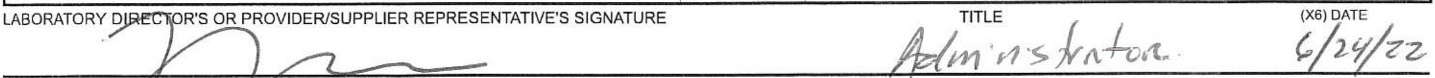
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING ___ B. WING ___	C 06/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 6/5/22 through 6/7/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/5/22 through 6/7/22. 4 complaints were investigated during the survey(VA00054938- substantiated with deficiency, VA00054411-unsubstantiated, VA00054136-substantiated with deficiency and VA00054058-substantiated with deficiency). 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 190 certified bed facility was 137 at the time of the survey. The survey sample consisted of 40 current resident reviews and 4 closed record reviews.	F 000		
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to	F 551	1. Resident # 428 no longer resides in the center. 2. An audit of all current residents was completed to ensure that accurate demographic information is available for and communication on needs is assessed for resident responsible parties. 3. Education was provided to the Admissions team and the social services team by the executive director on ensuring that the admissions process, policies and procedures are followed, and that resident and responsible party rights are maintained.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 6/24/22

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 551	Continued From page 1 exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law	F 551	4. The admissions director or designee will complete a weekly audit of all new admissions x 4 weeks then 10 per month x 2 months to ensure that the admissions intake process has been followed to include contact of the patients responsible party. Results will be forwarded to the monthly QA meeting for review and discussion.	7/12/22

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F 551	Continued From page 2 or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to facilitate a responsible party's (RP) right to make decisions for 1 of 44 residents in the survey sample, Resident #428. The findings include: The facility staff failed to facilitate Resident 428's (R428) responsible party's right to make decisions regarding their care during the admission process to the facility. On the most recent MDS (minimum data set), a five-day assessment with an ARD (assessment reference date) of 12/11/2021, the resident scored 5 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired for making daily decisions. The admission/readmission data collection assessment for R428 dated 12/4/2021 documented the resident alert and oriented to person only with a memory problem. A facility grievance dated 12/6/2021 for R428 documented in part, "...Describe concern in	F 551		

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F 551	Continued From page 3 detail: There was no contact with POA (power of attorney) until 12/6, POA upset no one had let her know how resident was doing and what the facility was doing to treat resident...Findings of investigation: On 12/6 SW (social worker) discovered there was no contact information in chart. SW was able to get information from resident and spoke w/ (with) wife who informed resident is coming home after therapy and she had POA paperwork. Wife brought in paperwork 12/7 and was uploaded..." Attached to the grievance was an email dated 12/3/2021 which documented in part, "...[Name of resident] is a [age and sex] who is coming to us from [Name of hospital]. [R428] is a patient who was admitted for a UTI (urinary tract infection) and sepsis. [R428] also has significant Dementia..." The facility "Admission Agreement" dated 12/4/2021 for R428 was reviewed. The agreement included information on the following: Basic charges, physician care, bed hold, right to leave/refuse treatment, refunds, room transfers, smoking, privacy, patient trust accounts, agreement for financial obligations, payment, discontinuance of Medicaid or Medicare, Denial or Medicare or Medicaid, interest and attorney's fees, valuables, patient identification, release from responsibility, liability, advanced directives and acknowledgement of receiving notices and explanations. The agreement was observed to be signed by R428 with a handwritten date of 12/10/98. The "Notification & Consent Form" for R428 documenting assignment of benefits, consent for services from vendors, advanced directives information, medical services, medications and acknowledgement of receipt of information was signed by R428 with a date of 12/10/21 witnessed by the previous admissions	F 551		

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F 551	Continued From page 4	F 551		

coordinator. The "Optional arbitration agreement" for R428 was signed by R428 and dated 12/10/2021. The "Social Services Consent Form-Virginia" which documented receipt of the information handbook, participation in out of facility activities, mail authorization, consent for Flu vaccine and notice of deemed consent to HIV blood testing was observed to be signed by R428 and dated 12/10/2021. The "Notice of Availability of Resource Assessments" was signed by R428 and dated 12/10/2021. The "Patient Pay and Use of DMAS 225" document was observed to contain R428's initials on each page.

On 6/7/2022 at 11:17 a.m., an interview was conducted with OSM (other staff member) #10, admissions coordinator. OSM #10 stated that they they were not the admissions coordinator when R428 was admitted. OSM #10 stated that when a resident was first admitted to the facility they kept in contact with the facility director of admissions and the hospital case managers. OSM #10 stated that they prepared admission packets for both families and the residents. OSM #10 stated that they preferred to communicate with family members prior to admission to arrange to have the admission paperwork completed if the resident was not able. OSM #10 stated that they provided a binder with name tags, an admission alert to the unit prior to arrival and also made sure the bed and room were ready by having a flash meeting prior to arrival. OSM #10 stated that they contacted the family prior to arrival to make sure any paperwork was ready. OSM #10 stated that they provided a copy of the admission packet after it was signed or prior to if requested. OSM #10 stated that they received responsible party contact information through the case manager at the hospital and they were able

