DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING ______ B. WING ______	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(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 3/22/2022 through 3/24/2022. The facility was found to be in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	The Laurels of Willow Creek wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged Compliance is April 19, 2022. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/22/2022 through 3/24/2022. Five complaints were investigated during the survey, VA00051908- unsubstantiated without deficiency, VA00054018- unsubstantiated without deficiency, VA00053616- substantiated with deficiencies, VA00052442- substantiated with deficiencies and VA00052374- substantiated without deficiency. Significant 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 120 certified bed facility was 105 at the time of the survey. The survey sample consisted of 41 current resident reviews and 10 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550	1. Resident #216 has had catheter bag replaced to provide privacy. 2. Residents with catheter bags were audited on April 1, 2022 to ensure privacy. Any concerns noted were corrected immediately. 3. Nursing staff and managers will be re-educated by April 18, 2020 to ensure catheter bags are covered for privacy by the Assistant Director of Nursing/designee.	4/19/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacie Shive LNHA	Administrator	6/13/22 04/25/2022

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 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide privacy and dignity to 1 of 51 residents in the survey sample, Resident #216. The facility staff failed to maintain the Foley	F 550	4. Department Managers/designee will conduct audits of residents with catheters 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure privacy and compliance. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	

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F 550	Continued From page 2 catheter bag in a manner to promote privacy and dignity for Resident #216. The findings include: On the most recent MDS (Minimum Data Set), an admission/5-day assessment with an ARD (Assessment Reference Date) of 12/10/21, Resident #216 scored a 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. The resident was not coded as having an indwelling catheter at that time. A review of the clinical record revealed physician's orders dated 3/3/22 for the use of a Foley catheter. On 3/22/22 at 2:28 PM, an observation was made of Resident #216. The Foley catheter bag was hanging on the side of the bed closest to the door, and was viewable from the door with no privacy bag covering it. Staff was in with the resident. On 3/22/22 at 4:12 PM, another observation was made of Resident #216. The Foley bag was observed exactly as before, and there was staff in the room with the roommate. On 3/24/22 at 10:00 AM, an interview was conducted with Resident #216. When asked how they felt about the catheter bag being uncovered and exposed, they stated: "Why would you uncover it?" When re-asked if having the Foley bag exposed so others can see it bothered them, they stated, "I don't know why it would be exposed."	F 550		

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F 550	Continued From page 3 A review of the resident's comprehensive care plan dated 3/3/22 revealed, in part: "At risk for urinary tract infection and catheter-related trauma: has Indwelling Catheter ...Ensure the drainage bag is secured properly with a dignity cover in place." On 3/23/22 at 11:28 AM, an interview was conducted with LPN #4 (Licensed Practical Nurse). When asked how the Foley catheter bag should be maintained, LPN #4 stated that it should be in a privacy bag. The facility policy, "Indwelling urinary catheter (Foley) care and management," was reviewed. This policy did not address maintaining the catheter bag in a manner that promotes privacy and dignity. On 3/24/22 at approximately 11:30 AM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and	F 561	1. Resident #313 no longer resides in the facility. 2. All residents have the potential to be affected by this alleged deficient practice. 3. Staff will be re-educated by April 18, 2022 regarding residents' right to make choices about aspects of his or her life in the facility that are significant to the resident by the ADON/ designee.	4/19/22

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F 561	Continued From page 4 waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, facility document review and clinical record review, it was determined that the facility staff failed to facilitate a resident's right for self-determination and choice for 1 of 51 residents in the survey sample, Resident #313. Resident #313 (R313) verbalized the desire for bed rails. The facility staff failed to honor this preference and assess the resident for the use of bed rails. The findings include: On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/22/21, the resident scored 15 out of 15 on the BIMS (brief interview for	F 561	4. DON/designee will conduct audits of nurses' notes in daily clinical meeting, Monday – Friday, 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure resident choices are explored. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	

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F 561	Continued From page 5	F 561		

mental status), indicating the resident is not cognitively impaired for making daily decisions.

A review of R313's clinical record revealed a nurse's note dated 12/15/21 that documented, "Resident new admit ...has voiced concerns that [R313] wants side rails (bed rails) on ...bed...is alert and oriented ...uses a walker to stand and pivot only. Metal brace to ...leg but ...refused to let nurse do a thorough skin assessment due to ...being upset about side rails." Further review of R313's clinical record (including nursing assessments and therapy notes from 12/16/21 through 3/22/22) failed to reveal any bed rail assessments.

On 3/22/22 at 1:02 p.m., an interview was conducted with R313. The resident stated they wanted half bed rails for mobility. R313 further stated that they had voiced this to several staff members and was told that they could not have bed rails due to corporate policy. No bed rails were observed on the resident's bed.

On 3/23/22 at 11:57 a.m., an interview was conducted with OSM (other staff member) #3 (the rehab director). OSM #3 stated she reviewed R313's therapy notes and spoke to the physical therapist. OSM #3 stated the therapy staff worked with R313 on bed mobility and transfers as part of the plan of care. OSM #3 stated R313 would not have been able to roll over to access a bed rail when initially admitted and the resident is currently independent with mobility and transfers so there is no need for bed rails. OSM #3 stated this information was not documented nor was any request that R313 wanted bed rails.

On 3/23/22 at 12:56 p.m., an interview was

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F 561	Continued From page 6 conducted with RN (registered nurse) #2. RN #2 stated some residents have assist bars (bed rails) if they are able to use them for maneuvering in bed such as for turning. RN #2 stated if a resident requests bed rails then nurses should complete a physical device evaluation to make sure bed rails are not a restraint and are safe for that resident to use, then create a work order for the bed rails to be put into place. On 3/23/22 at 4:41 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of operations) were made aware of the above concern. The facility document regarding residents' rights documented, "(1) Dignity, Respect & Quality of Life. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident." No further information was presented prior to exit.	F 561		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete	F 641	1. Resident #35 has had a BIMS completed. 2. All residents have the potential to be affected by this alleged deficient practice. 3. Social Service staff will be re-educated by the Administrator by April 18, 2022 on completing BIMs on the residents.	4/19/22

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F 641	Continued From page 7 MDS (minimum data set) for 1 of 51 residents in the survey sample, Resident #35. The facility staff failed to complete the BIMS (brief interview for mental status) assessment for Resident #35's (R35) quarterly MDS assessment with an ARD (assessment reference date) of 1/14/22. The findings include: Section B of R35's quarterly MDS assessment with an ARD of 1/14/22 coded the resident as being understood. Section C0100 documented the BIMS assessment should be conducted. All of the questions related to the BIMS assessment (C0200 through C0400) and the BIMS summary score were coded with dashes, indicating the areas were not assessed. On 3/23/22 at 9:41 a.m., an interview was conducted with OSM (other staff member) #2 (the social services director). OSM #2 stated R35's BIMS interview should have been done by the ARD date but the other social worker was off sick and the BIMS, "Got mixed in the shuffle." OSM #2 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when completing the BIMS assessment. On 3/23/22 at 4:41 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of operations) were made aware of the above concern. The CMS RAI manual documents the following: C0100: Should Brief Interview for Mental Status	F 641	4. Administrator/designee will conduct audits on BIMs being completed on the resident assessment 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure compliance on completing BIMs on the resident assessment. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	

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F 641	Continued From page 8 Be Conducted? Item Rationale Health-related Quality of Life ·Most residents are able to attempt the Brief Interview for Mental Status (BIMS). ·A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance. - Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis... ·Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method... Coding Tips ·Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD)..." No further information was presented prior to exit.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental	F 645	1. Resident #62 has had a PASARR completed. 2. An audit of current residents will be conducted to ensure PASARR assessments have been completed. Any residents noted without a PASARR, will have one completed. 3. Social Service and Admissions staff will be re-educated by the Administrator by April 18, 2022 on completing/ obtaining PASARRs on the residents. 4. Administrator/designee will conduct audits on completing/obtaining PASARRs on any new r esidents admitted 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure compliance on completing/ obtaining PASARRS on new residents. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	4/19/22

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F 645	Continued From page 9 condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual	F 645		

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is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, it was determined that the facility staff failed to evidence completion of a level 1 PASRR (preadmission screening and resident review) for 1 of 51 residents, Resident #62. The facility staff failed to complete a level 1 PASRR for Resident #62 who was admitted to the facility on 5/1/2018.

The findings include:

Resident #62 was admitted to the facility with diagnoses that included but were not limited to psychosis, major depressive disorder and dementia with behavioral disturbance. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 1/11/2022, the resident scored 4 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired for making daily decisions.

Review of Resident #62's clinical record failed to evidence a level 1 PASRR.

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On 3/22/2022 at approximately 5:17 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the Level 1 PASRR for Resident #62.

On 3/23/2022 at 2:53 p.m., an interview was conducted with OSM (other staff member) #2, the social services director. OSM #2 stated that the PASRR was a coordinated effort between social services and admissions. OSM #2 stated that admissions started the process and social services completed the assessment. OSM #2 stated that they were looking for the Level 1 PASRR for Resident #62.

On 3/24/2022 at 11:00 a.m., ASM #1 stated that they did not think that they were going to have a PASRR to provide for Resident #62.

On 3/23/2022 at 5:05 p.m., a request was made to ASM #1, the administrator for the facility policy regarding PASRR assessments.

On 3/24/2022 at 11:23 a.m., ASM #1, the administrator stated that the facility did not have a policy regarding the PASRR.

The document, "COVID-19 Emergency Declaration Waivers" updated 11/29/2021, documented in part on page 16, "Waive Pre-Admission Screening and Annual Resident Review (PASARR). CMS (Centers for Medicare and Medicaid Services) is waiving 42CFR 483.20(k), allowing nursing homes to admit new residents who have not received Level 1 or Level 2 Preadmission Screening. Level 1 assessments may be performed post-admission. On or before the 30th day of admission, new patients admitted to nursing homes with a mental illness (MI) or

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(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 645	Continued From page 12 intellectual disability (ID) should be referred promptly by the nursing home to State PASARR program for Level 2 Resident Review..." This information was obtained from the website: https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf On 3/24/2022 at approximately 11:00 a.m., ASM #1, the administrator and RN (registered nurse) #2, unit manager were made aware of the findings. No further information was provided prior to exit.	F 645		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a	F 655	1. Resident #316 no longer resides in the facility. 2. An audit will be conducted of residents admitted in the last 21 days to ensure baseline care plans are complete. 3. Licensed Nurses will be re-educated by April 18, 2022 on the facility baseline care plan policy for new admissions, including ensuring oxygen is added to the baseline care plan when applicable by the ADON/ designee. 4. DON/designee will conduct audits of baseline care plan completion on new admissions 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure compliance of baseline care plan completion including oxygen when ordered. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	4/19/22

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F 655	Continued From page 13 comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a complete baseline care plan for 1 of 51 residents in the survey sample, Resident #316. The facility staff failed to develop Resident #316's (R316) baseline care plan to include the use of oxygen. The findings include: R316's diagnoses included acute and chronic respiratory failure. R316's admission minimum data set assessment was not completed. A nursing comprehensive evaluation dated 3/18/22 documented R316 was alert and oriented to time,	F 655		

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F 655	Continued From page 14 place and person. The evaluation further documented R316 received oxygen therapy at four liters per minute. A review of R316's clinical record revealed a physician's order dated 3/18/22 for continuous oxygen at four liters per minute. A review of R316's baseline care plan dated 3/18/22 failed to document information regarding the resident's respiratory status or oxygen therapy. On 3/22/22 at 3:13 p.m., 3/22/22 at 4:33 p.m. and 3/23/22 at 7:51 a.m., R316 was observed in the bed room, receiving oxygen at three and a half liters per minute. On 3/23/22 at 12:56 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated the baseline care plan is created based on the nursing comprehensive evaluation then "tweaked" when reviewed. RN #2 stated the baseline care plan should include the use of oxygen but the nurse has to click on a button to trigger the baseline respiratory care plan. R316's nursing comprehensive evaluated dated 3/18/22 failed to reveal check marks to trigger the respiratory care plan. On 3/23/22 at 4:41 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of operations) were made aware of the above concern. The facility policy titled, "Care Planning" documented, "2. A Baseline Care Plan will be developed within 48 hours identifying any immediate needs, initial goals and interventions	F 655		

