrator because the administrator is the facility's abuse coordinator.

On 5/19/22 at 11:55 a.m., CNA (certified nursing assistant) #10 was interviewed. She stated she learned about the R802's report of being treated roughly "the day after it happened," but said she could not remember exactly what day this was. She stated the off going CNA told her the resident complained to her that a TNA had rolled her wrong in the bed and had hurt her leg. CNA #10 stated she believed it was approximately two days between when the injury happened and when R802 reported it to anyone.

On 5/19/22 at 1:05 p.m., LPN #7 was interviewed. She stated she remembered R802 very well. She stated on 4/8/22, she contacted the physician because R802 reported right hip pain, and R802's legs were swollen. The physician ordered an ultrasound of both legs and an X-ray of the hip. When asked if she asked R802 any questions regarding a possible cause of the pain and/or swelling, she stated she did not. LPN #7 stated

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F 609	Continued From page 29	F 609		

that on 4/10/22 during the evening shift (3:00 p.m. - 11:00 p.m.), she learned that R802 had reported to another staff member that R802 was handled roughly by a TNA (temporary nursing assistant) earlier in the week, and R802 believed that the rough handling was the source of the hip pain. LPN #7 stated R802 had told another staff member that a TNA had turned her over and "mashed down on her hip" earlier in the week. LPN #7 stated she did not interview R802 to confirm this report, and stated she immediately reported this new information to ASM (administrative staff member) #2, the DON (director of nursing). She stated when she reported this to ASM #2, she was told the resident had reported this earlier in the week and an investigation had already been done. LPN #7 stated she could not remember exactly who told her an investigation had been done. When asked if R802's report of a staff member treating her roughly was an allegation of abuse, she stated, "Yes. That's why I reported it." She stated she wanted "things to be taken care of."

On 5/23/22 at 12:44 p.m., ASM #2 was interviewed. When asked why the facility never followed their policy to report an allegation of abuse policy, she stated: "It certainly was not intentional. We have investigated plenty of other allegations."

On 5/23/22 at 12:57 p.m., ASM #1, the administrator, was interviewed. He stated that if he is aware of an allegation of abuse, he submits an initial FRI, and reports the allegation to the physician and the RR (resident representative), as well as to other agencies required by the regulations. He stated the allegation is thoroughly investigated. He stated a thorough

F 609 Continued From page 30 F 609

investigation should include staff interviews and resident interviews. He stated he submits a final FRI to the state agency. When asked why R802's allegation of abuse was never reported per the policy, he stated he could not answer that.

On 5/23/22 at 1:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns.

A review of the facility policy, "Patient Protection: Abuse, Neglect, Mistreatment, and Misappropriation Prevention," revealed, in part: "Procedures for Reporting...Employees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse, neglect, exploitation, mistreatment...The administrator is responsible for the investigating, reporting, and coordinating of the investigation process of any alleged or suspected abuse regardless of the source of the concern...as necessary, taking immediate action to prevent further potential violation of any resident right while the alleged violation is being investigated...immediately reporting all alleged violations involving neglect, abuse."

No further information was provided prior to exit.

Complaint deficiency

F 610 SS=D Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) F 610

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

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PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)	2125 HILLIARD ROAD RICHMOND, VA 23228

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F 610	Continued From page 31 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to investigate an allegation of abuse for one of 52 residents in the survey sample, Resident #802 (R802). The facility staff failed to investigate R802's allegation that a TNA (temporary nursing assistant) was rough during care for the resident in April 2022. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/3/22, R802 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R802 was coded as requiring the extensive assistance of two staff members for bed mobility and transfers. A review of R802's clinical record revealed the	F 610	610 – Investigate/Prevent/Correct Alleged Violation 1. R802 no longer resides in the facility. 2. Utilizing the "Investigations" QAPI tool – the director of nursing/designee will complete a review of injuries of unknown origin from 5.23.2022 to current to validate compliance of an investigation being completed. 3. The Regional Director of Operations will educate the Director of Nursing and Nursing Home Administrator on the "Focus on F-tag 607" and the "patient protection guideline" on or before the date of compliance. 4. Utilizing the "Investigation" QAPI tool – the Nursing home administrator/designee will audit incidents of injuries of unknown origin weekly times four weeks to validate compliance with completing investigations. Results will be reviewed with the QA&A committee.	6/30/2022

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F 610	Continued From page 32	F 610		

following progress note, dated 4/10/22 at 11:16 p.m. The note was written by LPN (licensed practical nurse) #7. "Patient's X-ray was positive for subcapital fracture of the right hip. MD (medical doctor) on call was [name of MD] was made aware and patient was sent to [name of local hospital] ER (emergency room) for evaluation and treatment."

Further review of R802's progress notes revealed no other documentation related to the circumstances surrounding R802's injury.

A review of the facility's FRIs (facility reported incidents) for April 2022 revealed nothing related to R802.

On 5/18/22 at 4:45 p.m., ASM (administrative staff member) #2 was asked if the facility had completed a FRI or any investigation regarding R802's right hip fracture in April 2022. ASM #2 stated when the resident originally complained of the hip pain, the resident was assessed. ASM #2 stated she spoke with R802 and asked the resident what happened. R802 told ASM #2 an aide "gave [R802] a shove and felt she was rough." ASM #2 stated she asked R802 if the resident thought the aide intentionally was rough, and R802 stated they did not think the aide intentionally hurt the resident. ASM #2 stated the resident was sent to the emergency room after the fracture was diagnosed. She added: "We didn't have time to do some of the things we usually do." ASM #2 stated the facility staff associated the fracture with the "shove." She stated the cause of the fracture was a known event. When asked if she interviewed the TNA who handled the resident roughly, she stated she did not. When asked if she interviewed any other

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F 610	Continued From page 33	F 610		

residents for whom the TNA cared, she stated she did not. When asked if the TNA was suspended pending any kind of investigation, she stated the TNA was from an agency and actually never worked in the facility again.

On 5/19/22 at 11:55 a.m., CNA (certified nursing assistant) #10 was interviewed. She stated she learned about the R802's report of being treated roughly "the day after it happened," but said she could not remember exactly what day this was. She stated the off going CNA told her the resident complained to her that a TNA had rolled her wrong in the bed and had hurt her leg. CNA #10 stated she believed it was approximately two days between when the injury happened and when R802 reported it to anyone.

On 5/19/22 at 1:05 p.m., LPN #7 was interviewed. She stated she remembered R802 very well. She stated on 4/8/22, she contacted the physician because R802 reported right hip pain, and R802's legs were swollen. The physician ordered an ultrasound of both legs and an X-ray of the hip. When asked if she asked R802 any questions regarding a possible cause of the pain and/or swelling, she stated she did not. LPN #7 stated that on 4/10/22 during the evening shift (3:00 p.m. - 11:00 p.m.), she learned that R802 had reported to another staff member that R802 was handled roughly by a TNA (temporary nursing assistant) earlier in the week, and R802 believed that the rough handling was the source of the hip pain. LPN #7 stated R802 had told another staff member that a TNA had turned her over and "mashed down on her hip" earlier in the week. LPN #7 stated she did not interview R802 to confirm this report, and stated she immediately reported this new information to ASM

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F 610	Continued From page 34	F 610		

(administrative staff member) #2, the DON (director of nursing). When asked if ASM #2 or any other member of the facility staff followed up with her about R802's allegation, LPN #7 said no one followed up with her. She stated when she reported this to ASM #2, she was told the resident had reported this earlier in the week and an investigation had already been done. LPN #7 stated she could not remember exactly who told her an investigation had been done. When asked if R802's report of a staff member treating her roughly was an allegation of abuse, she stated: "Yes. That's why I reported it." She stated she wanted "things to be taken care of."

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On 5/23/22 at 12:57 p.m., ASM #1, the administrator, was interviewed. He stated that if he is aware of an allegation of abuse, he submits an initial FRI, and reports the allegation to the physician and the RR (resident representative), as well as to other agencies required by the regulations. He stated the allegation is thoroughly investigated. He stated a thorough investigation should include staff interviews and resident interviews. He stated he submits a final FRI to the state agency. When asked why R802's allegation of abuse was never investigated per the policy, he stated he could not answer that.

On 5/23/22 at 1:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns.

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A review of the facility policy, "Patient Protection: Abuse, Neglect, Mistreatment, and Misappropriation Prevention," revealed, in part: "The administrator is responsible for the investigating, reporting, and coordinating of the investigation process of any alleged or suspected abuse regardless of the source of the concern...as necessary, taking immediate action to prevent further potential violation of any resident right while the alleged violation is being investigated...immediately reporting all alleged violations involving neglect, abuse...the facility must have evidence that all alleged violations are thoroughly investigated...key to investigating abuse allegations is an environment that facilitates the reporting of such allegations. Once reported, the center conducts a timely, thorough, and objective investigation of any allegations of abuse. Part of this investigation is the consideration of the indicators are possible abuse...Utilizing the investigation process, the center focuses on determining who, what, when, where, why and how for any occurrence to determine the root cause and appropriate course of action and response."

No further information was provided prior to exit.

Complaint deficiency

F 622 SS=E Transfer and Discharge Requirements — F 622
CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)

§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-

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PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)	2125 HILLIARD ROAD RICHMOND, VA 23228

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F 622	Continued From page 36 (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a	F 622	622 – Transfer and Discharge Requirements 1. R124, R106, R33, and R75 returned to the facility. 2. The director of nursing/designee will complete a comprehensive review from 5.23.2022 to current for any residents sent to acute care to validate appropriate discharge and transfer paperwork was sent at time of discharge. 3. The director of nursing/designee will educate the licensed nursing staff on "Focus on F-tag 622" on or before the date of compliance. 4. The director of nursing/designee will audit resident sent to the hospital five residents per week times four weeks to validate appropriate discharge and transfer paperwork was sent at time of discharge. Results will be reviewed with the QA&A committee.	6/30/2022

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resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure

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a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to evidence provision of required resident information to a receiving facility at the time of discharge for four of 52 residents in the survey sample, Residents #124, #106, #33, and #75.