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F 655	Continued From page 15 needed to provide effective and person-centered care." No further information was presented prior to exit.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656	1. Resident #216 no longer resides in the facility. Resident #217 no longer resides at the facility. Resident #112 now has documentation that reflects 24 hour foley output every evening shift. Resident #16 has had oxygen rate set to reflect five liters per minute. 2. All residents have the potential to be affected by this alleged deficient practice. 3. Nursing staff will be re-educated by April 18, 2022 regarding foley catheters are provided with privacy, 24 hour foley output documentation is completed timely, wound care documentation is completed timely and oxygen is set at the correct rate by the ADON/designee. 4. DON/designee will conduct audits of residents with catheters to ensure privacy is provided, 24 hour foley output is documented, oxygen is set at the correct rate, and wound care documentation is completed timely. Audits will be conducted 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure resident choices are explored. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	4/19/2022

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F 656	Continued From page 16 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 observation, resident interview, staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to develop and/or implement a comprehensive care plan for 5 of 51 residents in the survey sample; Residents #216, #217, #112, and #16. The findings include: 1. The facility staff failed to follow the comprehensive care plan for providing privacy of a Foley catheter drainage bag for Resident #216. On the most recent MDS (Minimum Data Set), an admission/5-day assessment with an ARD (Assessment Reference Date) of 12/10/21, Resident #216 scored a 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. The resident was not coded as having an indwelling catheter at that time. A review of the clinical record revealed physician's orders dated 3/3/22 for the use of a Foley catheter.	F 656		

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F 656	Continued From page 17 On 3/22/22 at 2:28 PM, an observation was made of Resident #216. The Foley catheter bag was hanging on the side of the bed closest to the door, and was viewable from the door with no privacy bag covering it. Staff was in with the resident. On 3/22/22 at 4:12 PM, another observation was made of Resident #216. The Foley bag was observed exactly as before, and there was staff in the room with the roommate. On 3/24/22 at 10:00 AM, an interview was conducted with Resident #216. When asked how they felt about the catheter bag being uncovered and exposed, they stated: "Why would you uncover it?" When re-asked if having the Foley bag exposed so others can see it bothered them, they stated, "I don't know why it would be exposed." A review of the resident's comprehensive care plan dated 3/3/22 revealed, in part: "At risk for urinary tract infection and catheter-related trauma: has Indwelling Catheter ...Ensure the drainage bag is secured properly with a dignity cover in place." On 3/23/22 at 11:28 AM, an interview was conducted with LPN #4 (Licensed Practical Nurse). When asked how the Foley catheter bag should be maintained, LPN #4 stated that it should be in a privacy bag. When asked if the catheter bag is uncovered and the care plan documented to cover the bag for dignity, was the care plan being followed, LPN #4 stated it was not. The facility policy, "Care Planning" was reviewed.	F 656		

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F 656	Continued From page 18	F 656		

This policy documented, "Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nursing and mental and psychosocial needs...."

On 3/24/22 at approximately 11:30 AM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings.

No further information was provided by the end of the survey.

2. The facility staff failed to follow the comprehensive care plan for providing wound care for Resident #217.

On the most recent MDS (Minimum Data Set), a 5-day assessment with an ARD (Assessment Reference Date) of 9/9/21, Resident #217 scored a 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. The resident was coded as being independent for eating and required limited to extensive assistance for all other areas of activities of daily living.

A physician's order dated 9/2/21 documented, "Right shin skin prep (1) every shift."

A review of the September 2021 TAR (Treatment Administration Record) revealed this order was scheduled for each shift starting on the night shift

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F 656	Continued From page 19	F 656		

on 9/2/21 and ended on day shift on 9/19/21 when the resident discharged. This accounted for a total of 50 opportunities of administration. Of these 50 opportunities, there were 5 opportunities that were not documented as being completed and/or refused.

A physician's order dated 9/6/21 documented "Skin Prep to blister on lower right leg every shift every shift for Prevention."

A review of the September 2021 TAR revealed that this treatment was scheduled for each shift starting on evening shift on 9/6/21 and ended on day shift 9/19/21 when the resident discharged. This accounted for a total of 39 opportunities of administration. Of these 39 opportunities, there were 5 opportunities that were not documented as being completed and/or refused.

A review of the comprehensive care plan for Resident #217 revealed one dated 9/2/21 for "[Resident #217] has Actual impairment to skin integrity r/t (related to) -trauma areas- left outer hand, right shin." This care plan included an intervention dated 9/3/21 for "Treatment to skin impairment per order."

On 3/23/22 at 11:28 AM an interview was conducted with LPN #4 (Licensed Practical Nurse). She stated that if the MAR has holes in it, she would assume it wasn't given or wasn't done. When asked if the care wasn't done and the care plan documented to provide the care as ordered, was the care plan being followed, LPN #4 stated it was not.

On 3/24/22 at approximately 11:30 AM, ASM #1 (Administrative Staff Member) the Administrator,

F 656 Continued From page 20 F 656

and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.

COMPLAINT DEFICIENCY

References:

1. Skin Prep - "A liquid protective barrier wipe designed to form protective film to reduce friction during removal of tapes and films as well as prep skin for drainage tubes, external catheters, surrounding ostomy sites and adhesives formulated to help skin breathe so tape and film adheres better indicated for use on intact skin only."
Information obtained from
https://www.medline.com/jump/product/x/Z05-PF32716#mrkDocumentation

3. The facility staff failed to implement the comprehensive care plan for the 24 hour foley output every evening shift for Resident #112.

Resident #112 was admitted to the facility with diagnosis that included but were not limited to: peripheral vascular disease and diabetes mellitus.

The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 3/1/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired.

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A review of the comprehensive care plan dated 2/22/22 revealed the following, NEED: Indwelling suprapubic catheter related to neurogenic bladder. INTERVENTIONS: Observed, record, report to physician no urine output.

A review of the physician orders dated 2/23/22, revealed the following, 24 hour foley output every evening shift.

A review of Resident #112's TAR (treatment administration record) from 2/23/22-2/28/22, revealed missing documentation of 24 hour foley output every evening shift for four out of six evening shifts, 2/23, 2/24, 2/27 and 2/28/22.

A review of Resident #112's TAR (treatment administration record) from 3/1/22-3/23/22, revealed missing documentation of 24 hour foley output every evening shift for four out of 23 evening shifts, 3/2, 3/7, 3/9 and 3/21/22.

An interview on 3/23/22 at 4:05 PM with LPN (licensed practical nurse) #1. When asked the purpose of the care plan, LPN #1 stated, the purpose of the care plan is to allow staff to know how to take care of the guests and to progress care. When asked if the care plan has been followed if there are blanks in treatment documentation, LPN #1 stated, No, it was not followed.

An interview was conducted with LPN #6 on 3/24/22 at 8:10 AM. When asked who documents foley output on the TAR, LPN #6 stated, the nurses document on the TAR. When asked what blanks on the TAR indicate, LPN #6 stated, if it's open and blank then it was not documented. When asked if there are blanks on

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the TAR, was the care plan followed, LPN #6 stated, No, it was not.

On 3/23/22 at approximately 4:35 PM, ASM (administrative staff member) #1, the Administrator, and ASM #2, the Director of Nursing and ASM #3, the Regional Director of Ops were made aware of the above concern.

No further information was provided prior to exit.

4. Facility staff failed to implement Resident # 16 comprehensive care plan for the administration of physician ordered oxygen at five liters per minute.

Resident # 16 was admitted to the facility with diagnoses that included but were not limited to: lung cancer, respiratory failure and a blood clot in the lungs. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/22/2022, 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 Resident #16 as receiving oxygen while a resident.

On 03/22/22 at approximately 1:02 p.m., an observation of Resident #16 revealed they were lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate between 4 and 5 liters per minute.

On 03/22/22 at approximately 4:00 p.m., an observation of Resident #16 revealed they were lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on oxygen the

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F 656	Continued From page 23 concentrator revealed an oxygen flow rate between 4 and 5 liters per minute. The physician order for Resident #16 documented, "Oxygen at 5 L (liters) continuous every shift. Order Date: 06/16/2021. Start Date 06/16/2021." The comprehensive care plan for Resident #16 dated 08/17/2021 documented in part, "Need. Respiratory distress- remains on oxygen ...Oxygen as ordered/emergent. Date Initiated: 08/17/2021." On 03/23/2022 at approximately 2:10 p.m., an observation of Resident #16's oxygen concentrator and interview was conducted with LPN (licensed practical nurse) #1. After reading the flow meter, LPN #1 stated, "It's between four and five liters per minute." When asked what the flow rate should be LPN #1 stated, "Five liters." When asked to describe the purpose of a care plan LPN #1 stated, "It tells how to take care of the guest and tells their progress." After reviewing Resident # 16's comprehensive care plan, LPN #1 was asked if the care plan was being followed for the administration of Resident # 16's oxygen. LPN #1 stated "No" On 03/23/2022 at approximately 4:35 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of clinical services and ASM #3, regional director of operations, were made aware of the above findings. No further information was provided prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657	1. Resident #53 comprehensive care plan was updated to reflect residents current code status. Resident #216 no longer resides in the facility.	4/19/22

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F 657	Continued From page 24 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to review and revise the care plan for two of 51 residents in the survey sample, Residents #53 and #216. The findings include: 1. For Resident #53 (R53), the facility staff failed	F 657	2. An audit will be conducted for residents to ensure the comprehensive care plan reflects the correct code status. An audit will also be completed on residents with falls in the last 30 days to ensure the care plans are revised/ updated to include interventions. 3. MDS, Nurse managers and Social Services will be re-educated by April 18, 2022 to ensure care plans are updated with new interventions for residents with falls and code status for residents are revised as needed by the ADON/ designee. 4. DON/designee will conduct audits of care plans for residents with fall 3 times weekly times 2 weeks, weekly time 2 weeks and monthly times 2 months to ensure the care plan is updated with a new intervention. ADM/ Designee will conduct audits of residents' comprehensive care plans to ensure code status reflects their current status, 3 times weekly times 2 weeks, weekly time 2 weeks and monthly times 2 months. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(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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to review and revise the care plan for a change in the resident's code status from a full code to a DNR (do not resuscitate).

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/31/2022, the resident scored a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions.

The physician order dated 2/15/2022, documented, "Do Not Resuscitate (No CPR - cardiopulmonary resuscitation)."

The clinical record contained the form, "Durable Do Not Resuscitate Order (DDNR)" dated 11/8/2021.

The review of the comprehensive care plan dated 1/5/2022 documented in part, "Need: [R53] is a full code ...Facility will make attempts to sustain life in emergency situations."

An interview was conducted with OSM (other staff member) #2, the social services director, on 3/23/2022 at 1:05 p.m. When asked whose responsibility it is to update the care plan for a change in the code status, OSM #2 stated it could be social services, nursing or whomever gets notified of the change. The above physician order and DDNR were reviewed with OSM #2. When asked if the care plan should have been updated to reflect the physician order and the DDNR form, OSM #2 stated she would like to review this before responding. On 3/23/2022 at 3:09 p.m. OSM #2 stated (R53)'s care plan was updated on 2/14/2022 and the new order came in

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on 2/15/2022. The care plan failed to evidence the review date of 2/14/2022. OSM #3 stated there was a lack of awareness to change the care plan. When asked what the purpose of the care plan is, OSM #3 stated it tells the staff the most updated plan of care. When asked if (R53)'s care plan should have been updated, OSM #2 stated, yes.

The facility policy "Care Planning" documented in part, "Policy: Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs identified in the comprehensive assessments and prepared by an interdisciplinary team who includes but not limited to; attending physician, a registered nurse who is responsible for the resident, a nurse aide, a member of food/nutrition services, the resident or resident representative, therapy staff as required and any other ancillary staff. Additional resources will also be utilized to ensure that any additional needs or risk areas are identified....9. The care plan and resident kardex will be updated on Admission, Quarterly, Annually and with significant changes. This includes adding new focuses, goals, and interventions and resolving ones that are no longer applicable as needed."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were made aware of the above concern on 3/23/2022 at 4:15 p.m.

No further information was obtained prior to exit.

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2. The facility staff failed to review and/or revise the comprehensive care plan after a fall on 1/12/22 for Resident #216.

On the most recent MDS (Minimum Data Set), an admission/5-day assessment with an ARD (Assessment Reference Date) of 12/10/21, Resident #216 scored a 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions.

A review of the clinical record revealed a nurse's note dated 1/12/22 that documented, "Writer called to residents room by staff stating that resident was in floor. Resident was observed sitting on [their] bottom in [their] bathroom. [They] was observed to have two wheelchair cushions in [their] wheelchair, with one hanging onto floor and the other secured to seat of wheelchair. No injuries noted at this time. Unsecured cushion taking from wheelchair. RP (responsible party) notified verbally. MD (medical doctor) notified."

A review of the comprehensive care plan dated 12/4/21 revealed, in part: "[Resident #216] is at risk for fall related injury and falls R/T: pain episode, mobility deficit, psychotropic medication use." Further review of this care plan failed to reveal any new interventions shortly after the above fall on 1/12/22, or any evidence it was reviewed after the 1/12/22 fall.

A review of the fall incident report dated 1/12/22 revealed the resident was reaching for something and slipped out of the wheel chair, as resident had 2 cushions in the wheel chair. It further documented that the extra cushions were

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F 657	Continued From page 28 removed from the wheel chair. In addition, the incident report documented, "New intervention after IDT (interdisciplinary team) review ...guest to have only one wc (wheel chair) cushion." The box for "Care plan/Kardex Updated" was not checked. On 3/24/22 at 7:54 AM an interview was conducted with RN #1 (Registered Nurse) the Assistant Director of Nursing. She stated that the intervention documented on the incident report should have been added to the care plan. On 3/24/22 at 8:44 AM, RN #1 followed up after reviewing the care plan further, and stated that the care plan was not updated. On 3/24/22 at approximately 11:30 AM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to follow professional standards of practice for 1 of 51 residents in the	F 658	1. Resident #80 medications for Tylenol and Tramadol were clarified and new orders given for parameters for pain scale to be utilized. 2. An audit will be conducted on residents who have multiple PRN pain medications ordered to ensure parameters for pain scale are in the orders. 3. Licensed nurses will be re-educated by April 18, 2022 on ensuring residents who have orders for multiple PRN pain medications have parameters for pain scale by the ADON/ Designee.	4/19/22

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F 658	Continued From page 29	F 658	4. DON/designee will conduct audits of residents who have orders for multiple PRN pain medications have parameters for pain scale 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	

survey sample; Resident #80. The facility staff failed to clarify physician's orders regarding parameters for the administration of PRN (as-needed) pain medication for Resident #80.

The findings include:

On the most recent MDS (Minimum Data Set), an admission assessment with an ARD (Assessment Reference Date) of 2/28/22, Resident #80 scored a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. The resident was coded as requiring supervision to total assistance for activities of daily living.

A review of the clinical record revealed a physician's order dated 2/21/22 for Tramadol (1) Tablet 50 MG (milligrams) Give 1 tablet by mouth every 6 hours as needed for pain.

A review of the clinical record also revealed a physician's order dated 2/21/22 for Acetaminophen (2) Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for pain or fever.

The above orders did not contain any parameters on when to give which one for pain, i.e., what pain level on a scale of 1 to 10 to give the Tramadol and what pain level to give the Acetaminophen.

A review of the March 2022 MAR (Medication Administration Record) revealed the resident was administered the Acetaminophen a total of 30 times, with a documented pain scale ranging 1 to 9. The pain scale that was documented was as follows: 1 time as 1; 1 time as 4; 11 times as 5; 13 times as 6; 3 times as 7; 1 time as 9. Further

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F 658	Continued From page 30 review revealed the resident was administered the Tramadol a total of 38 times, with a documented pain scale ranging 1 to 9. The pain scale that was documented was as follows: 1 time as 4; 16 times as 5; 13 times as 6; 6 times as 7; 1 time as 8; 1 time as 9. The MAR reflected that both medication options were frequently used for the same pain levels, as there were no parameters directing when to use which medication. On 3/23/22 at 11:28 AM an interview was conducted with LPN #4 (Licensed Practical Nurse). She stated that usually there would be a parameter in the order. She stated that if the order did not have a parameter, then to use nursing judgement for a pain scale on which one to give. On 3/24/22 at 8:44 AM an interview was conducted with RN #1 (Registered Nurse) the Assistant Director of Nursing. She stated that it is at the provider's (physician) discretion whether or not to set parameters. She stated when in doubt, call the doctor, and that best practice would be to call the doctor and clarify the order because it should have a parameter. On 3/24/22 at 9:00 AM an interview was conducted with RN #2. She stated that the order should be clarified, and that nurses should not be making the judgement. A review of the facility policy, "Pain Management" was conducted. This policy did not document ensuring or clarifying that physician's orders for as-needed pain medication included parameters. On 3/24/22 at approximately 11:30 AM, ASM #1	F 658		

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F 658	Continued From page 31 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. REFERENCES 1. Tramadol is used to relieve moderate to moderately severe pain. Information obtained from https://medlineplus.gov/druginfo/meds/a695011.html 2. Acetaminophen is used to relieve mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html	F 658		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, clinical record review, facility document review, staff interview and in the course of the medication administration observation, the facility staff failed to follow the physician's orders for 4 of 51	F 684	1. MD/NP was notified on not following MD orders for residents #16. New orders were given Residents #317 and #217 no longer resides in the facility. MD/NP was notified on not following MD orders for resident #9. 2. All residents have the potential to be affected by this alleged deficient practice. 3. Licensed nurses will be re-educated by April 8, 2022 on the following prescribed physician orders, to include the 5 rights of medication administration and documentation by the ADON/designee. 4. DON/designee will conduct random medication administration and treatment observations 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure prescribed physician orders are being followed and treatment completion is being documented. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	4/19/22

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F 684	Continued From page 32 residents in the survey sample, Residents #16, #317, and #217; to include one of five residents in medication administration observation, Resident #9. The findings include: 1. On 11/02/2021 at 10:00 p.m. and on 11/03/2021 at 6:00 a.m., the facility staff failed to follow the physician's order for Methadone, resulting in an overdose. Resident # 16 (R16) was administered 5ml (five milliliter) of methadone (1), ten times the physician-ordered dose, resulting in (R16's) oxygen saturation dropping to 77%, requiring an administration of Narcan (2) and being taken to the hospital for further interventions and monitoring. The overdose resulted in harm for Resident #16. (R16) was admitted to the facility with diagnoses that included but were not limited to: lung cancer, respiratory failure and a blood clot in the lungs. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/22/2021, 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 J0400 coded (R16) as frequently experiencing pain at a level of five out of 10 during the look back period. On 03/22/22 at approximately 1:11 p.m., (R16) stated that approximately four months ago they were given an overdose of methadone and were sent to the hospital. The physician's orders for (R16) documented in	F 684		

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part, "Methadone HCl (hydrochloride) Intensol Concentrate 10 MG(milligrams)/ML Give 0.5 ml orally every 8 (eight) hours for pain. Order Date: 11/02/2021 ...Narcan Liquid 4 MG/0.1ML (milliliter) (Naloxone HCl) 0.1 ml in nostril STAT (immediately) for Sedation -Start Date11/03/2021."

The comprehensive care plan for (R16) dated 06/15/2021 documented in part, "(R16) has pain r/t (related to): muscle weakness, Lung Cancer, Chronic Thromboembolic Pulmonary Hypertension ..., Date Initiated: 06/15/2021...Observe for side effects of pain medication. Date Initiated: 06/15/2021."

The facility's nurse's note dated 11/03/2021 documented, "7:25 a.m., Text: Med (medication) error noted during narcotic count at 7:15am. VS (vital signs) at that time 97.2 (temperature) -57 (pulse)-16 (respiration) -116/77 (blood pressure) O2 sat (oxygen saturation) 88-89% on 5L/min (five liters per minute) O2 via (by) NC (nasal cannula). Resident alert and responsive. UM (unit manager) notified of error and residents status. Hospice and MD (medical doctor) notified. New order for Narcan if O2 sat goes below 80%. CNA in room with resident. VS at 7:30 am 96.9-61-17-128/80 O2 sat 74%. Narcan given per order at 8:20am (a.m.). O2 sat increased to 87%. VS at 7:45am 97.1-60-18-130/86. MD in and stated to send resident to ER (emergency room) and increase O2 to 15L (liters) on non-rebreather mask. 911 called for transport. Resident becoming anxious- c/o (complaint of) being cold and shaky. VS at 8am 96.8-59-18-126/86 O2 sat 84%.Resident becoming restless. VS at 8:30am 97.1-71-18-127/88 O2 sat 91%. 911 in to transport at 8:50am. Family notified of residents

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condition and need to transport to hospital. Author: [Name of LPN (licensed practical nurse)] #2." Further review of the nurse's note revealed a handwritten noted that documented, "Nurse during count stated I must have given 5ml instead of .5ml (0.5ml)," and signed by LPN # 2.

The nurse's note dated 11/03/2021 at 8:36 a.m. documented, "VS 97.2-57-16-116/77 O2 sat 88-89% on 5L/min via NC. O2 mask applied. O2 sat 93% but dropped to 77%. Narcaine [sic] given at 8:20am per MD order. O2 sat 91% but dropped to 77%. MD in and stated to send to ER (emergency room). Hospice notified. VS taken every 15 min. Resident alert and talking but slow. Voices no complaints at this time."

The facility form "Analysis of Medication Event" for (R16) dated 11/03/2021 documented in part, "Date of Event: 11-2-21, 11-3-21. Time of Event: 2200 (10:00 p.m.) 6:00 a.m. Medication Given: Methadone. Dosage Given: 5mL. Route: po (by mouth). Cause of Event: How did the event occur?: Nurse gave wrong dosage X2 (times two) 2200 & (and) 6:00 am. What is the actual effect of the event on the guest? Decrease O2 Sat rate. How was event discovered? During am count by off going nurse and on coming nurse. Name(s) and title(s) of employee(s) involved: [Name of Registered Nurse (RN) #3]."

The facility's "Controlled Medication Utilization Record" for (R16) documented in part, "Methadone Intensol Concentrate 10 MG/1 (one)ML oral CONC (concentrate) 0.5 ml sublingually (under the tongue) three times daily for pain. Date: 11/2/21. Dose Given: 0.5 cc (cubic centimeter). Signature of Nurse: [Name of RN # 3]. Checked By: gave 5mL." Under Date:

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F 684	Continued From page 35 11/3/21" it documented, "Dose Given: 0.5 cc (cubic centimeter). Signature of Nurse: [Name of RN # 3]. Checked By: gave 5mL." The "Emergency Provider Report" for (R16) from [Name of Hospital] dated 11/03/2021 documented in part, "Free Text HPI (history of present illness) Notes. Patient with history significant for end-stage lung cancer, COPD, asthma, CAD, HTN, presents to the emergency department for reports of accidental overdose on methadone. Patient is on hospice in resides at [Name of Nursing Home], at which a hospice nurse visit him, helps distances [sic] pain medication. Reportedly patient is on known concentration of methadone, however was supposed to receive 0.5mL this morning, rather he received 5mL accidentally per staff. He then became minimally responsive. EMS (emergency medical services) was called, Narcan was administered EN (unknown abbreviation) route was immediately brought the patient around. Patient upon arrival reports being diffuse widespread pain, feeling as though he is going to vomit, having diarrhea. Patient denies feeling drowsy or having difficulty breathing currently. No chest pain. No recent fevers. No other medical complaints at this time." The "Discharge Summary" for (R16) from [Name of Hospital] dated 11/04/2021 documented in part, "Hospital Course. 68 year old with hx (history) of lung cancer ch (chronic history) resp (respiratory) failure on home O2 5lpm (liters per minute) was under Hospice care at SNF (skilled nursing facility) and was given accidental higher dose of methadone 5ml of intensol instead of 0.5ml and was noted to have AMS (altered mental status) and increase O2 needs, narcan given and pt (patient) was referred to ER, poison	F 684		

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F 684	Continued From page 36 control was called by ER provider and was advised to be admitted for observation. HOV [Name of Hospice]) was called and pt will be admitted overnight as GIP (general inpatient) for monitoring. At time of my eval (evaluation) is awake and alert complain gof [sic] pain all over, I was able to switch pt to 5lpm O2 via NC. Pt was placed on monitoring and did well and will proceed with dc (discharge) back to SNF with HOV. Staff at SNF to exercise caution with use of narcotics." On 03/23/2022 at approximately 12:10 p.m. an interview was conducted with LPN # 1 and LPN # 2, unit manager. When asked how the medication error was discovered LPN # 2 stated that when they were doing the medication count on 11/03/2021 for the 7:00 a.m. to 3:00 p.m. shift with RN #3, there was a discrepancy with the methadone. There was more was missing than should have been. LPN # 2 stated that RN #3 realized that [Name of R16] received too much methadone. When asked how much methadone had been administered to R16, LPN # 2 stated that they had received 5 milliliters instead of 0.5 milliliters. LPN # 2 stated that they checked [Name of R16's] vital signs, went back to the nurse's station and informed LPN # 1. LPN # 1 stated they informed LPN # 2 to call and notify hospice due to the fact that (R16) was under hospice care, then they assigned a CNA (certified nursing assistant) in (R16's) room to monitor their oxygen saturation. LPN #1 further stated that they notified the physician and they gave an order and to monitor the oxygen saturation and for narcan if the oxygen saturation dropped below 80%. When asked if the narcan was used LPN #1 stated that (R16's) oxygen saturation dropped to 77% and that LPN # 2 administered the	F 684		

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narcan. LPN # 1 further stated that the physician was in the facility at that time, checked (R16's) vital signs and gave an order to have (R16) sent to the hospital by 911 and that by the time the EMTs (emergency medical technicians) arrived (R16's) oxygen saturation was up to 84%. When asked to interview RN #3, LPN # 1 stated that [Name of RN # 3] returned the next day, was supervised during their medication administration, and has never return to the facility. When asked how a nurse ensures the physician's orders are followed for medication administration, LPN # 1 stated that if it is a narcotic they should triple check the narcotic book, with the physician's orders, with the medication and follow the seven rights of medication administration that include the right route, medication, dose, patient, time, documentation and response.