The findings include:

1. For Resident #124 (R124), the facility failed to evidence the provision of contact information of the practitioner responsible for care of the resident, resident representative information, advance directive information, instructions for ongoing care and comprehensive care plan goals to the receiving facility when R124 was discharged to the hospital on 3/27/22, 4/19/22, and 5/5/22 due to medical emergencies.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/13/22, R124 was coded as being severely cognitively intact for making daily decisions, having scored zero out of 15 on the BIMS (brief interview for mental status).

A review of R124's clinical record revealed the following progress notes:
- 3/27/22 at 2:03 p.m.: "Resident is non responsive to sternal rubs and hypotensive (low blood pressure). New order to send out to ER (emergency room)."
- 4/19/22 at 10:41 p.m.: "Resident found with rectal hemorrhaging, MD (medical doctor) notified. Gave orders to send to ER. DON

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(director of nursing) and RP (responsible party) notified."
- 5/5/22 at 12:43 p.m.: "Patient is lethargic, eyes open, non-responsive, unable to follow command. Patient was not able to eat meal. Was assess (sic) by...NP (nurse practitioner) and advised to sent to ER for evaluation. Pick up by 911 and sent to [name of local hospital]."

Further review of R124's clinical record revealed no evidence that the required paperwork necessary to care for the resident was ever sent to the receiving hospital for any of the above dates of discharge.

On 5/18/22 at 4:15 p.m., ASM (administrative staff member) #2, the director of nursing, stated she could not locate any additional evidence of paperwork sent to the hospital for R124's discharges.

On 5/19/22 at 9:30 a.m., RN (registered nurse) #1 was interviewed. She stated the nursing staff sends the completed acute care transfer form, the transfer checklist, a facesheet, any pertinent labs or x-rays, the H&P, and the medication list with a resident when the resident is discharged to the hospital. She stated the transfer checklist goes with the resident and the facility does not keep a copy to evidence what has been sent to the hospital.

On 5/19/22 at 5:11 p.m., ASM #1, the administrator and ASM #2 were informed of these concerns.

A review of the facility policy, "Focus of F623," revealed only a recapitulation of the regulatory language. The document did not provide policies

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or procedures for the facility to follow.

No further information was provided prior to exit.

2. For Resident #106 (R106), the facility failed to evidence the provision of contact information of the practitioner responsible for care of the resident, resident representative information, advance directive information, instructions for ongoing care and comprehensive care plan goals to the receiving facility when R106 was discharged to the hospital on 3/25/22 due to a medical emergency.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/8/22, R106 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status).

A review of R106's progress notes revealed the following note dated 3/25/22 at 11:49 a.m.: "Abdominal x-ray revealed colonic ileus. Abdomen is distended and round, bowel sounds hypoactive. No bowel movement this morning...Notified doctor...advised to send to ER (emergency room)."

Further review of R106's clinical record revealed no evidence that the required paperwork necessary to care for the resident was ever sent to the receiving hospital for the 3/25/22 discharge

On 5/18/22 at 4:15 p.m., ASM (administrative staff member) #2, the director of nursing, stated she could not locate any additional evidence of paperwork sent to the hospital for R106's

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discharge.

On 5/19/22 at 9:30 a.m., RN (registered nurse) #1 was interviewed. She stated the nursing staff sends the completed acute care transfer form, the transfer checklist, a facesheet, any pertinent labs or x-rays, the H&P, and the medication list with a resident when the resident is discharged to the hospital. She stated the transfer checklist goes with the resident and the facility does not keep a copy to evidence what has been sent to the hospital.

On 5/19/22 at 5:11 p.m., ASM #1, the administrator and ASM #2 were informed of these concerns.

No further information was provided prior to exit.

3. The facility staff failed to evidence provision of required resident information to a receiving facility at the time of discharge for Resident #33. Resident #33 was transferred to the hospital on 2/16/22.

Resident #33 was admitted to the facility on 7/13/21 with diagnosis that included but were not limited to: congestive heart failure, diabetes, dementia, pacemaker and obstructive sleep apnea.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/8/22, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as

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requiring extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; supervision for locomotion and eating. Section O-special procedures/treatments coded the resident as oxygen "yes". No annual assessment, unable to see that smoking was coded as yes under section J.

A review of the comprehensive care plan dated 2/26/22, which revealed, "FOCUS: The resident has altered cardiovascular status related to hypertension and pacemaker.
INTERVENTIONS: Monitor/report to MD signs and symptoms of CAD: chest pain or pressure especially with activity, heartburn, nausea and vomiting, shortness of breath, excessive sweating, dependent edema, changes in cap refill, color/warmth of extremities."

A review of the nursing progress note dated 2/16/22 at 11:22 AM, revealed the following, "Resident went out to the hospital with a diagnosis of Hypoxia and altered mental status. RP is aware and NP ordered transfer. Resident went to hospital."

A review of the nursing progress note dated 2/16/22 at 5:41 PM, revealed the following, "Writer called hospital and was told that resident is being admitted for Chronic CHF, Peripheral Vascular disease, and Hypoxia."

On 5/17/22 at approximately 4:30 PM, a request was made to provide evidence of Resident #33's clinical documentation provided to the receiving facility on 2/16/22.

On 5/18/22 at approximately 7:30 AM, note which revealed, "Resident #33's transfer sheet not

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dated or provided for 2/16/22 hospital transfer." The facility's "Acute Care Transfer Document Checklist" reveals the following, "Copies of Documents Sent with Resident/Patient (check all that apply): Documents recommended to accompany resident/patient: resident/patient transfer form, face sheet, current medication list, SBAR (situation, background, assessment, recommendation), advance directives, advance care orders, bed hold policy. Send these documents if available: notification of transfer, most recent history and physical, recent hospital discharge summary, recent physician/nurse practitioner orders, flow sheets, relevant lab results, relevant x-ray results, current care plan."

An interview was conducted on 5/17/22 at approximately 2:00 PM with Resident #33. When asked if he had been transferred to the hospital, Resident #33 stated, "Yes, a couple of months ago, I went to the hospital because I was having trouble breathing."

An interview was conducted on 5/19/22 at 7:15 AM with LPN (licensed practical nurse) #1. When asked what papers are sent with the resident to the hospital, LPN #1 stated, "I send the clinical documents, medication list, orders, care plan. When asked if this is documented anywhere in the medical record, LPN #1 stated, "There is a folder we put the information in, but I do not always copy the envelope. I think we are to copy the envelope."

On 5/19/22 at 5:30 PM, ASM #2, the director of nursing confirmed that no further evidence of clinical documentation was obtainable for the resident.

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On 5/19/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the director of human resources were made aware of the findings.

According to the facility's policy "Discharge: Other Institution or Non-Emergency Acute Setting" dated 2009, which reveals, "To provide safe departure from center to other institution or acute care setting. Complete required transfer information, assemble equipment (discharge and transfer paperwork, wheelchair or stretcher), complete discharge summary paperwork and place into medical record."

No further information was provided prior to exit.

4. The facility staff failed to evidence provision of required resident information to a receiving facility at the time of discharge for Resident #75. Resident #75 was transferred to the hospital on 5/9/22.

Resident #75 was admitted to the facility on 9/2/21 with diagnosis that included but were not limited to: diabetes, bipolar, osteomyelitis and methicillin resistant staph aureus.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/12/22, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, hygiene and bathing;

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supervision for locomotion and eating.

A review of the comprehensive care plan dated 5/5/22, which revealed, "FOCUS: Infection of wound/skin. INTERVENTIONS: Administer medication per physician orders. Obtain Labs as ordered and notify physician of results."

A review of the nursing progress note dated 5/9/22 at 2:54 PM, reveals the following, "Received x-ray results and shows: Moderate-sized retrocalcaneal skin wound with moderate subcutaneous emphysema surrounding the calcaneous. Cannot exclude gas gangrene or osteomyelitis. Consider CT or MRI for further evaluation."

A review of the nursing progress note dated 5/9/22 at 3:12 PM, reveals the following, "NP called and states to send patient out to the hospital. Patient made aware of transport."

On 5/19/22 during the closed record review a request was made to provide evidence of Resident #75's clinical documentation provided to the receiving facility on 5/9/22.

On 5/19/22 at approximately 2:45 PM, a note revealed, "Resident #75 no dated hospital transfer packet sheet for 5/9/22." The facility's "Acute Care Transfer Document Checklist" reveals the following, "Copies of Documents Sent with Resident/Patient (check all that apply): Documents recommended to accompany resident/patient: resident/patient transfer form, face sheet, current medication list, SBAR (situation, background, assessment, recommendation), advance directives, advance care orders, bed hold policy. Send these

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documents if available: notification of transfer, most recent history and physical, recent hospital discharge summary, recent physician/nurse practitioner orders, flow sheets, relevant lab results, relevant x-ray results, current care plan."

An interview was conducted on 5/19/22 at 7:15 AM with LPN (licensed practical nurse) #1. When asked what papers are sent with the resident to the hospital, LPN #1 stated, "I send the clinical documents, medication list, orders, care plan." When asked if this is documented anywhere in the medical record, LPN #1 stated, There is a folder we put the information in, but I do not always copy the envelope. I think we are to copy the envelope."

On 5/19/22 at 5:30 PM, ASM #2, the director of nursing confirmed that no further evidence of clinical documentation was obtainable for the resident.

On 5/19/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the director of human resources were made aware of the findings.