On 03/23/2022 at 12:45 p.m., ASM (administrative staff member) # 1, administrator and ASM # 2, director of nursing, were informed of the above findings.

On 03/23/2022 at approximately 9:46 a.m., an interview was conducted with ASM #4, nurse practitioner. When asked about the use of methadone, ASM #4 stated that it is used for pain. When asked what the negative outcome would be if a resident was given an overdose of methadone, ASM #4 stated they would become too sedated, decrease their respiration and would have low oxygen saturation. When asked about the course of action that would be taken if an overdose occurred, ASM #4 stated that the resident would be monitored. When informed of the above resident and circumstances, ASM #4 stated that it was not their resident and that the actions taken sounded reasonable.

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On 03/23/2022 at approximately 2:35 p.m., a telephone interview was conducted with ASM #5, (R16's) physician. ASM #5 recalled the circumstances of (R16's) overdose of methadone and stated that they received a call from the nurse, gave an order to monitor the oxygen saturation and for Narcan if the saturation dropped. ASM # 5 stated they were in the facility when the overdose was discovered, saw the oxygen saturation was declining, and sent the resident out to the hospital.

On 3/24/22 at 9:01 a.m., an interview was conducted with RN (registered nurse) #2, regarding following physician's orders for medication administration. RN #2 stated nurses should read the MAR (medication administration record), find the medication, read the MAR again, read the medication and double check the medication against the MAR. RN #2 stated nurses should follow seven rights of medication administration that include the right individual, medication, dose, time, route, documentation and response. RN #2 stated she obtained this information several years ago from the national institute of health website.

On 3/22/22 at 11:42 AM, ASM #2 (Administrative Staff Member) the Director of Nursing, stated the facility uses Lippincott as the Standard of Practice.

Fundamentals of Nursing Lippincott Williams and Wilkins- Ambler PA 2007 page 181 "Nurses carry a great deal of responsibility for making sure that patients get the right drugs at the right time, in the right dose and by the right routes ...this includes accurate documentation and explanation if doses

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are missed or not administered ..."

The facility's policy "Medication Administration" documented in part, "Physician's Orders - Medications are administered in accordance with written orders of the attending physician. 2. Verify the medication label against the medication administration record for guest/resident name, time, drug, dose, and route. a. The nurse is responsible to read and follow precautionary instructions on prescription labels. b. If the label and medication sheet are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule."

No further information was provided prior to exit.

References:
(1) Used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682134.html

(2) Administered by injection or as a nasal spray to reverse the effects of opioids especially in the emergency treatment of opioid overdose. This information was obtained from the website: https://www.merriam-webster.com/dictionary/naloxone.
2. The facility staff failed to administer the correct physician prescribed dose of the Pfizer COVID-19 vaccine to Resident #317 (R317).

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On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/20/21, the resident scored 9 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately impaired for making daily decisions.

A review of R317's clinical record revealed a physician's order dated 12/16/21 for 0.3 ml (milliliters) of the Pfizer COVID-19 vaccine. A medication error report dated 12/16/21 documented R317 was administered 1.8 ml of the Pfizer vaccine. The report further documented the physician was notified, ordered intravenous normal saline at 50 ml per hour for one hour and R317 had no adverse outcome.

R 317's comprehensive care plan revised on 12/17/21 documented, "[R317] is at risk for adverse reaction r/t (related to) unintentional over dosage of medication. IV (Intravenous) and run NS (normal saline) at 50ml/hr x 1 bag..."

On 3/24/22 at 8:03 a.m., an interview was conducted with LPN (licensed practical nurse) #3 (the nurse who administered the Pfizer vaccine to R317). LPN #3 stated on 12/16/21, he assisted the assistant director of nursing with administering the Pfizer vaccine to residents. LPN #3 stated he was unclear on the instructions for diluting the medication and he administered the incorrect dose to R317. LPN #3 stated he was given instructions for administering the vaccine but he wasn't aware the medication had to be diluted and this was the first time he had drawn up the medication.

On 3/24/22 at 8:21 a.m., an interview was conducted with RN (registered nurse) #1 (the

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assistant director of nursing). RN #1 stated 12/16/21 was the first day she was charge at the facility and the director of nursing was not present. RN #1 stated on that day, she was completing multiple tasks and LPN #3 offered to assist with the Pfizer vaccines. RN #1 stated that at the time, she was not aware that the director of nursing usually drew up the vaccines and LPN #3 only administered them. LPN #3 stated she thought LPN #3 knew how to draw up the medication but she should have went with him and observed.

On 3/24/22 at 9:01 a.m., an interview was conducted with RN (registered nurse) #2, regarding following physician's orders for medication administration. RN #2 stated nurses should read the MAR (medication administration record), find the medication, read the MAR again, read the medication and double check the medication against the MAR. RN #2 stated nurses should follow seven rights of medication administration that include the right individual, medication, dose, time, route, documentation and response. RN #2 stated she obtained this information several years ago from the national institute of health website.

On 3/24/22 at 9:20 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the regional director of operations) were made aware of the above concern.

The manufacturer's instructions for the Pfizer vaccine administered to R317 documented, "Each vial must be thawed and diluted prior to administration. Dilute the vial contents using 1.8 mL of sterile 0.9% Sodium Chloride Injection..."

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No further information was presented prior to exit.
3. The facility staff failed to follow orders for wound care for Resident #217.

On the most recent MDS (Minimum Data Set), a 5-day assessment with an ARD (Assessment Reference Date) of 9/9/21, Resident #217 scored a 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. The resident was coded as being independent for eating and required limited to extensive assistance for all other areas of activities of daily living.

A physician's order dated 9/2/21 documented, "Right shin skin prep (1) every shift."

A review of the September 2021 TAR (Treatment Administration Record) revealed this order was scheduled for each shift starting on the night shift on 9/2/21 and ended on day shift on 9/19/21 when the resident discharged. This accounted for a total of 50 opportunities of administration. Of these 50 opportunities, there were 5 opportunities that were not documented as being completed and/or refused.

A physician's order dated 9/6/21 documented "Skin Prep to blister on lower right leg every shift every shift for Prevention."

A review of the September 2021 TAR revealed that this treatment was scheduled for each shift starting on evening shift on 9/6/21 and ended on day shift 9/19/21 when the resident discharged. This accounted for a total of 39 opportunities of administration. Of these 39 opportunities, there were 5 opportunities that were not documented

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as being completed and/or refused.

On 3/23/22 at 11:28 AM an interview was conducted with LPN #4 (Licensed Practical Nurse). She stated that if the MAR has holes in it, she would assume it wasn't given or wasn't done.

A review of Resident #217's comprehensive care plan dated 9/2/21 revealed: "Actual impairment to skin integrity r/t (related to) -trauma areas- left outer hand, right shin...Treatment to skin impairment per order."

A review of the facility policy, "Physician's Orders" was reviewed. This policy did not specifically document that physician's orders must be followed, however, it did document, "Treatment rendered to a guest/resident must be in accordance with the specific standing, written, verbal, or telephone order of a physician or other licensed health professional ordering within their scope of practice and clinical privileges."

On 3/24/22 at approximately 11:30 AM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings.

No further information was provided by the end of the survey.

COMPLAINT DEFICIENCY

REFERENCES
1. Skin Prep - "A liquid protective barrier wipe designed to form protective film to reduce friction during removal of tapes and films as well as prep skin for drainage tubes, external catheters, surrounding ostomy sites and adhesives

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formulated to help skin breathe so tape and film adheres better indicated for use on intact skin only."
Information obtained from
https://www.medline.com/jump/product/x/Z05-PF32716#mrkDocumentation

4. The facility staff failed to follow the physician's order by giving a double dose of a nasal spray to Resident # 9 (R9).

On the most recent MDS (minimum data set) assessment, an admission assessment with an ARD (assessment reference date) of 12/30/2021, the resident was coded as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions.

Observation was made of LPN (licensed practical nurse) #4 administering medications to R9 on 3/23/2022 at 8:15 a.m. LPN #4 administered all of the oral medications and then administered the nasal spray, Fluticasone Propionate (Flonase) Nasal Spray (used for the management of nasal symptoms of perennial nonallergic[sic] rhinitis) (1). LPN #4 administered two sprays in each nostril. After LPN #4 had finished administering the nasal spray, LPN #4 went back to the medication cart and started to sign out the medications on the MAR (medication administration record). When LPN #4 got to the entry for the administration of the nasal spray, they turned toward the surveyor and stated they made an error, and had given two sprays in each nostril instead of one in each nostril. When asked what they had to do next, LPN #4 stated they needed to contact the nurse practitioner about the error and notify the responsible party. When

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F 684	Continued From page 45 asked the process for administering medications, LPN #4 stated they had checked the resident's name, medication, dose prior to going into the room. LPN #4 stated they didn't know why they gave the two sprays, and that they were nervous. The physician order dated 12/23/2021 documented, "Flonase Suspension 50 MCG/ACT (micrograms per activation) 1(one) spray in both nostrils one time a day for allergies." The nurse's note dated 3/23/2022 at 8:39 a.m. documented, "Writer in room administering Flonase, writer gave two sprays in each nostril instead of one, writer notified NP (nurse practitioner) in facility, no new orders, will monitor guest for any changes." The nurse's note dated, 3/24/2022 at 7:30 a.m. documented, "RP (responsible party) made aware of med (medication) error and that no new orders were given by the NP." Review of the comprehensive care plan dated 12/23/2021 failed to reveal information regarding the use of a nasal spray. On 3/24/2022 at 9:01 a.m., an interview was conducted with RN (registered nurse) #2 regarding following physician's orders for medication administration. RN #2 stated nurses should read the MAR (medication administration record), find the medication, read the MAR again, read the medication and double check the medication against the MAR. RN #2 stated nurses should follow seven rights of medication administration that include the right individual, medication, dose, time, route, documentation and response. RN #2 stated she obtained this	F 684		

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F 684	Continued From page 46 information several years ago from the national institute of health website. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were made aware of the above concern on 3/23/2022 at 4:15 p.m. No further information was obtained prior to exit. References: (1) This information was obtained from the package insert of the box for the medication, Fluticasone Propionate Nasal Spray by West-Ward Pharmaceuticals Corp.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and facility document review it was determined that the facility staff failed to provide	F 686	1. LPN #1 was re-educated on 3/23/22 on proper procedure for cleaning a wound. 2. All residents have the potential to be affected by this alleged deficient practice. 3. Licensed nurses will be re-educated by April 18. 2022 on using professional standards of care when providing wound care, to include using different gauzes to clean separate pressure injuries by the ADON/designee. 4. DON/designee will conduct random treatment observations of wound care 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure staff is using professional standards of care. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	4/19/22

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treatment to promote healing of a pressure injury for 1 of 51 residents in the survey sample, Resident #3. The facility staff failed to follow professional standards of care when providing treatment to Resident #3's pressure injury on 3/23/2022. LPN (licensed practical nurse) #1 was observed using one piece of gauze to clean off three separate pressure injuries located on Resident #3.

The findings include:

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/10/2021, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section M documented Resident #3 having two Stage 4 pressure ulcers.

On 3/23/2022 at 9:47 a.m., an observation was made of ASM (administrative staff member) #6, wound physician, assessing the pressure injuries for Resident #3. After assessing and debriding the pressure injuries as needed, ASM #6 advised LPN #1 the treatment to be applied to the wounds and left the room. LPN #1 was observed to use a single four by four gauze pad to wipe off the wound to the left upper sacral area, then to the left ischium, and then to the right ischium prior to applying the prescribed treatments.

On 3/23/2022 at 10:25 a.m., an interview was conducted with LPN #1. LPN #1 stated that Resident #3 has three pressure injuries on their buttocks and each were treated as a separate wound. When asked about the observation on 3/23/2022 at 9:47 a.m., of using the one gauze to

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wipe off all three wounds, LPN #1 stated that they only had one gauze available and had turned the gauze corners for each wound so they did not touch. LPN #1 stated that they should have used a separate gauze to wipe off each wound to prevent any cross contamination between the wounds.

The physician orders for Resident #3 documented in part: "Cleanse left ischium with normal saline. Apply Santyl and calcium alginate cover with dry dressing every day shift for wound. Order Date: 12/01/2021 ...Cleanse right ischium with NS (normal saline), apply Medihoney cover with foam every day shift for wound. Order Date: 01/09/2022 ...Sacrum: cleanse with NS, apply Medihoney and foam dressing. Every day shift. Order Date: 01/28/2022."

The comprehensive care plan for Resident #3 documented in part, "[Resident #3] has an actual impaired skin integrity related to pressure injury. -left ischium (buttocks) chronic full thickness tissue loss wound with history of infections/surgical intervention. - removes wound care dressings. - pressure ulcer of right ankle, stage 4. Patient Plan- MRI (magnetic resonance imaging) ordered to r/o (rule out) osteomyelitis, MRI pending. - Start Augmentin while wait for MRI results. - Sacrum- partial loss of dermis (trauma from wound-care application removal), - right ischium - unable to stage. Date Initiated: 09/07/2021, Revision on: 03/23/2022."

On 3/22/22 at 11:42 AM, RN (registered nurse) #2, unit manager, stated the facility uses Lippincott as the Standard of Practice.

The facility policy "Clean dressing change" failed

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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 686	Continued From page 49 to document guidance on cleaning multiple wounds during dressing changes. In Fundamentals of Nursing Made Incredibly Easy, Lippincott, Williams & Wilkins, 2007, page 428; "When cleaning, be sure to move from the least-contaminated area to the most-contaminated area. For a linear shaped wound, such as an incision, gently wipe from top to bottom in one motion, starting directly over the wound and moving outward. For an open wound, such as a pressure ulcer, gently wipe in concentric circles, again starting directly over the wound and moving outward. Us a separate gauze pad each time the wound is cleaned. Discard the gauze pad for each wiping motion, repeat the procedure until you've cleaned the entire wound. Dry the wound with 4" X 4" gauze pads, using the same procedure as for cleaning. Discard the used gauze pads in the plastic bag." On 3/23/2022 at 4:35 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of operations were notified of the findings. No further information was provided prior to exit.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695	1. Resident #1 has had the nebulizer mask bagged appropriately. Resident #316 no longer resides in the facility. Resident #16 has had nebulizer mask bagged appropriately and oxygen set at the correct rate. 2. An audit was conducted to ensure residents with prescribed oxygen were receiving the correct rate and nebulizer masks were bagged appropriate.	4/19/2022

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	495257	A. BUILDING ______ B. WING ______	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 50 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide respiratory services for three of 51 residents in the survey sample, Residents #1, #316 and #16. The findings include: 1. The facility staff failed to store Resident #1's nebulizer in a sanitary manner. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/25/2022, the resident scored 15 of 15 on the BIMS (brief interview for mental assessment), indicating the resident is cognitively intact for making daily decisions. Section O documented Resident #1 receiving oxygen while a resident at the facility, and as receiving respiratory therapy 7 days during the assessment period. On 3/22/2022 at approximately 1:20 p.m., an interview was conducted with Resident #1 in their room. Resident #1 was observed sitting in a wheelchair beside the bed. A nebulizer delivery device with mask attachment sat uncovered on top of a nebulizer machine on the nightstand behind Resident #1. When asked about the nebulizer mask, Resident #1 stated that they received medication for breathing through it. Resident #1 stated that the nurses provided the medication and removed the mask when it was	F 695	3. Nursing staff and managers will be re-educated by April 18, 2022 on ensuring oxygen is set at the correct rate and nebulizer masks are bagged appropriately by the ADON/designee. 4. Managers/designee will conduct audits of residents who have prescribed oxygen and prescribed nebulizer 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure that oxygen is set at the correct rate and nebulizer masks are bagged appropriately. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	

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F 695	Continued From page 51 complete and put the mask on the nightstand. Additional observations of Resident #1's room on 3/22/2022 at 3:25 p.m. and 4:15 p.m., revealed the findings above. The physician's orders dated 3/24/2022 for Resident #1 documented in part: "Ipratropium-Albuterol Solution 0.5-2.5 (3) MG(milligram)/3 ML (milliliter) 3 ml inhale orally two times a day for COPD (chronic obstructive pulmonary disease) before breakfast and before dinner. Order Date: 06/08/2021...Perforomist Mobilization Solution 20 MCG (microgram)/2 ML (Formoterol Fumarate) 2 ml inhale orally via nebulizer two times a day for COPD. Order Date: 06/08/2021." The eMAR (electronic medication administration record) dated 3/1/2022-3/31/2022 documented Resident #1 receiving the Ipratropium-Albuterol Solution on 3/22/2022 at 8:00 a.m. and the Perforomist nebulization solution on 3/22/2022 at 10:00 a.m. The comprehensive care plan for Resident #1 dated 3/31/2021 documented in part, "[Resident #1] has a potential for difficulty breathing and risk for respiratory complications R/T (related to): COPD, DHF (diastolic heart failure)... Date Initiated: 03/31/2021. Revision On: 02/25/2022." On 3/23/2022 at approximately 1:00 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that nebulizers were changed once a week. LPN #1 stated that when the resident was done with the nebulizer treatment, the medication cup was emptied out and the nebulizer mask and delivery	F 695		

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F 695	Continued From page 52	F 695		

device were stored in a plastic bag. LPN #1 stated that the purpose of the bag was to keep the nebulizer from getting contaminated. LPN #1 was made aware of the observations in Resident #1's room on 3/22/2022 and stated that the nebulizer mask should have been covered and they would check it frequently.

On 3/22/22 at 11:42 AM, RN (registered nurse) #2, unit manager, stated the facility uses Lippincott as the Standard of Practice.

According to The Lippincott Manual of Nursing Practice 10th Edition, 2014, page 236, Procedure Guidelines 10-11 documented in part, "Follow-up phase 1. Record medication used and description of secretions. 2. Disassemble and clean nebulizer after each use. Keep this equipment in the patient's room. The equipment is changed according to facility policy. Each patient has own breathing circuit (nebulizer, tubing and mouthpiece). Through proper cleaning, sterilization, and storage of equipment, organisms can be prevented from entering the lungs."

On 3/23/2022 at 4:35 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of operations were made aware of the findings.

No further information was provided prior to exit.

2. The facility staff failed to administer oxygen to Resident #316 (R316) per the physician prescribed rate of four liters.

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F 695	Continued From page 53 R316's diagnoses included acute and chronic respiratory failure. R316's admission minimum data set assessment was not completed. A nursing comprehensive evaluation dated 3/18/22 documented R316 was alert and oriented to time, place and person. The evaluation further documented R316 received oxygen therapy at four liters per minute. A review of R316's clinical record revealed a physician's order dated 3/18/22 for continuous oxygen at four liters per minute. A review of R316's baseline care plan dated 3/18/22 failed to document information regarding the resident's respiratory status or oxygen therapy. On 3/22/22 at 3:13 p.m., 3/22/22 at 4:33 p.m. and 3/23/22 at 7:51 a.m., R316 was observed in the bed room, receiving oxygen at three and a half liters per minute as evidenced by the ball in the oxygen concentrator flowmeter positioned on the three and a half liter line. On 3/23/22 at 12:56 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated nurses should verify physician's orders for oxygen and verify the correct amount of oxygen is being administered every shift. RN #2 stated the center of the ball in the oxygen concentrator flowmeter should pass through the four liter line for a physician's order of four liters. RN #2 stated R316 was currently receiving oxygen via a portable tank because the staff noticed the concentrator was not properly functioning about an hour before this interview. On 3/23/22 at 4:41 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional	F 695		

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F 695	Continued From page 54	F 695		

director of operations) were made aware of the above concern.

The manufacturer's instructions for the oxygen concentrator documented, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liter per minute) line prescribed."

No further information was presented prior to exit.

3a. Facility staff failed to maintain Resident # 16's oxygen flow rate at five liters per minute per the physician's orders.

Resident # 16 was admitted to the facility with diagnoses that included but were not limited to: lung cancer, respiratory failure and a blood clot in the lungs. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/22/2022, 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 Resident #16 for "Oxygen Therapy" while a resident.

On 03/22/22 at approximately 1:02 p.m., an observation of Resident #16 revealed they were lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on oxygen concentrator revealed an oxygen flow rate between 4 and 5 liters per minute.

On 03/22/22 at approximately 4:00 p.m., an observation of Resident #16 revealed they were

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F 695	Continued From page 55	F 695		

lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on oxygen concentrator revealed an oxygen flow rate between 4 and 5 liters per minute.

The physician order for Resident #16 documented, "Oxygen at 5 L (liters) continuous every shift. Order Date: 06/16/2021. Start Date 06/16/2021."

The comprehensive care plan for Resident #16 dated 08/17/2021 documented in part, "Need. Respiratory distress- remains on oxygen ...Oxygen as ordered/emergent. Date Initiated: 08/17/2021,"

On 03/23/2022 at approximately 2:10 p.m., an observation of Resident #16's oxygen concentrator and an interview was conducted with LPN (licensed practical nurse) #1. After reading the flow meter, LPN #1 stated, "It's between four and five liters per minute. When asked how to read the oxygen flow rate on an oxygen concentrator, LPN #1 stated, "The liter line goes through the middle of the ball." When asked what the flow rate should be LPN #1 stated, "Five liters." When asked how often the oxygen flow rate is checked, LPN #1 stated, "Every shift."

On 03/23/2022 at approximately 4:35 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of clinical services and ASM #3, regional director of operations, were made aware of the above findings.

No further information was provided prior to exit.

3b. Facility staff failed to store Resident # 16's nebulizer mask in a sanitary manner.

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F 695	Continued From page 56 On 03/22/22 at approximately 1:02 p.m., an observation of Resident #16's nebulizer mask revealed it was lying on Resident # 16's bed uncovered. On 03/22/22 at approximately 4:00 p.m., an observation of Resident #16's nebulizer mask revealed it was lying on their bedside table uncovered. On 03/23/22 at approximately 8:22 a.m., an observation of Resident #16's nebulizer mask revealed it was lying on their bedside table uncovered. The physician order for Resident #16 documented in part, "Albuterol Sulfate Nebulization Solution (2.5 MG (milligrams)/3ML (milliliters)) 0.083% (percent) 3 ml inhale orally two times a day related to malignant neoplasm of unspecified part of unspecified bronchus or lung ...Order Date: 06/17/2021. Start Date 06/17/2021." On 03/23/2022 at approximately 2:10 p.m., an interview was conducted with LPN #1. When informed of the observation of Resident # 16's nebulizer mask LPN #1 stated, "It should be stored in a bag to keep it clean." On 03/23/2022 at approximately 4:35 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of clinical services and ASM #3, regional director of operations, were made aware of the above findings. No further information was provided prior to exit.	F 695		

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F 757	Continued From page 57	F 757		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to prevent a resident from receiving an unnecessary medication for one five residents in the medication administration observation, Resident #9. The facility staffadministered a double dose of nasal spray to Resident #9. The findings include: On the most recent MDS (minimum data set)	F 757	1. MD/NP was notified of resident #9 being administered a double dose of nasal spray. Resident #317 no longer resides in facility. 2. All residents have the potential to be affected by this alleged deficient practice. 3. Licensed nurses will be re-educated by April 18, 2022 on the following prescribed physician orders, to include the 5 rights of medication administration.ng documentation of wound care timely by the ADON/Designee. 4. DON/designee will conduct random medication administration observations 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure prescribed physician orders are being followed. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	4/19/2022

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F 757	Continued From page 58	F 757		

assessment, an admission assessment with an ARD (assessment reference date) of 12/30/2021, the resident was coded as scoring a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions.