According to the facility's policy "Discharge: Other Institution or Non-Emergency Acute Setting" dated 2009, which reveals, "To provide safe departure from center to other institution or acute care setting. Complete required transfer information, assemble equipment (discharge and transfer paperwork, wheelchair or stretcher), complete discharge summary paperwork and place into medical record."

No further information was provided prior to exit.

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F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623	623 – Notice Requirements Before Transfer/Discharge 1. R124, R106, R33, R75 and R 68 returned to the facility. 2. Utilizing the "Unexpected hospital readmission" QAPI tool – the director of nursing/designee will complete a comprehensive review from 5.23.2022 to current for any residents sent to acute care to validate notice requirements prior to discharge were documented in the clinical chart. 3. The director of nursing/designee will educate the licensed nursing staff on "Focus on F-tag 623" and the "Care transitions" procedure on or before the date of compliance. 4. Utilizing the "Unexpected hospital readmission" QAPI tool – the director of nursing/designee will audit five residents per week times four weeks to validate documented discharge requirements are in the clinical chart. Results of the audits will be reviewed with the QA&A committee.	6/30/2022

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(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.

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PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)	2125 HILLIARD ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide written notice to the RR (resident representative) and/or Office of the State Long-Term Care Ombudsman for resident discharges for five of 52 residents in the survey sample, Residents #124, #106, #33, #75, and #68.

The findings include:

1. The facility staff failed to provide written notice to the RR and the ombudsman, for Resident #124 (R124) when the resident was discharged on 3/27/22, 4/19/22, and 5/5/22 due to medical emergencies.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/13/22, R124 was coded as being severely cognitively intact for making daily

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decisions, having scored zero out of 15 on the BIMS (brief interview for mental status).

A review of R124's clinical record revealed the following progress notes:
- 3/27/22 at 2:03 p.m.: "Resident is non responsive to sternal rubs and hypotensive (low blood pressure). New order to send out to ER (emergency room)."
- 4/19/22 at 10:41 p.m.: "Resident found with rectal hemorrhaging, MD (medical doctor) notified. Gave orders to send to ER. DON (director of nursing) and RP (responsible party) notified."
- 5/5/22 at 12:43 p.m.: "Patient is lethargic, eyes open, non-responsive, unable to follow command. Patient was not able to eat meal. Was assess (sic) by...NP (nurse practitioner) and advised to send to ER for evaluation. Pick up by 911 and sent to [name of local hospital]."

Further review of R124's clinical record revealed no evidence that the RR or the ombudsman were notified in writing of any of the discharges on the above dates.

On 5/18/22 at 12:52 p.m., OSM (other staff member) #4, social services, was interviewed. She stated she does not notify the ombudsman when a resident is discharged to the hospital. She stated she only notifies the ombudsman when a resident is discharged from the facility back to the resident's home. She stated this is how she was trained by a previous social worker. She stated the nursing staff calls the resident representative. She stated the written notification to the RR would have to be done by the nursing staff. She stated the social worker has never provided written notification to the RR when a resident is

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discharged to the hospital.

On 5/18/22 at 4:15 p.m., ASM (administrative staff member) #2, the director of nursing, stated she could not locate any additional evidence of written notification to the ombudsman or RR for R124's discharges.

On 5/19/22 at 9:30 a.m., RN (registered nurse) #1 was interviewed. She stated the nursing staff calls the resident representative, but does not send a written notification of transfer to anyone.

On 5/19/22 at 5:11 p.m., ASM #1, the administrator and ASM #2 were informed of these concerns.

A review of the facility policy, "Focus of F623," revealed only a recapitulation of the regulatory language. The document did not provide policies or procedures for the facility to follow.

No further information was provided prior to exit.

2. For Resident #106 (R106), the facility failed to provide written notice to the RR and the ombudsman for Resident #106 (R124) when the resident was discharged on 3/25/22 due to a medical emergency.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/8/22, R106 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status).

A review of R106's progress notes revealed the

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following note dated 3/25/22 at 11:49 a.m.: "Abdominal x-ray revealed colonic ileus. Abdomen is distended and round, bowel sounds hypoactive. No bowel movement this morning...Notified doctor...advised to send to ER (emergency room)."

Further review of R106's clinical record revealed no evidence that the RR and the ombudsman were notified in writing of any of the discharges on 3/25/22.

On 5/18/22 at 12:52 p.m., OSM (other staff member) #4, social services, was interviewed. She stated she does not notify the ombudsman when a resident is discharged to the hospital. She stated she only notifies the ombudsman when a resident is discharged from the facility back to the resident's home. She stated this is how she was trained by a previous social worker. She stated the nursing staff calls the resident representative. She stated the written notification to the RR would have to be done by the nursing staff. She stated the social worker has never provided written notification to the RR when a resident is discharged to the hospital.

On 5/18/22 at 4:15 p.m., ASM (administrative staff member) #2, the director of nursing, stated she could not locate any additional evidence of written notification to the ombudsman or RR for R106's discharge.

On 5/19/22 at 9:30 a.m., RN (registered nurse) #1 was interviewed. She stated the nursing staff calls the resident representative, but does not send a written notification of transfer to anyone.

On 5/19/22 at 5:11 p.m., ASM #1, the

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administrator and ASM #2 were informed of these concerns.

No further information was provided prior to exit.

3. The facility staff failed to evidence written notification to the ombudsman and/or RP (responsible party) for a discharge of a resident to a receiving facility for Resident #33. Resident #33 was transferred to the hospital on 2/16/22.

Resident #33 was admitted to the facility on 7/13/21 with diagnosis that included but were not limited to: congestive heart failure, diabetes, dementia, pacemaker and obstructive sleep apnea.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/8/22, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired.

A review of the nursing progress note dated 2/16/22 at 11:22 AM, revealed the following, "Resident went out to the hospital with a diagnosis of Hypoxia and altered mental status. RP is aware and NP ordered transfer. Resident went to hospital."

An interview was conducted on 5/18/22 at 2:15 PM with OSM (other staff member) #3, the admissions coordinator. When asked who provides written notification to the RP and ombudsman for residents being transferred to the hospital, OSM #3 stated, "We do not have the ombudsman notification for this resident in

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February or March. There should be a written notification to the ombudsman and the RP. Nursing notifies the RP by phone. I started here a few weeks ago."

An interview was conducted on 5/19/22 at 7:15 AM with LPN (licensed practical nurse) #1. When ask who notifies the RP or ombudsman upon hospital transfer, LPN #1 stated, "I would call the RP, I do not know who notifies the ombudsman. When asked who notifies the RP in writing, LPN #1 stated, I do not notify anyone in writing."

On 5/19/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the director of human resources were made aware of the findings.

According to the facility's "Notice Requirements before Transfer/Discharge" policy with no date, revealed the following, "Before a facility transfers or discharges a resident, the facility must notify the resident and the resident's representative (s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Timing of notice: Notice must be made as soon as practicable before transfer or discharge when the resident's health improves sufficiently to allow a more immediate transfer or discharge."

No further information was provided prior to exit.

4. The facility staff failed to evidence written notification to the ombudsman and/or RP (responsible party) for a discharge of a resident to a receiving facility for Resident #75. Resident #75 was transferred to the hospital on 5/9/22.

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Resident #75 was admitted to the facility on 9/2/21 with diagnosis that included but were not limited to: diabetes, bipolar, osteomyelitis and methicillin resistant staph aureus.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/12/22, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired.

A review of the nursing progress note dated 5/9/22 at 2:54 PM, reveals the following, "Received x-ray results and shows: Moderate-sized retrocalcaneal skin wound with moderate subcutaneous emphysema surrounding the calcaneous. Cannot exclude gas gangrene or osteomyelitis. Consider CT or MRI for further evaluation."

A review of the nursing progress note dated 5/9/22 at 3:12 PM, reveals the following, "NP called and states to send patient out to the hospital. Patient made aware of transport."

An interview was conducted on 5/19/22 at 7:15 AM with LPN (licensed practical nurse) #1. When ask who notifies the RP or ombudsman upon hospital transfer, LPN #1 stated, "I would call the RP, I do not know who notifies the ombudsman." When asked who notifies the RP in writing, LPN #1 stated, "I do not notify anyone in writing."

An interview was conducted on 5/19/22 at 3:15 PM with OSM (other staff member) #3, the admissions coordinator. When asked who

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provides written notification to the RP and ombudsman for residents being transferred to the hospital, OSM #3 stated, "We do not have the ombudsman notification for this resident yes, because still in May. There should be a written notification to the ombudsman and the RP. Nursing notifies the RP by phone. I started here a few weeks ago."

On 5/19/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the director of human resources were made aware of the findings.

According to the facility's "Notice Requirements before Transfer/Discharge" policy with no date, reveals the following, "Before a facility transfers or discharges a resident, the facility must notify the resident and the resident's representative (s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Timing of notice: Notice must be made as soon as practicable before transfer or discharge when the resident's health improves sufficiently to allow a more immediate transfer or discharge."

No further information was provided prior to exit.
5. The facility staff failed to notify the State Long-Term Care Ombudsman when Resident #68 (R68) was transferred to the hospital on 2/25/2022.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/15/2022, the resident scored 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the

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resident was moderately cognitively impaired for making daily decisions.

The nurse's note dated, 2/25/2022 at 7:34 p.m. documented, "At [initials of hospital] ER (emergency room)."

The nurse's note dated 2/28/2022 at 9:05 a.m. documented, "Resident went LOA (leave of absence) to wound clinic appt (appointment) on 2/25/2022 and did not return. Resident was sent to [initials of hospital] ER for evaluation. Admission Dx (diagnosis) osteomyelitis. RP (responsible party) aware, NP (nurse practitioner) aware."

On 5/17/2022 a request was made for the notice to the ombudsman of R68's transfer to the hospital on 2/25/2022.

An interview was conducted with OSM (other staff member) #4, social services on 5/18/2022 at 12:51 p.m. When asked if she is responsible for the notification to the ombudsman when a resident is sent to the hospital, OSM #4 stated the facility does not notify the ombudsman when they go to the hospital, only when the residents are discharged home. OSM #4 stated that is how she was trained by the social worker that used to work at the facility.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and OSM (other staff member) #2, the human resources director, were made aware of the above concern on 5/18/2022 at 4:57 p.m.

No further information was provided prior to exit.

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F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide written notice of the facility's bed hold policies at the time of discharge for five of 52 residents in the survey sample, Residents #124, #106, #33,	F 625	625 – Notice of Bed Hold Policy Before/Upon Transfer 1. R124, R106, R33, R75 and R 68 returned to the facility. 2. Utilizing the "Unexpected hospital readmission" QAPI tool – the director of nursing/designee will complete a comprehensive review from 5.23.2022 to current for any residents sent to acute care to validate bed hold notification is documented in the clinical chart. 3. The director of nursing/designee will educate the licensed nursing staff on "Focus on F-tag 625" and the "Care transitions" procedure on or before the date of compliance. 4. Utilizing the "Unexpected hospital readmission" QAPI tool – the director of nursing/designee will audit five residents per week times four weeks to validate bed hold notifications are documented in the clinical chart. Results of the audits will be reviewed with the QA&A committee.	6/30/2022

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#75, and #68.

The findings include:

1. The facility staff failed to provide written notice of the facility's bed hold policies to Resident #124 (R124) when the resident was discharged due to medical emergencies on 3/27/22, 4/19/22, and 5/5/22.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/13/22, R124 was coded as being severely cognitively intact for making daily decisions, having scored zero out of 15 on the BIMS (brief interview for mental status).

A review of R124's clinical record revealed the following progress notes:
- 3/27/22 at 2:03 p.m.: "Resident is non responsive to sternal rubs and hypotensive (low blood pressure). New order to send out to ER (emergency room)."
- 4/19/22 at 10:41 p.m.: "Resident found with rectal hemorrhaging, MD (medical doctor) notified. Gave orders to send to ER. DON (director of nursing) and RP (responsible party) notified."
- 5/5/22 at 12:43 p.m.: "Patient is lethargic, eyes open, non-responsive, unable to follow command. Patient was not able to eat meal. Was assess (sic) by...NP (nurse practitioner) and advised to send to ER for evaluation. Pick up by 911 and sent to [name of local hospital]."

Further review of R124's clinical record revealed no evidence that the resident was provided with the facility's bed hold policies for of any of the discharges on the above dates.

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On 5/18/22 at 2:15 p.m., OSM (other staff member) #3, the admissions director, was interviewed. She stated bed holds are done for residents who are discharged to the hospital. She stated the resident receives a paper notice of the bed hold.

On 5/18/22 at 4:15 p.m., ASM (administrative staff member) #2, the director of nursing, stated she could not locate any additional evidence of bed hold notifications for R124's discharges.

On 5/19/22 at 9:30 a.m., RN (registered nurse) #1 was interviewed. She stated the bed hold notice is provided on admission and the admissions office should follow up with them after the resident is admitted to the hospital.

On 5/19/22 at 5:11 p.m., ASM #1, the administrator and ASM #2 were informed of these concerns.

A review of the facility policy, "Focus on F625," revealed only a recapitulation of the regulatory language. The document did not provide policies or procedures for the facility to follow.

A review of the facility policy, "Discharge: Other Institution or Non-Emergency Acute Setting," revealed, in part: "Provide bed hold policy as required by state or county regulations (available from admissions office."

No further information was provided prior to exit.

2. For Resident #106 (R106), the facility staff failed to provide written notice of the facility's bed hold policies for the 3/25/22 discharge to the

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hospital due to a medical emergency.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/8/22, R106 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status).

A review of R106's progress notes revealed the following note dated 3/25/22 at 11:49 a.m.: "Abdominal x-ray revealed colonic ileus. Abdomen is distended and round, bowel sounds hypoactive. No bowel movement this morning...Notified doctor...advised to send to ER (emergency room)."

Further review of R106's clinical record revealed no evidence that the resident received notice of bed hold policies for the discharge on 3/25/22.

On 5/18/22 at 2:15 p.m., OSM (other staff member) #3, the admissions director, was interviewed. She stated bed holds are done for residents who are discharged to the hospital. She stated the resident receives a paper notice of the bed hold.

On 5/18/22 at 4:15 p.m., ASM (administrative staff member) #2, the director of nursing, stated she could not locate any additional evidence of bed hold notifications for R106's discharges.

On 5/19/22 at 9:30 a.m., RN (registered nurse) #1 was interviewed. She stated the bed hold notice is provided on admission and the admissions office should follow up with them after the resident is admitted to the hospital.

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On 5/19/22 at 5:11 p.m., ASM #1, the administrator and ASM #2 were informed of these concerns.

No further information was provided prior to exit.
The findings include:

3. The facility staff failed to evidence provision of bed hold notification at the time of discharge to a receiving facility for Resident #33. Resident #33 was transferred to the hospital on 2/16/22.

Resident #33 was admitted to the facility on 7/13/21 with diagnosis that included but were not limited to: congestive heart failure, diabetes, dementia, pacemaker and obstructive sleep apnea.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/8/22, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired.

A review of the nursing progress note dated 2/16/22 at 11:22 AM, revealed the following, "Resident went out to the hospital with a diagnosis of Hypoxia and altered mental status. RP is aware and NP ordered transfer. Resident went to hospital."

A review of the nursing progress note dated 2/16/22 at 5:41 PM, revealed the following, "Writer called hospital and was told that resident is being admitted for Chronic CHF, Peripheral Vascular disease, and Hypoxia."

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An interview was conducted on 5/17/22 at approximately 2:00 PM with Resident #33. When asked if he had been transferred to the hospital, Resident #33 stated, yes, a couple of months ago, I went to the hospital because I was having trouble breathing.

An interview was conducted on 5/18/22 at 2:15 PM with OSM (other staff member) #3, the admissions coordinator. When asked who provides the bed hold notice for residents being transferred to the hospital, OSM #3 stated, "Bed holds are done for transfers out to the hospital and entered into the system and a paper is sent to the resident. I do not see a bed hold was done for this resident. There is nothing in the computer to indicate a bed hold was done. I started here a few weeks ago."

On 5/19/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the director of human resources were made aware of the findings.

According to the facility's policy "Notice of Bed Hold Policy before/upon transfer", which reveals, "Notice of transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies the duration of the state bed hold policy. These provisions require facilities to issues two notices related to bed hold policies. The second notice must be provided to the resident and if applicable the resident's representative at the time of transfer or in the cases of emergency transfer, within 24 hours.

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No further information was provided prior to exit.

4. The facility staff failed to evidence provision of bed hold notification at the time of discharge to a receiving facility for Resident #75. Resident #75 was transferred to the hospital on 5/9/22.

Resident #75 was admitted to the facility on 9/2/21 with diagnosis that included but were not limited to: diabetes, bipolar, osteomyelitis and methicillin resistant staph aureus.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/12/22, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired.

A review of the nursing progress note dated 5/9/22 at 2:54 PM, reveals the following, "Received x-ray results and shows: Moderate-sized retrocalcaneal skin wound with moderate subcutaneous emphysema surrounding the calcaneous. Cannot exclude gas gangrene or osteomyelitis. Consider CT or MRI for further evaluation."

A review of the nursing progress note dated 5/9/22 at 3:12 PM, reveals the following, "NP called and states to send patient out to the hospital. Patient made aware of transport."

On 5/19/22 at approximately 2:45 PM, a note was reviewed which revealed, "Resident #75 no dated hospital transfer packet sheet for 5/9/22." The facility's "Acute Care Transfer Document

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Checklist" reveals the following, "Copies of Documents Sent with Resident/Patient (check all that apply): Documents recommended to accompany resident/patient: resident/patient transfer form, face sheet, current medication list, SBAR (situation, background, assessment, recommendation), advance directives, advance care orders, bed hold policy. Send these documents if available: notification of transfer, most recent history and physical, recent hospital discharge summary, recent physician/nurse practitioner orders, flow sheets, relevant lab results, relevant x-ray results, current care plan."

An interview was conducted on 5/19/22 at 3:15 PM with OSM (other staff member) #3, the admissions coordinator. When asked who provides the bed hold notice for residents being transferred to the hospital, OSM #3 stated, bed holds are done for transfers out to the hospital and entered into the system and a paper is sent to the resident. I do not see a bed hold was done for this resident. There is nothing in the computer to indicate a bed hold was done. I started here a few weeks ago.

On 5/19/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the director of human resources were made aware of the findings.

According to the facility's policy "Notice of Bed Hold Policy before/upon transfer", which reveals, "Notice of transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies the duration

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of the state bed hold policy. These provisions require facilities to issues two notices related to bed hold policies. The second notice must be provided to the resident and if applicable the resident's representative at the time of transfer or in the cases of emergency transfer, within 24 hours."

No further information was provided prior to exit.
5. The facility staff failed to evidence provision of bed hold notification at the time of discharge to a receiving facility for Resident #68. Resident #68 was transferred to the hospital on 2/25/22.

An interview was conducted with OSM (other staff member) #1, the business office manager, on 5/18/2022 at 4:04 p.m. When asked the process for giving a bed hold notice when a resident is transferred to the hospital, OSM #1 stated, when a resident goes to the hospital, admissions gives the notice to the nursing staff, it goes to the hospital with the patient.