Observation was made of LPN (licensed practical nurse) #4 administering medications to R3 on 3/23/2022 at 8:15 a.m. LPN #4 administered all of the oral medications, and then administered the nasal spray, Fluticasone Propionate (Flonase) Nasal Spray (used for the management of nasal symptoms of perennial nonallergic[sic] rhinitis) (1). LPN #4 administered two sprays in each nostril. After LPN #4 had finished administering the nasal spray, LPN #4 went back to the medication cart and started to sign out the medications on the MAR (medication administration record). When LPN #4 reached the point for signing off the administration of the nasal spray, they turned toward the surveyor and stated they made an error, and had given two sprays in each nostril instead of one in each nostril. When asked what to do next, LPN #4 stated they needed to contact the nurse practitioner about the error and notify the responsible party. When asked the process for administering medications, LPN #4 stated they had checked the resident's name, medication, and dose prior to going into the room. LPN #4 stated they didn't know why they gave the two sprays, and that they stated they were nervous.

The physician order dated 12/23/2021 documented, "Flonase Suspension 50 MCG/ACT (micrograms per activation) 1(one) spray in both nostrils one time a day for allergies."

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The nurse's note dated 3/23/2022 at 8:39 a.m. documented, "Writer in room administering Flonase, writer gave two sprays in each nostril instead of one, writer notified NP (nurse practitioner) in facility, no new orders, will monitor guest for any changes."

The nurse's note dated, 3/24/2022 at 7:30 a.m. documented, "RP (responsible party) made aware of med (medication) error and that no new orders were given by the NP."

The "Analysis of Medication Event" dated, 3/23/2022, documented in part: "R9's name, the date and time of the event: 3/23/2022 at 8:30 a.m. Medication: Flonase 50 mcg/act - 2 sprays each nostril administered. Type of event: dose. What is the actual effect of the event on the guest? No effect on the guest. How was the event discovered: Nurse realized immediately following administration. Nurse: [LPN #4]. Name of physician notified: [ASM (administrative staff member) # 4, the nurse practitioner]...Physician follow up orders/statement: No new orders. Name of Employee involved: [LPN #4]. What precautions have been taken to prevent similar event? Verbally educated nurse on seven rights of medication administration."

Review of the comprehensive care plan dated 12/23/2021 failed to reveal any information regarding the use of a nasal spray.

On 3/24/2022 at 9:01 a.m., an interview was conducted with RN (registered nurse) #2, regarding unnecessary medications. RN #2 stated that in order to prevent excessive administration of nasal spray, the nurse should not squirt twice if the order is for one spray.

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ASM #1, the administrator and ASM #3, the regional director of operations, were made aware of the above concern on 3/24/2022 at 9:18 a.m.

No further information was obtained prior to exit.

References:
(1) This information was obtained from the package insert of the box for the medication, Fluticasone Propionate Nasal Spray by West-Ward Pharmaceuticals Corp.
3. The facility staff failed to administer the physician prescribed dose of 0.3 ml (milliliters) of the Pfizer COVID-19 vaccine to Resident #317 (R317). Instead, the facility staff administered 1.8 ml of the vaccine to the resident.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/20/21, the resident scored 9 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately impaired for making daily decisions.

A review of R317's clinical record revealed a physician's order dated 12/16/21 for 0.3 ml of the Pfizer COVID-19 vaccine. A medication error report dated 12/16/21 documented R317 was administered 1.8 ml of the Pfizer vaccine. The report further documented the physician was notified, ordered intravenous normal saline at 50 ml per hour for one hour and R317 had no adverse outcome.

On 3/24/22 at 8:03 a.m., an interview was conducted with LPN (licensed practical nurse) #3 (the nurse who administered the Pfizer vaccine to R317). LPN #3 stated on 12/16/21, he assisted

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F 757	Continued From page 61	F 757		

the assistant director of nursing with administering the Pfizer vaccine to residents. LPN #3 stated he was unclear on the instructions for diluting the medication and he administered the incorrect dose to R317. LPN #3 stated he was given instructions for administering the vaccine but he wasn't aware the medication had to be diluted, and this was the first time he had drawn up the medication.

On 3/24/22 at 8:21 a.m., an interview was conducted with RN (registered nurse) #1 (the assistant director of nursing). RN #1 stated 12/16/21 was the first day she was charge at the facility and the director of nursing was not present. RN #1 stated on that day, she was completing multiple tasks and LPN #3 offered to assist with the Pfizer vaccines. RN #1 stated that at the time, she was not aware that the director of nursing usually drew up the vaccines and LPN #3 only administered them. LPN #3 stated she thought LPN #3 knew how to draw up the medication but she should have gone with him and observed.

On 3/24/22 at 9:01 a.m., an interview was conducted with RN (registered nurse) #2, regarding unnecessary medications. RN #2 stated she assisted with the administration of COVID vaccines when they first became available. RN #2 stated she read the medication instructions and knew the medication needed to be diluted.

On 3/24/22 at 9:20 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the regional director of operations) were made aware of the above concern.

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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 757	Continued From page 62 The manufacturer's instructions for the Pfizer vaccine administered to R317 documented, "Each vial must be thawed and diluted prior to administration. Dilute the vial contents using 1.8 mL of sterile 0.9% Sodium Chloride Injection..." No further information was presented prior to exit.	F 757		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on resident interview, clinical record review, facility document review, and staff interview, it was determined that the facility staff failed to ensure a resident was free of a significant medication error for one of 51 residents in the survey sample, Resident #16 (R16). On 11/02/2021 at 10:00 p.m. and on 11/03/2021at 6:00 a.m., facility staff overdosed Resident # 16 R16 by administering 5ml (five milliliters) of Methadone (1), which was ten times the physician ordered dose, resulting in (R16's) oxygen saturation dropping to 77% and requiring administration of Narcan (2). The resident was taken to the hospital for further interventions and monitoring. The deficient practice resulted in harm to the resident. The findings include: R16 was admitted to the facility with diagnoses that included but were not limited to: lung cancer, respiratory failure and a blood clot in the lungs. On the most recent MDS (minimum data set), a	F 760	PAST NON COMPLIANCE	

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F 760	Continued From page 63 quarterly assessment with an ARD (assessment reference date) of 12/22/2021, 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 J0400 coded R16 as frequently experiencing pain at a level of five out of 10 during the look back period. On 03/22/22 at approximately 1:11 p.m., R16 stated that approximately four months ago they were given an overdose of methadone and were sent to the hospital. The physician's orders for R16 documented in part, "Methadone HCl (hydrochloride) Intensol Concentrate 10 MG(milligrams)/ML Give 0.5 ml orally every 8 (eight) hours for pain. Order Date: 11/02/2021 ...Narcan Liquid 4 MG/0.1ML (milliliter) (Naloxone HCl) 0.1 ml in nostril STAT (immediately) for Sedation -Start Date11/03/2021." The comprehensive care plan for R16 dated 06/15/2021 documented in part, "R16 has pain r/t (related to): muscle weakness, Lung Cancer, Chronic Thromboembolic Pulmonary Hypertension ..., Date Initiated: 06/15/2021...Observe for side effects of pain medication. Date Initiated: 06/15/2021." The facility's nurse's note dated 11/03/2021 documented, "7:25 a.m., Text: Med (medication) error noted during narcotic count at 7:15am. VS (vital signs) at that time 97.2 (temperature) -57 (pulse)-16 (respiration) -116/77 (blood pressure) O2 sat (oxygen saturation) 88-89% on 5L/min (five liters per minute) O2 via (by) NC (nasal cannula). Resident alert and responsive. UM (unit	F 760		

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F 760	Continued From page 64	F 760		

manager) notified of error and residents status. Hospice and MD (medical doctor) notified. New order for Narcan if O2 sat goes below 80%. CNA in room with resident. VS at 7:30 am 96.9-61-17-128/80 O2 sat 74%. Narcan given per order at 8:20am (a.m.). O2 sat increased to 87%. VS at 7:45am 97.1-60-18-130/86. MD in and stated to send resident to ER (emergency room) and increase O2 to 15L (liters) on non-rebreather mask. 911 called for transport. Resident becoming anxious- c/o (complaint of) being cold and shaky. VS at 8am 96.8-59-18-126/86 O2 sat 84%.Resident becoming restless. VS at 8:30am 97.1-71-18-127/88 O2 sat 91%. 911 in to transport at 8:50am. Family notified of residents condition and need to transport to hospital. Author: [Name of LPN (licensed practical nurse)] #2." Further review of the nurse's note revealed a handwritten noted that documented, "Nurse during count stated I must have given 5ml instead of .5ml (0.5ml)," and signed by LPN # 2.

The nurse's note dated 11/03/2021 at 8:36 a.m. documented, "VS 97.2-57-16-116/77 O2 sat 88-89% on 5L/min via NC. O2 mask applied. O2 sat 93% but dropped to 77%. Narcaine [sic] given at 8:20am per MD order. O2 sat 91% but dropped to 77%. MD in and stated to send to ER (emergency room). Hospice notified. VS taken every 15 min. Resident alert and talking but slow. Voices no complaints at this time."

The facility form "Analysis of Medication Event" for R16 dated 11/03/2021 documented in part, "Date of Event: 11-2-21, 11-3-21. Time of Event: 2200 (10:00 p.m.) 6:00 a.m. Medication Given: Methadone. Dosage Given: 5mL. Route: po (by mouth). Cause of Event: How did the event occur?: Nurse gave wrong dosage X2 (times two)

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F 760	Continued From page 65 2200 & (and) 6:00 am. What is the actual effect of the event on the guest? Decrease O2 Sat rate. How was event discovered? During am count by off going nurse and on coming nurse. Name(s) and title(s) of employee(s) involved: [Name of Registered Nurse (RN) #3]." The facility's "Controlled Medication Utilization Record" for R16 documented in part, "Methadone Intensol Concentrate 10 MG/1 (one)ML oral CONC (concentrate) 0.5 ml sublingually (under the tongue) three times daily for pain. Date: 11/2/21. Dose Given: 0.5 cc (cubic centimeter). Signature of Nurse: [Name of RN # 3]. Checked By: gave 5mL." Under Date: 11/3/21" it documented, "Dose Given: 0.5 cc (cubic centimeter). Signature of Nurse: [Name of RN # 3]. Checked By: gave 5mL." The "Emergency Provider Report" for R16 from [Name of Hospital] dated 11/03/2021 documented in part, "Free Text HPI (history of present illness) Notes. Patient with history significant for end-stage lung cancer, COPD, asthma, CAD, HTN, presents to the emergency department for reports of accidental overdose on methadone. Patient is on hospice in resides at [Name of Nursing Home], at which a hospice nurse visit him, helps distances [sic] pain medication. Reportedly patient is on known concentration of methadone, however was supposed to receive 0.5mL this morning, rather he received 5mL accidentally per staff. He then became minimally responsive. EMS (emergency medical services) was called, Narcan was administered EN (unknown abbreviation) route was immediately brought the patient around. Patient upon arrival reports being diffuse widespread pain, feeling as though he is going to vomit, having diarrhea.	F 760		

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Patient denies feeling drowsy or having difficulty breathing currently. No chest pain. No recent fevers. No other medical complaints at this time."

The "Discharge Summary" for R16 from [Name of Hospital] dated 11/04/2021 documented in part, "Hospital Course. 68 year old with hx (history) of lung cancer ch (chronic history) resp (respiratory) failure on home O2 5lpm (liters per minute) was under Hospice care at SNF (skilled nursing facility) and was given accidental higher dose of methadone 5ml of intensol instead of 0.5ml and was noted to have AMS (altered mental status) and increase O2 needs, narcan given and pt (patient) was referred to ER, poison control was called by ER provider and was advised to be admitted for observation. HOV [Name of Hospice]) was called and pt will be admitted overnight as GIP (general inpatient) for monitoring. At time of my eval (evaluation) is awake and alert complain gof [sic] pain all over, I was able to switch pt to 5lpm O2 via NC. Pt was placed on monitoring and did well and will proceed with dc (discharge) back to SNF with HOV. Staff at SNF to exercise caution with use of narcotics."