R68s date of transfer on 2/25/2022 was reviewed. OSM #1 stated the resident's AR (account representative) would have been called and asked if they wanted a bed hold and here's how much it costs. OSM #1 further stated there are times when the bed hold notice is given by the business office. OSM #1 stated if the business office staff made contact with the family regarding a bed hold then it would be documented in the section of [name of computer program] under the collections tab. OSM #1 reviewed the collection notes for R68 for the time frame when they went to the hospital on 2/25/2022, she could not find any documentation related to the bed hold. OSM #1 stated, "If it isn't documented it didn't happen." OSM #1 stated, There is no documentation so it

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F 625	Continued From page 67 wasn't done." OSM #1 stated she was pretty sure it wasn't done. On 5/19/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the director of human resources were made aware of the findings.	F 625		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as 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	F 656		

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F 656	Continued From page 68 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and facility document review, it was determined the facility staff failed to develop and/or implement the comprehensive care plan for three of 52 residents in the survey sample, Residents #33, #16 and #63. The findings include: 1. The facility staff failed to implement the comprehensive care plan for smoking for Resident #33. The care plan was not updated to reflect smoking until after surveyor entrance and after surveyor observation of Resident #33 smoking on 5/17/22. Resident #33 was observed smoking on 5/17/22 at 4:00 PM and again on 5/19/22 at 1:00 PM. Staff provided cigarettes and lighter to resident from a locked box they brought with them. Resident #33 was admitted to the facility on 7/13/21 with diagnosis that included but were not limited to: congestive heart failure, diabetes,	F 656	656 – Develop/Implement Comprehensive Care Plan 1. R33 had a new smoking assessment completed and appropriate care plans updated. R 16 care plan for dialysis monitoring was updated and the communication sheets were initiated with the dialysis clinic. R63 was seen by the dietician and the care plan was updated to reflect the current plan of care. 2. Utilizing the Care Planning QAPI tool – a comprehensive review of current residents who smoke, residents requiring dialysis and any resident with a significant weight change since 5.23.2022 will be completed by the Director of Nursing/designee to validate appropriate updates to the plan of care. 3. The director of nursing/designee will educate the licensed nursing staff on "Focus on F-tag 656 and "Smoking guidelines," "hemodialysis," and "change of condition" procedure on or before the date of compliance. 4. Utilizing the Care Planning QAPI tool – the Director of nursing/designee will audit five residents per week times four weeks who currently smoke, those residents on dialysis or any residents that have a significant weight change to validate appropriate updates to the plan of care.	6/30/2022

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dementia, pacemaker and obstructive sleep apnea.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/8/22, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; supervision for locomotion and eating. Section O-special procedures/treatments coded the resident as oxygen "yes".

A review of the comprehensive care plan dated 5/18/22, revealed, "FOCUS: History of smoking in community/Inappropriate smoking. INTERVENTIONS: Complete Smoking Evaluation per facility guidelines. Secure smoking materials at nurses' station or other designated area for storage. Allow to smoke in designated area(s) at designated smoking times."

An interview was conducted on 5/17/22 at 4:00 PM with Resident #33. When asked how long he has smoked while he has been a resident, Resident #33 stated, "I have been smoking since I came here."

An interview was conducted on 5/19/22 at 7:15 AM with LPN (licensed practical nurse) #1. When asked the purpose of the care plan, LPN #1 stated the purpose is to look at the care of the resident and know what to do to monitor and prevent any issues with the resident. When asked if a resident that smokes should have that

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on their care plan, LPN #1 stated, "Yes, a resident that smokes should have it on their care plan." When ask why it should be on the care plan, LPN #1 stated, "It should be there because it is a safety issue."

On 5/19/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the director of human resources were made aware of the findings.

According to the facility's policy "Interdisciplinary Care Planning" dated 2018, which reveals, "The facility must develop and implement a comprehensive person-centered care plan for each patient that includes measurable objectives and timeframes to meet a patient's medical, nursing, mental and psychosocial needs that are identified."

According to the facility's policy "Smoking Guidelines" dated 2019, which reveals, "The IDT (interdisciplinary team) completes a comprehensive patient care plan that reflects the: smoking evaluation outcome, smoking supervision that is necessary, type of protective equipment needed and education on smoking guidelines."

No further information was provided prior to exit.
2a. The facility staff failed to implement Resident #16's (R16) comprehensive care plan for the monitoring of the dialysis access bruit and thrill (1).

(R16) was admitted to the facility with diagnoses included but were not limited to: end stage renal disease (2), dependent on renal dialysis.

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On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 02/24/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded (R16) for "Dialysis" while a resident.

The physician's order summary for (R16) documented in part, "Check AV (arterial/venous) fistula (3) site thrill/bruit (4) every day shift for AV fistula site thrill/bruit check. Order Date: 03/11/2022. Start Date: 03/12/2022."

The comprehensive care plan for (R16) dated 05/22/2019 documented in part, "Focus. Renal insufficiencies related to: ESRD (end stage renal disease), dependence on renal dialysis. Date Initiated: 05/22/2019." Under "Interventions" it documented in part, "Check access site for lack of thrill/bruit, evidence of infection, swelling, or excessive bleeding per facility guidelines. Report abnormalities to physician Date Initiated: 05/22/2019."

Review of the eTAR (electronic treatment administration record) for (R16) dated March 2022 documented in part, "Check AV fistula site thrill/bruit every day shift for AV fistula site thrill/bruit check." Further review of the eTAR revealed blanks (not signed) on 03/17/22 and 03/25/2022.

Review of (R16's) eTAR dated April 2022 documented in part, as stated above. Further review of the eTAR revealed blanks on

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04/15/2022, 04/24/2022.

Review of (R16's) eTAR dated May 2022 documented in part, as stated above. Further review of the eTAR revealed a blank on 05/13/2022.

On 05/19/2022 at approximately 2:45 p.m., an interview was conducted with LPN (licensed practical nurse) # 5 regarding the blanks on (R16's) eTARs for March, April and May 2022. After reviewing the eTARs for the dates listed above LPN # 5 was asked to interpret the blanks for the bruit and thrill checks. LPN # 5 stated that if the eTAR was blank it indicated that the bruit and thrill was not checked. After reviewing the comprehensive care plan for (R16) LPN # 5 was asked if the care plan was being implemented for monitoring (R16's) bruit and thrill if there were blanks on the eTARs dated above. LPN # 5 stated that the care plan was not being followed.

On 05/19/2022 at approximately 5:10 p.m., ASM (administrative staff member) # 1, administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was presented prior to exit.

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

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cess/#:~:text=When%20you%20slide%20your%20fingertips,is%20still%20in%20good%20condition
.

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

2b. The facility staff failed to implement (R16's) comprehensive care plan for coordinating care with the dialysis center by completing the dialysis communication forms.

The facility staff failed to provide complete dialysis communication forms for (R16's) on 05/02/2022, 05/04/2022, 05/06/2022, 05/09/2022, 05/11/2022, 05/13/2022, 05/16/2022 and on 05/18/2022.

The physician's order for (R16) documented in part, "Hemodialysis per physician order M-W-F (Monday - Wednesday-Friday) 0530-0900 (5:30 a.m. to 9:00 a.m.). Order date: 05/02/2022."

The comprehensive care plan for (R16) dated 05/22/2019 documented in part, "Focus. Renal insufficiencies related to: ESRD (end stage renal disease), dependence on renal dialysis. Date Initiated: 05/22/2019." Under "Interventions" it documented in part, "Coordinate dialysis care with dialysis treatment center Date Initiated: 05/22/2019."

Review of the facility's "Hemodialysis Communication Forms" for (R16's) dialysis failed to evidence documentation of the following: description of the dialysis site , patient status,

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laboratory tests, and the nurse's signature on 05/02/2022, 05/04/2022, 05/06/2022, 05/09/2022, 05/11/2022, 05/13/2022, 05/16/2022 and on 05/18/2022 and (R16's) temperature on 05/02/2022, 05/04/2022, 05/13/2022 and 05/16/2022.

On 05/19/2022 at approximately 2:45 p.m., an interview was conducted with LPN (licensed practical nurse) # 5 regarding the facility's "Hemodialysis Communication Forms" for (R16) dated 05/02/2022, 05/04/2022, 05/06/2022, 05/09/2022, 05/11/2022, 05/13/2022, 05/16/2022 and on 05/18/2022. When asked to describe the procedure for completing the dialysis communication form LPN # 5 stated that the top of the form that included vital signs, status of the dialysis site, patient status and signed by the nurse. After reviewing (R16's) dialysis communication forms dated above LPN # 5 stated that the forms were incomplete. After reviewing the comprehensive care plan for (R16) LPN # 5 was asked if the care plan was being implemented for coordinating dialysis care with the dialysis facility if the facility's dialysis communication forms listed above were incomplete. LPN # 5 stated that the care plan was not being followed.

On 05/19/2022 at approximately 5:10 p.m., ASM (administrative staff member) # 1, administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was presented prior to exit.

3. The facility staff failed to implement Resident #63's (R63's) care plan for nutrition when she experienced a significant weight loss between

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PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)	2125 HILLIARD ROAD RICHMOND, VA 23228

(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 656		F 656		

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12/7/21 and 1/14/22.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/14/22, R63 was coded as being severely cognitively impaired for making daily decisions, having scored zero out of 15 on the BIMS (brief interview for mental status). R63 was coded as having no significant weight loss during the look back period.

A review of R63's care plan dated 10/8/19 and reviewed 3/15/22 revealed, in part: "[R63] has the potential for nutrition/hydration imbalance...BMI (body mass index) is underweight...RD (registered dietician) to monitor and f/u (follow up) per protocol...review weights and notify physician and responsible party of significant weight change."

A review of R63's clinical record revealed the following weights on the following dates:
On 12/7/21, the resident weighed 93 lbs. On 1/14/22, the resident weighed 87 pounds. The loss was a 6.45 % loss.

Further review of R63's clinical record revealed no dietary or nutrition notes related to this loss, and no evidence that the provider was notified of this significant weight loss.

On 5/19/22 at 9:29 a.m., OSM (other staff member) #12, the RD was interviewed. She stated she has only been working at the facility since March 2022, and was not responsible for reviewing weights for R63 in December 2021 or January 2022. She stated she pulls the weekly weights for at-risk residents and reviews them. She stated if she identifies a significant loss, she

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would contact the physician, and recommend interventions, if appropriate for the resident. She stated a 6.45% weight loss in 30 days is a significant weight loss, and should have been addressed by the RD at the time. She stated the RD should document in the clinical record regarding awareness of the significant weight loss and any interventions recommended to the physician. After reviewing R63's care plan related to nutrition, OSM #12 stated R63's care plan was not followed when the significant weight loss was not addressed by the facility staff.

On 5/19/22 at 5:11 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

F 657 SS=D Care Plan Timing and Revision F 657
CFR(s): 483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s).
An explanation must be included in a resident's

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F 657	Continued From page 77 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 observation, clinical record review, staff interview and facility document review it was determined facility staff failed to revise the care plan for one of 52 residents in the survey sample, Resident #61. The findings include: The facility staff failed to revise the care plan for elopement after 1:1 monitoring was no longer required for Resident #61 (R61). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/17/2022, the resident scored an 10 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is moderately impaired for making daily decisions. Section E documented R61 having wandering behaviors 4 to 6 days during the assessment period. On 5/17/2022 at approximately 12:45 p.m., an observation was made of R61 in their room. R61 was observed dressed lying on top of his made bed reading a book. R61 was observed wearing	F 657	657 – Care Plan Timing and Revision 1. R61 no longer resides in the facility. 2. Utilizing the Exit Seeking Care Plan tool – the director of nursing/designee will audit current residents with known exit seeking behavior to validate appropriate plans of care. 3. The director of nursing/designee will educate the licensed nursing staff on "Focus on F-tag 657" and the "interdisciplinary care planning" procedure on or before the date of compliance. 4. Utilizing the Exit Seeking Care Plan tool – the director of nursing/designee will audit five residents per week times four weeks to validate any new elopement attempts or actual elopements have appropriate care plan revisions. Results will be reviewed with the QA&A committee.	6/30/2022

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a wandergaurd bracelet on the right wrist. R61 was observed to be in the room alone with no staff 1:1 supervision.

Additional observations of R61 on 5/17/2022 at 2:45 p.m., 5/17/2022 at 4:15 p.m. and 5/18/2022 at 8:30 a.m. revealed no 1:1 staff supervision.

The comprehensive care plan for R61 documented in part, "Exit seeking/elopement risk related to: cognitive impairment. Date Initiated: 12/01/2021. Revision on: 12/01/2021." Under "Interventions/Tasks" it documented in part, "1:1 Supervision, Date Initiated: 12/17/2021..."

The progress notes for R61 documented in part,
- "12/14/2021 17:41 (5:41 p.m.) RP (responsible party) notified left message of his exit from building. MD (medical doctor) has been made aware. Now on 1 on 1 monitoring by staff."
- "12/23/2021 14:01 (2:01 p.m.) Resident monitored frequently remains on 1:1 monitoring. No behaviors displayed or reported. Alert bracelet in place."
- "1/4/2022 15:36 (3:36 p.m.) Care plan note: SS (social services), UM (unit manager) and activities assistant and therapy met for resident's care conference...Nursing reports resident is stable currently with no acute medical issues...No changes currently."

On 5/18/2022 at 3:55 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that the purpose of the care plan was to show the residents problems, goals and interventions in place to care for the resident. LPN #4 stated that the care plan was updated when there was a change in status or new order. LPN #4 stated that the care plan was revised and

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reevaluated at the care plan meetings to see if the problems, goals and interventions were still appropriate or needed to be changed. LPN #4 stated that R61 was not on 1:1 observation and had not been since they had been working on the unit at the end of December. LPN #4 stated that R61's care plan was not up to date if it documented 1:1 supervision because they did not require it at this time.

On 5/19/2022 at 9:30 a.m., an interview was conducted with RN (registered nurse) #1, unit manager. RN #1 stated that they worked with an agency and had been there for 2 months. RN #1 stated that R61 had not been on 1:1 since they had been working on the unit. RN #1 stated that the purpose of the care plan was to give staff a picture of the care being provided to the resident. RN #1 reviewed the comprehensive care plan for R61 which documented 1:1 supervision under interventions and stated that the care plan was not current because they did not require 1:1 supervision any longer.

The facility policy "Interdisciplinary Care Planning" dated 3/2018 documented in part, "...The patient's care plan is a communication tool that guides members of the interdisciplinary healthcare team in how to meet each individual patient's needs. It also identifies the types and methods of care that the patient should receive...A comprehensive care plan must be-...reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive, quarterly, and significant change review assessments..."

On 5/18/2022 at 4:49 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the

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F 657	Continued From page 80 director of nursing and OSM (other staff member) #2, the human resource director were made aware of the above concern. No further information was presented prior to exit.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to follow professional standards of practice for nursing documentation, for one of 52 residents in the survey sample, Resident #802 (R802). The facility staff failed to document acute changes in condition, resident report of injury, and assessment results for Resident #802 in April 2022. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/3/22, R802 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R802 was coded as requiring the extensive assistance of two staff members for bed mobility and	F 658		

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F 658	Continued From page 81 transfers. A review of R802's clinical record revealed the following progress note, dated 4/10/22 at 11:16 p.m. The note was written by LPN (licensed practical nurse) #7. "Patient's X-ray was positive for subcapital fracture of the right hip. MD (medical doctor) on call was [name of MD] was made aware and patient was sent to [name of local hospital] ER (emergency room) for evaluation and treatment." Further review of R802's progress notes revealed no other documentation related to the circumstances surrounding R802's injury or nursing assessments of R802's injury. A review of R802's comprehensive care plan dated 10/28/21 revealed no information related to a hip fracture. On 5/19/22 at 1:05 p.m., LPN #7 was interviewed. She stated she remembered R802 very well. She stated on 4/8/22, she contacted the physician because R802 reported right hip pain, and R802's legs were swollen. The physician ordered an ultrasound of both legs and an X-ray of the hip. When asked if she documented any of these findings or conversations, she stated she thought she had. After reviewing R802's progress notes, LPN #7 stated she must have "just missed it." She stated she should have documented the assessment findings and the conversation with the provider in the progress notes. LPN #7 stated that on 4/10/22 early in the evening shift (3:00 p.m. - 11:00 p.m.), she learned that R802 had reported to another staff member that R802 was handled roughly by a TNA (temporary nursing assistant) earlier in the week, and R802 believed	F 658	658 – Services Provided Meet Professional Standards 1. R 802 no longer resides in the facility. 2. Utilizing the "change in condition" QAPI tool – a comprehensive review of residents with injuries of unknown origin from 5.23.2022 to current will be completed by the Director of Nursing/designee to validate documentation is in the clinical record related to changes in condition. 3. The director of nursing/designee will educate the licensed nursing staff on the "focus on f-tag 658" and "Change in condition" procedure on or before the date of compliance. 4. Utilizing the "Change in condition" QAPI tool – the director of nursing/designee will audit any injuries of unknown origin weekly times four weeks to validate documentation in the clinical chart.	6/30/2022

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that the rough handling was the source of the hip pain. LPN #7 stated she immediately reported this to the supervisor and to ASM (administrative staff member) #2, the DON (director of nursing). When asked if she documented any of these conversations, she stated she did not. She stated: "I just did not think of it at the time." She repeated that she should have documented these conversations.

On 5/23/22 at 11:14 a.m., LPN #5 was interviewed. She stated all nursing care should be documented. She stated there are several options for nursing documentation, including progress notes, pain assessments, medication administration notes, and other formal assessments in the EMR (electronic medical record). She stated all nursing care should be documented because it helps the whole staff take better care of the resident. She stated: "If it's not documented, it's technically not done."

On 5/23/22 at 1:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. During the entrance conference on 5/17/22 at 12:00 p.m., ASM #2 had stated the facility uses its policies and an online nursing resource (Lippincott) as its professional reference.

A review of the facility policy, "Clinical Record Resource Manual," revealed, in part: "Chart entries are documented as close to the time of the event as possible, prior to the conclusion of the shift during which patient care was given. If the information is documented during the shift as a summary of an event or of a patient's status at an earlier time in the shift, such as the patient's condition upon admission, the entry is identified

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with the present time and identifies the actual time of the event in the narrative note...A complete record contains an accurate and functional representation of the actual experience of the patient in the center and reflects an interdisciplinary approach to assessment, care planning and care delivery. Review of clinical record documentation is an important aspect of the Quality Assurance and Performance Improvement (QAPI) process."

According to "Fundamentals of Nursing Made Incredibly Easy," Lippincott, Williams and Wilkins, Philadelphia PA page 23: "Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team."

No further information was provided prior to exit.