On 03/23/2022 at approximately 12:10 p.m. an interview was conducted with LPN # 1 and LPN # 2, unit manager. When asked how the medication error was discovered LPN # 2 stated that when they were doing the medication count on 11/03/2021 for the 7:00 a.m. to 3:00 p.m. shift with RN #3, there was a discrepancy with the methadone. There was more was missing than should have been. LPN # 2 stated that RN #3 realized that [Name of R16] received too much methadone. When asked how much methadone had been administered to R16, LPN # 2 stated

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F 760	Continued From page 67	F 760		

that they had received 5 milliliters instead of 0.5 milliliters. LPN # 2 stated that they checked [Name of R16's] vital signs, went back to the nurse's station and informed LPN # 1. LPN # 1 stated they informed LPN # 2 to call and notify hospice due to the fact that R16 was under hospice care, then they assigned a CNA (certified nursing assistant) in (R16's) room to monitor their oxygen saturation. LPN #1 further stated that they notified the physician and they gave an order and to monitor the oxygen saturation and for Narcan if the oxygen saturation dropped below 80%. When asked if the Narcan was used LPN #1 stated that (R16's) oxygen saturation dropped to 77% and that LPN # 2 administered the Narcan. LPN # 1 further stated that the physician was in the facility at that time, checked (R16's) vital signs and gave an order to have R16 sent to the hospital by 911 and that by the time the EMTs (emergency medical technicians) arrived (R16's) oxygen saturation was up to 84%. When asked to interview RN #3, LPN # 1 stated that [Name of RN # 3] returned the next day, was supervised during their medication administration, and has never return to the facility. When asked how a nurse ensures the physician's orders are followed for medication administration, LPN # 1 stated that if it is a narcotic they should triple check the narcotic book, with the physician's orders, with the medication and follow the seven rights of medication administration that include the right route, medication, dose, patient, time, documentation and response.

On 03/23/2022 at 12:45 p.m., ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were informed of the above findings.

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F 760	Continued From page 68	F 760		

On 3/24/22 at 9:01 a.m., an interview was conducted with RN (registered nurse) #2, regarding the facility process for when a medication error occurs. RN #2 stated the nurse should notify the nurse practitioner, notify the responsible party, monitor the resident, and follow orders provided by the nurse practitioner.

Review of the facility's documents for an action plan to correct this deficient practice revealed credible evidence that an in-service was conducted on 11/04/2021 for all licensed nurses. The in-service content addressed the facility's policy on medication administration to all RNs and LPNs, including the rights of medication administration. The credible evidence included documentation that management staff conducted medication administration observations with licensed nurse on 11/04/2021 and 11/05/2021. On 03/24/2022 at approximately 9:20 a.m., an interview was conducted with ASM # 1. When asked when the facility was in compliance regarding the in-service and medication administration observations, ASM # 1 stated that the facility was in compliance by 11/19/2021.

The pharmacy information sheet for methadone documented in part, "Dosage Forms and Strengths. Oral concentrate: each mL contains 10 mg of Methadone hydrochloride." Under "10 OVERDOSAGE" it documented in part, "Clinical presentation: Acute overdose with methadone can be manifested by respiratory depression, somnolence progressing to stupor or coma, skeletal- muscle flaccidity, cold and clammy skin, constricted pupils, and in some cases, pulmonary edema, bradycardia, hypotension, partial or complete airway obstruction, atypical snoring, and death. Marked mydriasis rather than miosis may

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be seen with hypoxia in overdose situations [see Clinical Pharmacology (12.2)]. In severe overdosage, particularly by the intravenous route, apnea, circulatory collapse, cardiac arrest, and death may occur.

Treatment of overdose: In case of overdose, priorities are the re-establishment of a patient abd protected airway and institution of assisted or controlled ventilation, if needed. Employ other supportive measures (including oxygen, vasopressors) in the management of circulatory shock and pulmonary edema as indicated. Cardiac arrest or arrhythmias will require advanced life support techniques. The opioid antagonists, Naxolone and Nalmefene, are specific antidotes to respiratory depression resulting from opioid overdose. For clinically significant respiratory or circulatory depression secondary to methadone overdose, administer an opioid antagonist. Opioid antagonists should not be administered in the absence of clinically significant respiratory or circulatory depression secondary to methadone overdose.

Because the duration of reversal would be expected to be less than the duration of action of methadone in Methadone Hydrochloride Intensol, carefully monitor the patient until spontaneous respiration is reliably reestablished. If the response to opioid antagonists is suboptimal or not sustained, administer additional antagonist as directed in the product's prescribing information."(3).

No further information was provided prior to exit.

Past noncompliance

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F 760	Continued From page 70 References: (1) Used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682134.html (2) Administered by injection or as a nasal spray to reverse the effects of opioids especially in the emergency treatment of opioid overdose. This information was obtained from the website: https://www.merriam-webster.com/dictionary/naloxone. (3) This information was obtained from the website: https://dailymed.nih.nih.gov.	F 760		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to prepare food in a manner that was palatable for meal enjoyment.	F 804	1. No ill effects were noted with the residents. 2. All residents on pureed food have the potential to be affected by this alleged deficient practice. 3. Dietary staff will be re-educated by April 18, 2022 on serving palatable food to residents, to include serving food that is not bland and is served hot for meal enjoyment by the dietary manager/designee. 4. Dietary Manager/designee will conduct audits on food served to residents to ensure palatability 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	4/19/2022

F 804 Continued From page 71 F 804

The findings include:

On 3/22/22 at 5:05 PM, the dinner tray line service was observed. The temperatures were checked of each food item by OSM #13 (Other Staff Member) the dietary cook, utilizing a facility thermometer. The food temperatures were as follows:

Regular meal:
Pulled Pork BBQ 185
3-bean cooked salad 185
Potato wedge fries 190

Alternate meal items:
Hot dogs 177
Peas 176
Chicken Alfredo 175

Puree meal items:
Mashed potatoes 161
Puree chicken 175
Puree mix veggies 172

On 3/22/22 at 6:10 PM as the last service cart was being prepared, a test tray was requested from OSM #13. On 3/22/22 at 6:17 the service cart left the kitchen and was delivered to the 700 unit. The cart arrived to the unit at 6:20 PM,

On 3/22/22 at 6:32 PM, once all residents were served, OSM #10 (the Dietary Manager), pulled each test tray from the cart and checked the temperatures with a facility thermometer. The temperatures were as follows:

Regular meal:
Pulled Pork BBQ 132 degrees (a 54 degree drop)
3-bean cooked salad 115 degrees (a 70 degree

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F 804	Continued From page 72 drop) Potato wedge fries 120 degrees (a 70 degree drop) Alternate meal items: Hot dogs 123 degrees (a 54 degree drop) Peas 121 degrees (a 55 degree drop) Chicken Alfredo 113 degrees (a 62 degree drop). Puree meal items: Mashed potatoes 118 degrees (a 43 degree drop) Puree chicken 117 degrees (a 58 degree drop) Puree mix veggies 117 degrees (a 55 degree drop) On 3/22/22 at 6:40 PM, two surveyors and OSM #10 taste tested each food item. All agreed that each of the 3 pureed items and chicken alfredo were bland to taste and were room temperature and were not hot for meal enjoyment. On 3/23/22 at approximately 2:12 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. On 3/23/22 at 5:05 PM a policy list was provided to ASM #1 (Administrative Staff Member) the Administrator. A policy for food palatability was requested on this list. On 3/24/22 at 11:23 AM ASM #1 stated that there was not a policy for food palatability. No further information was provided by the end of the survey. COMPLAINT DEFICIENCY	F 804		

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F 812	Continued From page 73	F 812		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to store and prepare food in a sanitary manner in one of one facility kitchens. The findings include: On 3/22/22 at 11:54 AM, the Kitchen tour was conducted with OSM #10 (Other Staff Member) the Dietary Manager. The following was noted: At 11:56 AM, food residue was observed on the meat slicer. When asked about this, OSM #10 stated that the meat slicer was supposed to be clean and ready to use, and should not have	F 812	1. Meat slicer has been cleaned. Meatless meatball, box of veggie chicken nuggets, veggie burger patties and box of beef and pepper patties in the freezer were sealed immediately. The smoked deli ham was resealed immediately. The plastic bag covering the mixer was removed and the mixer has been cleaned. The 6-eye gas stove has been cleaned. 2. No other concerns noted. 3. Dietary staff will be re-educated by April 18, 2022 on the proper storage of food and cleaning of dietary equipment by the dietary manager/ designee. 4. Dietary Manager/designee will conduct random audits of storage of food and equipment 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure food is stored appropriately and dietary equipment is cleaned properly. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	4/19/2022

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F 812	Continued From page 74 residue on it. At 12:00 PM, in the walk-in freezer, the following was observed: a box of meatless meatballs, a box of veggie chicken nuggets, a box of veggie burger patties, and a box of beef and pepper patties were all unsealed and exposed to the freezer environment. When asked about this, OSM #10 stated, "How should the bags be sealed?" At 12:03 PM, the reach-in fridge was noted to contain a plastic resealable style bag of smoked deli ham, which was opened with the ham exposed to the refrigerator environment. When asked about this, OSM #10 stated that the bag should not be open. At 12:06 PM the mixer was observed with a plastic bag covering over it. The bag was noted to have a damp brown substance on the inside of plastic covering, touching the mixer, and in bottom of the mixer bowl was a nickel sized drip of a wet brown substance. When asked about this, OSM #10 stated that the mixer was supposed to be clean and ready to use, and should not have residue on it. At 12:12 PM, the 6-eye gas stove was noted with large loose chunk of burnt food residue on the back center eye, and burnt black and yellow residue appearing like cheese on the front center eye. Crumbs and burnt/charred residue was all over the top. When asked about this, OSM #10 stated the stove is cleaned every Monday (this observation was on Tuesday). When asked if food should be prepared on a stove with burnt food residue all over it, she stated no.	F 812		

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F 812	Continued From page 75 The facility policy, "Dietary Cleaning and Sanitation" was reviewed. This policy documented, "It is the policy of this facility to maintain the sanitation of the kitchen through proper cleaning and sanitizing stationary food service equipment and food contact surfaces to minimize the growth of microorganisms that may result in food contamination...The Dietary Manager or Dietitian will inspect the kitchen thoroughly to ensure cleaning schedules are completed as assigned." The facility policy, "Food Purchasing and Storage" was reviewed. This policy documented, "...All food items in refrigerators will be properly dated, labeled, and placed in containers with lids, will be wrapped, or stored in sealed food storage bags (See Cold Storage Chart). All frozen food will be dated, labeled and wrapped or sealed. Moisture-proof, tight-fitting materials will be used to prevent freezer burn..." On 3/23/22 at approximately 2:12 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842	1. Licensed nurses were re-educated on completing documentation of the TARs and MARs. 2. All residents have the potential to be affected by this alleged deficient practice. 3. Licensed nurses will be re-educated on ensuring MARs/TARs are completed timely by the ADON/designee.	4/19/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 842	Continued From page 76 agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained	F 842	4. DON/designee will conduct audits of MARs/TARs 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure MARs/TARs are completed. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	

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F 842	Continued From page 77	F 842		

for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to evidence a complete and accurate medical record for three of 51 residents in the survey sample, Resident #112, Resident #416 and Resident #3.