Complaint deficiency

F 684 Quality of Care F 684
SS=E CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure

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F 684	Continued From page 84 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide care and services in a manner to promote a resident's highest level of well-being for two of 52 residents in the survey sample, Residents #802 and #16. The findings include: 1. For Resident #802 (R802), the facility staff failed to provide timely radiology services and treatment for R802's fractured right hip. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/3/22, R802 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R802 was coded as requiring the extensive assistance of two staff members for bed mobility and transfers. A review of R802's clinical record revealed the following progress note, dated 4/10/22 at 11:16 p.m. The note was written by LPN (licensed practical nurse) #7. "Patient's X-ray was positive for subcapital fracture of the right hip. MD (medical doctor) on call was [name of MD] was made aware and patient was sent to [name of local hospital] ER (emergency room) for evaluation and treatment."	F 684	684 – Quality of Care 1. R802 no longer resides in the facility. R16 fluid restriction worksheet was updated by the dietician. 2. Utilizing the "Change in condition" QAPI tool the director of nursing/designee will review any radiology reports or fluid restrictions from 5.23.2022 to current to validate appropriate documentation in the clinical chart. 3. The director of nursing/designee will educate the licensed nurses on "focus on f-tag 684" and "change in condition" procedure on or before the date of compliance. 4. Utilizing the "Change in condition" QAPI tool the director of nursing/designee will review five residents per week times five weeks to validate residents with radiology diagnostics or fluid restrictions have appropriate documentation in the clinical chart. Results will be reviewed with the QA&A committee.	6/30/2022

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R802 was admitted to the facility on 10/28/21 with diagnoses including right femur fracture, osteopenia, and osteoarthritis.

A review of R802's clinical record revealed the resident received as-needed Tylenol 650 mg (milligrams) on 4/7/22 at 4:57 p.m. for a pain level of 6 out of 10; on 4/8/22 at 5:14 p.m. for a pain level of 4 out of 10; on 4/9/22 at 9:00 a.m. for a pain level of 3 out of 10; and on 4/10/22 at 5:41 p.m. for a pain level of 4 out of 10. The Tylenol was documented as effective after all administrations.

Further review of R802's progress notes revealed no other documentation related to the circumstances surrounding R802's injury, nursing assessments of R802's injury, attempts to obtain urgent radiology services, or communication with providers regarding the potential delay in treatment for a fractured hip.

A review of the physician's orders for R802 revealed the following order, dated 8/8/22 at 11:27 p.m.: "X-ray to right hip and right knee...for pain to right hip and knee. D/c (discontinue) order once performed." The order was entered by LPN #7.

A review of R802's discharge summary from the local hospital dated 4/21/22 revealed R802 was admitted with a fractured right hip. During the hospital stay from 4/10/22 through 4/21/22, R802 underwent surgery on 4/11/22 to repair the right hip fracture, and experienced septic shock, requiring admission to the intensive care unit.

A review of R802's comprehensive care plan

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dated 10/28/21 revealed no information related to a hip fracture.

On 5/19/22 at 1:05 p.m., LPN #7 was interviewed. She stated she remembered R802 very well. She stated on 4/8/22, she contacted the physician because R802 reported right hip pain, and R802's legs were swollen. The physician ordered an ultrasound of both legs and an X-ray of the hip. When asked if she documented any of these findings or conversations, she stated she thought she had. After reviewing R802's progress notes, LPN #7 stated she must have "just missed it." She stated she should have documented the assessment findings and the conversation with the provider in the progress notes. LPN #7 stated she worked 4/8/22, 4/9/22, and 4/10/22, and cared for R802 on each of these days. She stated the X-ray was ordered 4/8/22, but the X-ray company did not arrive at the facility to perform the X-ray until late in the evening on 4/10/22. When asked why X-ray company did not arrive until nearly 48 hours after the order, she stated: "That's not unusual for them." When asked what kind of care the resident received between the time the X-ray was ordered and the X-ray was performed, she stated: "I gave some Tylenol." When asked if R802 was turned and repositioned during the 48 hour gap, she stated the resident was provided incontinence care, and was turned and repositioned frequently. When asked if it is best practice to continue to turn and reposition a resident with a potentially fractured hip, she stated she had not thought of it in this way. She stated: "No, it's not. We probably shouldn't have done that." When asked if she made any attempts to contact the X-ray company to determine when they would arrive or to ask if someone could arrive sooner than originally

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PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)	2125 HILLIARD ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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planned, she stated she did not. When asked if she contacted the physician/NP (nurse practitioner) to let them know the X-ray could not be performed immediately, she stated she did not. When asked if the delay in the X-ray resulted in a delay or treatment for R802's hip fracture, she stated: "Yes, absolutely."

On 5/23/22 at 11:14 a.m., LPN #5 was interviewed. When asked about the process for obtaining mobile X-rays, she stated the nurse fills out a form, then calls the mobile X-ray company. She stated the X-ray company usually does not give a time when they anticipate someone will be there to perform the X-ray. She stated if she orders the X-ray at the beginning of her shift and she has not heard from the X-ray company by the end of the shift, she will call the company back to determine a more exact time when the company will arrive to do the X-ray. She stated: "Sometimes they will tell you they will be here the next day because they are so backed up." She stated if a resident has a potential fracture, and the X-ray company cannot come immediately, she calls the provider to let them know that the X-ray is delayed, and will ask the provider what should be done next. She stated the provider will often say to send the resident out to the ER, and not to wait for the mobile X-ray. When asked if a 48 hour delay in an X-ray of a potentially fractured hip can result in a delay of treatment for the fracture, she stated: "Yes. Absolutely."

On 5/23/22 at 12:44 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. ASM #2 stated that any movement of a resident who has a potentially fractured hip could possibly result in further injury of the fracture. She stated the provider should be

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consulted if an X-ray cannot be obtained immediately.

On 5/23/22 at 1:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns.

A review of the facility policy, "Clinical Records Resource Manual," revealed no information related to preventing a delay in treatment for a resident's injury.

No further information was provided prior to exit.

Complaint Deficiency
2. The facility staff failed to monitor (R16's) fluid restriction.

(R16) was admitted to the facility with diagnoses included but were not limited to: end stage renal disease (4), dependent on renal dialysis.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 02/24/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded (R16) for "Dialysis" while a resident.

The physician's order summary documented in part, "Fluid Restriction - Total: 1500 mLs (milliliters)/ (per) 24 hours every shift Total Provided by Nursing: 540 ml -Day: 240 ml -Evening: 180 ml -Night: 120 ml. Order Date: 02/22/2022. Start Date: 02/22/2022."

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The comprehensive care plan for (R16) dated 05/22/2019 documented in part, "Focus. Renal insufficiencies related to: ESRD (end stage renal disease), dependence on renal dialysis. Date Initiated: 05/22/2019." Under "Interventions" it documented in part, "Fluid restriction as ordered: Date Initiated: 10/31/2019."

The eTAR (electronic treatment administration record) documented the physician's order as stated above. The eTAR documented three opportunities for documenting the amount of fluids taken at 6:30 a.m., 2:30 p.m., and at 10:30 p.m. Further review of the eTAR failed to evidence the amount of fluid consumed by (R16) with each meal and a total of (R16's) fluid intake in a 24 hour period.

Review of the nurse's notes for (R16) dated 05/01/2022 through 05/18/2022, failed to evidence documentation regarding the fluid restriction.

On 05/19/2022 at approximately 2:45 p.m., an interview was conducted with LPN (licensed practical nurse) # 5 regarding the monitoring of (R16's) fluid restrictions. After reviewing (R16's) eTAR dated May 2022 LPN # 5 was asked if it documented the amount of fluid (R16) consumed at each meal and the total intake of fluid within each 24 hour period. LPN stated that the eTAR did not include (R16's) fluid intake at each meal and did not have a daily total of fluid intake. When asked how they were monitoring (R16's) total fluid intake in each 24 hour period if there was a lack of documentation of fluid intake at each meal and no totals in each 24 hour period. LPN # 5 stated that there was no way to tell how much fluid (R16) consumed. When asked why it

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was important to ,monitor a resident's fluid intake LPN # 5 stated that if a resident receives too much fluid it could cause shortness of breath, congestive heart failure or swelling in their legs.

On 05/19/2022 at approximately 5:10 p.m., ASM (administrative staff member) # 1, administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was presented prior to exit.

F 687 SS=D Foot Care
CFR(s): 483.25(b)(2)(i)(ii) F 687

§483.25(b)(2) Foot care.
To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:
(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and
(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, resident interview and clinical record review, it was determined that the facility staff failed to provide foot care services for one of 52 residents in the survey sample, Resident #30.

The facility staff failed to provide care and services for Resident #30's (R30) toenails.

The findings include:

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F 687	Continued From page 91 R30 was admitted to the facility with diagnosis that included but were not limited to quadriplegia and atherosclerotic heart disease. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/2/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is not cognitively impaired for making daily decisions. Section G documented R30 requiring extensive assistance of one person for personal hygiene and having functional limitations in range of motion to both upper and lower extremities. On 5/18/2022 at 10:00 a.m., an interview was conducted with R30. R30 was observed sitting in a wheelchair in their room. R30 stated that they had a concern with the communication with residents in the facility. R30 stated that they had long toenails that the staff could not trim because of how thick they were and they had not seen a podiatrist in over a year. R30 stated that they knew they had a podiatrist who came to the facility but no one would ever tell them when the podiatrist was coming so they could get their nails trimmed. R30 stated that they never found out the podiatrist had come until after he had already left the building. R30 stated that they had asked the aides and nurses to let them know when the podiatrist was coming so they would stay on the unit to get their nails done but it had not happened. R30 stated that they were not diabetic but had long, thick toenails and the nurses did not have the proper tools to trim the nails. R30 stated that they wore slip on shoes and were still able to get them on but was not sure how much	F 687	687 – Foot Care 1. R30 was seen by the podiatrist. 2. The Director of nursing/ designee will review current residents to validate podiatry care is addressed if needed. 3. The director of nursing/designee will educate the licensed nurses on "Focus on F-tag 687" on or before the date of compliance. 4. The director of nursing/designee will review five residents per week times four weeks to validate podiatry lists are updated to maintain foot care. Results of the audits will be reviewed with the QA&A committee.	6/30/2022

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longer they would be able to do so.