The findings include:

1. A. The facility staff failed to document the 24 hour Foley output for Resident #112, per physician's order.

Resident #112 was admitted to the facility with diagnosis that included but were not limited to: peripheral vascular disease and diabetes mellitus. The most recent MDS (minimum data set) assessment, an admission assessment, with

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F 842	Continued From page 78 an ARD (assessment reference date) of 3/1/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the comprehensive care plan dated 2/22/22 revealed the following, NEED: Indwelling suprapubic catheter related to neurogenic bladder ...Observe, record, report to physician no urine output." A review of the physician orders dated 2/23/22, revealed the following: "24 hour Foley output every evening shift." A review of Resident #112's TAR (treatment administration record) from 2/23/22-2/28/22, revealed missing documentation of 24 hour Foley output every evening shift for four out of six evening shifts, 2/23, 2/24, 2/27 and 2/28/22. A review of Resident #112's TAR (treatment administration record) from 3/1/22-3/23/22, revealed missing documentation of 24 hour Foley output every evening shift for four out of 23 evening shifts, 3/2, 3/7, 3/9 and 3/21/22. An interview was conducted on 3/23/22 at 4:05 PM with LPN (licensed practical nurse) #1. When asked if blanks on the TAR indicate a complete and accurate medical record, LPN #1 stated, no, that is not a complete and accurate medical record if there are holes in the documentation. An interview was conducted with LPN #6 on 3/24/22 at 8:10 AM. When asked what blanks on the TAR indicate, LPN #6 stated if record is blank, then the care was not documented. When asked	F 842		

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F 842	Continued From page 79 if the blanks indicate a complete and accurate medical record, LPN #6 stated, no, if there are blanks, it is not complete. On 3/23/22 at approximately 4:35 PM, ASM (administrative staff member) #1, the Administrator, and ASM #2, the Director of Nursing and ASM #3, the Regional Director of Operations were made aware of the above concern. According to the facility's "Medical Records Management" policy dated 1/31/22, revealed the following, "Medical records must be complete, accurately documented, readily accessible, systematically organized, and maintained in a safe and secure environment." No further information was provided prior to exit. 1. B. The facility staff failed to document physician ordered treatment for a skin tear to Resident #112's left lower extremity. A review of the comprehensive care plan dated 2/22/22 revealed the following: "NEED: Actual impaired skin integrity left lower calf ... Treatment as ordered." A review of the physician orders dated 2/22/22, revealed the following: "Left lower extremity: apply Bactroban over skin tear, apply nonstick dressing, and change daily every day shift. Order revised on 3/1/22 to change time of treatment to every evening shift." A review of Resident #112's TAR (treatment administration record) from 2/23/22-2/28/22, revealed missing documentation of left lower	F 842		

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extremity treatment for three out of six day shifts, 2/23, 2/24 and 2/26/22.

A review of Resident #112's TAR (treatment administration record) from 3/1/22-3/23/22, revealed missing documentation of left lower extremity treatment for two out of 23 evening shifts, 3/2 and 3/20/22.

An interview was conducted on 3/23/22 at 4:05 PM with LPN (licensed practical nurse) #1. When asked if blanks on the TAR indicate a complete and accurate medical record, LPN #1 stated, no, that is not a complete and accurate medical record if there are holes in the documentation.

An interview was conducted with LPN #6 on 3/24/22 at 8:10 AM. When asked what blanks on the TAR indicate, LPN #6 stated if record is blank, then the care was not documented. When asked if the blanks indicate a complete and accurate medical record, LPN #6 stated, no, if there are blanks, it is not complete.

On 3/23/22 at approximately 4:35 PM, ASM (administrative staff member) #1, the Administrator, and ASM #2, the Director of Nursing and ASM #3, the Regional Director of Operations were made aware of the above concern.

No further information was provided prior to exit.

2. A. The facility staff failed to document treatment of Resident #416's diabetic ulcer.

Resident #416 was admitted to the facility with diagnoses that included, but were not limited to: peripheral vascular disease, popliteal-tibial

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F 842	Continued From page 81 bypass right leg and diabetes mellitus. The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an ARD (assessment reference date) of 6/22/21, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired. A review of the comprehensive care plan dated 6/15/21 revealed the following: "NEED: Actual impairment to skin integrity related to diabetes and below knee popliteal to distal posterior tibial artery bypass graft and debridement right foot wound ...Treatment to skin impairment per order." A review of the physician orders dated 6/16/21 revealed the following: "Right lateral foot: cleanse with normal saline, cover with Medihoney and dry dressing every day shift." A review of Resident #416's TAR (treatment administration record) from 6/16/21-6/30/21, revealed missing documentation of five out of twelve day shifts, 6/18, 6/19, 6/23, 6/26 and 6/29/21. Treatment was discontinued 6/30/21 as diabetic wound was resolved. An interview was conducted on 3/23/22 at 4:05 PM with LPN (licensed practical nurse) #1. When asked if blanks on the TAR indicate a complete and accurate medical record, LPN #1 stated, no, that is not a complete and accurate medical record if there are holes in the documentation. An interview was conducted with LPN #6 on 3/24/22 at 8:10 AM. When asked what blanks on the TAR indicate, LPN #6 stated if record is blank, then the care was not documented. When asked if the blanks indicate a complete and accurate	F 842		

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F 842	Continued From page 82 medical record, LPN #6 stated, no, if there are blanks, it is not complete. On 3/23/22 at approximately 4:35 PM, ASM (administrative staff member) #1, the Administrator, and ASM #2, the Director of Nursing and ASM #3, the Regional Director of Ops were made aware of the above concern. No further information was provided prior to exit. 2. B. The facility staff failed to document treatment on Resident #416's right leg incisions. A review of the comprehensive care plan dated 6/15/21 revealed the following: "NEED: Actual impairment to skin integrity related to diabetes and below knee popliteal to distal posterior tibial artery bypass graft and debridement right foot wound ...Treatment to skin impairment per order." A review of the physician orders dated 6/29/21, revealed the following "Cleanse with normal saline, pat dry cover with Xeroform and cover with dry gauze every other day for wound care." A review of Resident #416's TAR (treatment administration record) from 6/16/21-6/30/21, revealed missing documentation of two out of four day shifts, 7/5 and 7/7/21. Resident was discharged home on 7/9/21. An interview was conducted on 3/23/22 at 4:05 PM with LPN (licensed practical nurse) #1. When asked if blanks on the TAR indicate a complete and accurate medical record, LPN #1 stated, no, that is not a complete and accurate medical record if there are holes in the documentation.	F 842		

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F 842	Continued From page 83 An interview was conducted with LPN #6 on 3/24/22 at 8:10 AM. When asked what blanks on the TAR indicate, LPN #6 stated if record is blank, then the care was not documented. When asked if the blanks indicate a complete and accurate medical record, LPN #6 stated, no, if there are blanks, it is not complete. On 3/23/22 at approximately 4:35 PM, ASM (administrative staff member) #1, the Administrator, and ASM #2, the Director of Nursing and ASM #3, the Regional Director of Ops were made aware of the above concern. No further information was provided prior to exit. 3. The facility staff failed to maintain a complete and accurate medical record documenting treatment to a pressure injury for Resident #3. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/10/2021, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section M documented Resident #3 having two Stage 4 pressure ulcers. The physician orders for Resident #3 documented in part, - "Cleanse left ischium with normal saline apply Santyl and calcium alginate cover with dry dressing every day shift for wound. Order Date: 12/01/2021." - "Cleanse right ischium with NS (normal saline), apply Medihoney cover with foam every day shift for wound. Order Date: 01/09/2022." - "Sacrum: cleanse with NS, apply Medihoney	F 842		

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and foam dressing. Every day shift. Order Date: 01/28/2022."
- "right ankle- cleanse with normal saline, pat dry, cover with Santyl and dry dressing every day shift for wound. Order Date: 11/12/2021."

The eTAR (electronic treatment administration record) dated 1/1/2022-1/31/2022 failed to evidence documentation for the following treatments on the following dates:
- "Cleanse left ischium with normal saline apply Santyl and calcium alginate cover with dry dressing every day shift for wound." On 1/3/2022, 1/5/2022, 1/11/2022, 1/12/2022, and 1/18/2022.
- "Cleanse right ischium with NS (normal saline), apply Medihoney cover with foam every day shift for wound." On
- "Sacrum: cleanse with NS, apply Medihoney and foam dressing." On 1/3/2022, 1/5/2022, 1/11/2022, 1/12/2022, and 1/18/2022.
- "right ankle- cleanse with normal saline, pat dry, cover with Santyl and dry dressing every day shift for wound." On 1/3/2022, 1/5/2022, 1/11/2022, 1/12/2022, and 1/18/2022.

The eTAR dated 2/1/2022-2/28/2022 failed to evidence documentation for the following treatments on the following dates:
- "Cleanse left ischium with normal saline apply Santyl and calcium alginate cover with dry dressing every day shift for wound." On 2/13/2022 and 2/24/2022.
- "Cleanse right ischium with NS (normal saline), apply Medihoney cover with foam every day shift for wound." On 2/13/2022 and 2/24/2022.
- "Sacrum: cleanse with NS, apply Medihoney and foam dressing." On 2/13/2022 and 2/24/2022.
- "right ankle- cleanse with normal saline, pat dry,

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cover with Santyl and dry dressing every day shift for wound." On 2/13/2022 and 2/24/2022.

The eTAR dated 3/1/2022-3/31/2022 failed to evidence documentation for the following treatments on the following dates:
- "Cleanse left ischium with normal saline apply Santyl and calcium alginate cover with dry dressing every day shift for wound." On 3/5/2022, 3/6/2022, 3/14/2022 and 3/21/2022.
- "Cleanse right ischium with NS (normal saline), apply Medihoney cover with foam every day shift for wound." On 3/5/2022, 3/6/2022, 3/14/2022 and 3/21/2022.
- "Sacrum: cleanse with NS, apply Medihoney and foam dressing." On 3/5/2022, 3/6/2022, 3/14/2022 and 3/21/2022.
- "right ankle- cleanse with normal saline, pat dry, cover with Santyl and dry dressing every day shift for wound." On 3/5/2022, 3/14/2022 and 3/21/2022.

On 3/23/2022 at 3:20 p.m., an interview was conducted with LPN #1. LPN #1 stated that pressure injury treatments were documented on the eTAR after they were completed. LPN #1 stated that blanks on the eTAR meant that the nurse probably got busy and forgot to sign off that they did the treatment. LPN #1 stated the medical record was not complete when there were blanks on the eTAR.

On 3/23/2022 at 4:35 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of operations were notified of the findings.

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
	495257	A. BUILDING ______ B. WING ______	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(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 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, clinical record review and facility document review, it was determined the facility staff failed to evidence a bed inspection was provided for one of 51 residents in the survey sample, Resident #412. The facility staff failed to perform bed rail inspections for the use of positioning/assist bars for Resident #412. The findings include: Resident #412 was admitted to the facility with diagnoses that included but were not limited to: diabetes mellitus and morbid obesity. Resident #412's most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an assessment reference date of 3/14/22, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. On 3/22/22 at 1:20 PM and 3/23/22 at 8:20 AM, Resident #412 was resting in bed, with half rails raised on the left side of the bed.	F 909	1. Resident #412 no longer resides in the facility. 2. An audit of beds with side rails/grab bars was conducted to ensure assessments were completed by the maintenance director. Any assessments noted not to have been completed, will be completed immediately. 3. Maintenance director will be re-educated by April 18, 2022 by the Administrator/ designee on conducting regular inspections of all bed frames, mattresses and bed rails, if any, as a part of a regular maintenance program to identify areas of possible entrapment. 4. ADM/designee will conduct audits on the maintenance director conducting regular inspections of all bed frames, mattresses and bed rails, if any, as a part of a regular maintenance program to identify areas of possible entrapment. 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure assessments are completed. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow committee recommendations.	4/19/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 909	Continued From page 87 A review of the physician order dated 3/21/22, revealed the following: "One one/half side rail up as an enabler when in bed every shift." A review of the clinical record revealed a "Physical Device Evaluation" form dated 3/21/22 for the use of assist bars. The form documented: "Evaluation-reason for enabler device use: repositioning support, enable/increase bed mobility, enhance mobility and enable/increase independence." Consent was included on the form. A review of Resident #412's comprehensive care plan dated 3/8/22 and revised 3/22/22, revealed: "NEED: assistance with ADL's (activities of daily living) related to impaired mobility. INTERVENTIONS: one assist bar up as enabler to assist with turning and repositioning." An interview was conducted on 3/22/22 at 1:20 PM with Resident #412. When asked if the rail was used, Resident #412 stated they use the rail to help turn in bed and to position themselves. On 3/23/22 at approximately 10:00 AM, a request was made to administration for the bed rail inspections for all the beds in the facility. On 3/23/22 at approximately 3:00 PM, OSM (other staff member) #12, the maintenance director provided the bed rail inspections. When asked about the inspections, OSM #12 stated the beds are inspected, and the list of rails is included. This is done by resident room /bed number. Upon review of the inspections, room #412-P was not on the list. On 3/23/22 at approximately 4:35 PM, ASM	F 909		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 909	Continued From page 88 (administrative staff member) #1, the Administrator, and ASM #2, the Director of Nursing and ASM #3, the Regional Director of Ops were made aware of the above concern. On 3/24/22 at approximately 9:30 AM, OSM #12 was asked to clarify the rail assessment list and to indicate where room #412-P was assessed. OSM #12 stated that nursing must have put the rail on the bed recently. It was not on the list and had not been checked. On 3/24/22 at 11:02 AM, ASM #1 stated, "We do not have any policy related to bed inspections." No further information was provided prior to exit.	F 909		