The comprehensive care plan for R30 documented in part, "Altered ADL (activities of daily living) function related to physical limitations R/T (related to) incomplete quadrpilegia [sic] at C3 (cervical vertebra #3) level. Has no AROM (active range of motion) of legs; shoulder, elbow, hand limitations. Date Created: 6/4/2007; Revision on: 12/16/2016..." Under "Interventions/Tasks" it documented in part, "...Assist with daily hygiene, grooming, dressing, oral care and eating as needed. Date Initiated: 11/29/2019..."

The quarterly care conference notes dated 3/9/2022 for R30 documented in part, "...Ancillary services provided since the last care conference. No ancillary services provided...Ancillary services that the patient could benefit from. No ancillary services are indicated at this time..."

Review of the clinical record for R30 failed to evidence documentation of any podiatry services provided.

On 5/19/2022 at approximately 9:25 a.m., a request was made to ASM (administrative staff member) #2, the director of nursing for the most recent podiatry notes for R30.

On 5/19/2022 at 9:10 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 stated that they have a podiatrist who came in the building to see residents every three months. LPN #6 stated that the podiatrist sees residents on the unit unless they refuse or are out of the facility. LPN #6 stated that the social worker lets them know when the podiatrist is

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coming and gives them a list of residents that they are seeing. LPN #6 stated that they add any residents who they know need attention to the list prior to the podiatrist coming and that the podiatrist visits were not posted anywhere and the residents relied on the staff to tell them when they were coming. LPN #6 stated that the nurses were allowed to trim toenails of residents who were not diabetic if they were able. LPN #6 observed R30's toenails with their permission and stated that they needed to be trimmed by the podiatrist. LPN #6 described the toenails as long, dry, cracked and thick. LPN #6 stated that with R30's thick nails, lower leg swelling and swelling in the feet, the nursing staff would not trim their toenails and would defer them to the podiatrist for care. LPN #6 agreed that observation of R30's toenails revealed the great toenail to be long, thick, dry, jagged and curved over to the second toenail, the second and third toenails were observed to be long, dry, thick and jagged.

On 5/19/2022 at 9:30 a.m., an interview was conducted with RN (registered nurse) #1, unit manager. RN #1 stated that the nurses let them know when a resident needed to see the podiatrist and they let social services know to put them on a list. RN #1 stated that the social worker provided them a list of residents who were to be seen when when the podiatrist came in and the nurses coordinated who was seen in their room and who was seen in an examination area on the first floor. RN #1 stated that they did not keep the list after residents were seen.

On 5/19/2022 at 9:45 a.m., an interview was conducted with OSM (other staff member) #4, social worker. OSM #4 stated that the podiatrist came to the building every two to three months.

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F 687	Continued From page 94 OSM #4 stated that prior to the podiatrist coming in they requested a census list of all residents and facesheets for all residents to plan their visit. OSM #4 stated that the podiatrist goes room to room to see all residents when in the facility. OSM #4 stated that they received two to three weeks notice before the podiatrist came in normally and they contacted responsible parties to get consents if needed. OSM #4 stated that they notified each nurses station of the date so they would have residents up and ready for the podiatrist. OSM #4 stated that on the day of the podiatry visit they would go through the census list with the podiatrist to let them know who was out of the building. OSM #4 stated that if any resident was not in their room, the podiatrist would normally let them know. OSM #4 stated that if a resident was not available they were put on the list for the next visit. OSM #4 stated that they write on their note if they cannot find them. OSM #4 stated that they did not see a note for R30 but they would look in their files for one. On 5/19/2022 at 2:50 p.m., OSM #4 provided a podiatric evaluation and management note for R30 dated 3/18/2022 which documented, "N/R-Not in Room." OSM #4 provided a second podiatric evaluation and management note dated 3/26/2021 which documented podiatry services received on that date. At that time an interview was conducted with OSM #4. OSM #4 stated that R30 was not seen by the podiatrist on 3/18/2022 because they were not in their room. OSM #4 stated that they discuss the podiatry visits in their morning meeting where the director of nursing attends and they should pass the information to the nursing units. OSM #4 stated that if they see particular residents they let them know about the podiatry visits but there was no	F 687		

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formal notice given to residents. OSM #4 stated that the nurses would be responsible for making sure R30 was in their room when the podiatrist was on the unit. OSM #4 stated that podiatry services were provided to all residents and R30 may have been out of the room when the podiatrist came by. OSM #4 stated that residents should be made aware when the podiatrist was coming in so they would be ready. OSM #4 stated that if R30 refused the service there should be documentation in the progress notes regarding this.

The progress notes for R30 failed to evidence refusal of podiatry services on 3/18/2022.

On 5/23/2022 at approximately 10:00 a.m., a request was made to ASM #2 for the facility policy regarding podiatry services and foot care.

On 5/23/2022 at 11:11 a.m., ASM #2 provided requested policies via email. The policies failed to evidence a policy regarding podiatry services or foot care.

On 5/23/2022 at approximately 1:30 p.m., ASM #2 stated that they had provided any policies they had and podiatry services were contracted.

During the survey entrance on 5/17/22 at 12:00 p.m., ASM #2 stated the facility's standard of practice is Lippincott online and their policies.

According to the Fundamentals of Nursing Lippincott Williams and Wilkins 2007 Lippincott Company Philadelphia, page 349, "Daily bathing of feet and regular trimming of toenails promotes cleanliness, prevents infection, stimulates peripheral circulation, and controls odors by

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F 687	Continued From page 96 removing debris from between the toes and under toenails. Foot care is particularly important for bed ridden patient and those especially susceptible to foot infection such as patients with peripheral vascular disease and diabetes mellitus ...consult a podiatrist if the nails need trimming..." On 5/19/2022 at 5:11 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the human resource director were made aware of the findings. No further information was provided prior to exit.	F 687		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to evaluate smoking hazard and risk for one of 52 residents, Resident #33. The facility staff failed to evidence that they performed a safe smoking assessment for Resident #33. The findings include: Resident #33 was observed smoking on 5/17/22	F 689		

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F 689	Continued From page 97 at 4:00 PM and again on 5/19/22 at 1:00 PM. Staff provided cigarettes and lighter to residents from locked box they brought with them. Two staff were present with residents as they smoked. Resident #33 did not exhibit any unsafe smoking behavior. A list of smoking times revealed smoking times of 9:00 AM, 1:00 PM, 4:00 PM and 8:00 PM. Resident #33 was admitted to the facility on 7/13/21 with diagnosis that included but were not limited to: congestive heart failure, diabetes, dementia, pacemaker and obstructive sleep apnea. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/8/22, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; supervision for locomotion and eating. Section O-special procedures/treatments coded the resident as oxygen "yes". No annual assessment, unable to see that smoking was coded as yes under section J. A review of the comprehensive care plan dated 5/18/22, , which revealed, "FOCUS: History of smoking in community/Inappropriate smoking. INTERVENTIONS: Complete Smoking Evaluation per facility guidelines. Secure smoking materials at nurses' station or other designated area for storage. Allow to smoke in designated	F 689	689 – Free of Accident Hazards/Supervision/Devices 1. R33 smoking assessment was updated. 2. Utilizing the "Smoking" QAPI tool – the director of nursing/designee will complete a comprehensive audit to validate updated smoking assessments are in place. 3. The director of nursing/designee will educate the licensed nursing staff on "Focus on f-tag 689 and "smoking guidelines" on or before the date of compliance. 4. Utilizing the "smoking" QAPI tool the Director of nursing/designee will audit five residents per week times four weeks to validate current smoking assessments are in place. Results will be reviewed with the QA&A committee.	6/30/2022

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area(s) at designated smoking times." The care plan did not include smoking till 5/18/22 after observation of resident smoking.

An interview was conducted on 5/17/22 at 4:00 PM with Resident #33. When asked how long he has smoked, while he has been a resident, Resident #33 stated, I have been smoking since I came here.

On 5/17/22 at 4:10 PM, an interview was conducted with OSM (other staff member) #11, the laundry aide. When asked how long Resident #33 has been smoking, OSM #11 stated, a long time.

On 5/19/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the director of human resources were made aware of the findings.

On 5/19/22, Resident #33 had completed safe smoking evaluation in his record with date of 5/18/22 at 6:01 PM. A review of the smoking evaluation dated 5/18/22 at 6:01 PM, revealed the following, "Safe smoker-capable and safe, requires no assistance to smoke." Smoking evaluation completed by ASM (administrative staff member) #2.

According to the facility's policy "Smoking Guidelines" dated 2019, which reveals, "Evaluate patients that smoke utilizing the Smoking Evaluation Tool either upon admission, if unsafe practices in the smoker are observed or when there is a significant change in medical condition".

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495045	A. BUILDING ______ B. WING ______	C 05/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)	2125 HILLIARD ROAD RICHMOND, VA 23228

(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 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to address a resident's significant weight loss for one of 52 residents in the survey sample, Resident #63 (R63). Between 12/7/21 and 1/14/22, R63 experienced a 6.45% weight loss, and the facility staff failed to implement interventions. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/14/22, R63 was coded as	F 692	692 – Nutrition/Hydration Status Maintenance 1. R63 was seen by the dietician and an updated nutrition assessment was completed. 2. Utilizing the "change in condition" QAPI tool – the director of nursing/designee will complete a review of any significant weight changes from 5.23.2022 to current to validate updated nutritional assessments were completed. 3. The director of nursing/designee will educate the dietician on "focus on f-tag 692" on or before the date of compliance. 4. Utilizing the "change in condition" QAPI tool the registered dietician will review five residents per week times four weeks to validate significant changes in weight have updated nutritional assessments completed. Results will be reviewed with the QA&A committee.	6/30/2022