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F 551	Continued From page 5 to pull up the facesheet information on the computer to provide to the nursing unit. OSM #10 stated that the resident also arrived with paperwork from the hospital. OSM #10 stated that they were the one responsible for getting the admission agreements signed and at times had problems reaching responsible parties. OSM #10 stated that they determine a resident's BIMS score through the social worker to determine if they are able to sign their admissions paperwork and they also trust their gut. OSM #10 stated that any resident with a BIMS of 12 or better would be able to sign their admission paperwork. OSM #10 stated that they would not have a resident with a BIMS of 5 sign their paperwork because that score deemed them not cognitively able to know what was going on. OSM #10 stated that they would see if that resident had a responsible party or power of attorney to sign the paperwork. OSM #10 stated that they also made contact with each new admissions family member within 24 hours of admission to notify them that the resident had arrived. The facility policy "Sign-In Procedure" dated 8/19/2018 documented in part, "...Verbal authorization to treat must be obtained from the responsible party by the Business Development Coordinator and a witness. These are valid for 24 hours. All admission paperwork will be completed by responsible party and returned within 24 hours or a second verbal authorization must be obtained. A maximum of 2 verbal authorizations may be obtained. The Director of Admissions/designee may fax admission paperwork to the responsible party for signatures. The responsible party should complete and return all paperwork with a copy of his/her driver's license and appropriate POA/Admissions	F 551		

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F 551	Continued From page 6 paperwork..." On 6/7/2022 at approximately 3:45 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the assistant director of nursing were made aware of the above concern. No further information was presented prior to exit. Complaint deficiency	F 551		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined the facility staff failed to ensure a resident's call bell was within their reach while in bed for one of 44 residents in the survey sample, Resident #122 (R122). The findings include: On the most recent MDS (minimum data set) assessment, a quarterly assessment with an assessment reference date of 5/23/2022, the resident scored a seven out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is severely cognitively impaired for making daily decisions. Observation was made on 6/5/2022 at 3:22 p.m.	F 558	1. Resident #122 call bell was place within resident reach. 2. A Quality review of residents was conducted to ensure call bells are in place and are within reach. 3. Staff re- education (across disciplines) was conducted on ensuring residents' call bells are functional, in place, and within reach. 4. The interdisciplinary team will audit call bells to ensure they are functional, in place, and within reach. Audit reports daily for 4 weeks, weekly x4 and then monthly for 3 months turn results into the Administrator and/or designee for review.	

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F 558	Continued From page 7 of R122 in their bed. The call bell was not within the resident's reach. A second observation was made on 6/6/2022 at 10:25 a.m. of R122 in their bed. The call bell was not within the resident's reach, it was located on a foot pedal, which had been removed from a wheelchair, sitting next to their bed. A third observation was made on 6/6/2022 at 4:48 p.m. The call bell was not within the resident's reach, it was located on a foot pedal, which had been removed from a wheelchair, sitting next to their bed. The comprehensive care plan dated, 2/18/2022 documented in part, "Focus: (R122) is at risk for falls." The "Interventions" documented in part, "2/18/2022 - call bell encouraged. 4/6/2022 - Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed." An interview was conducted with LPN (licensed practical nurse) #6 on 6/6/2022 at 4:46 p.m. When asked where a resident's call bell should be when the resident is in bed, LPN #6 stated it should be on the bed within the resident's reach. When asked if R122 can use their call bell, LPN #6 stated that the resident could use the call bell. ASM (administrative staff member) #1, the executive director, and ASM #2, the assistant director of nursing, were made aware of the above concern on 6/7/2022 at 2:54 p.m. A request was made for the policy on call bells on 6/7/2022 at approximately 5:00 p.m. On 6/7/2022 at 6:07 p.m. ASM #1 sent an email stating the facility did not have a policy on call bells. According to "Handbook of Nursing Procedures-	F 558	Results will be reviewed and will be discussed by the administrator and/or designee at the Quality Assurance Performance Improvement meetings monthly for three months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. Compliance	7/12/22

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F 558	Continued From page 8 Fall Prevention and Management- Correct potential dangers in the patient's room. Position the call light so that he can reach it..."(1) No further information was provided prior to exit. (1) Handbook of Nursing Procedures Springhouse Corporation, Springhouse PA 2001, page 323- Fall Prevention and Management.	F 558	1. a. The tiles in resident #97s bathroom we replaced and repaired b. The privacy curtain for resident #45 was placed with a clean curtain c. The based board in the room of resident #52 was secured to ensure proper installation and the room was cleaned d. The tiles and gouges in the bathroom of resident #31were repaired. The toilet was secured to ensure proper installation. The door to the bathroom was repaired to ensure no gouges and chips were present. e. The gouges and chips in the outer door frame was repaired for resident #1. The gouges in the bathroom door were repaired. The air conditioner filter was removed and the air conditioner was cleaned. The	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		

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F 584	Continued From page 9 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to maintain a clean, comfortable, homelike environment for 7 of 44 residents in the survey sample, Residents #97, #45, #52, #31, #1, #54 and #114. The findings include: 1. The facility staff failed to maintain Resident #97's (R97) bathroom in a homelike manner. Three tiles on the bathroom wall were duct taped to adjoining tiles and one tile was broken and caved into the wall. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/7/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. On 6/5/22 at 4:28 p.m., R97 was observed lying	F 584	bathroom was cleaned to include the toilet bases. The gouges in the bathroom walls were repaired. The hole in the wall behind the bed was repaired. f. The area under the sink in resident #54's room was repaired. The baseboards were replaced to ensure proper installation. g. The area under the sink in resident #114's room was repaired to ensure proper installation. 2. An audit was completed by the Maintenance Director/designee on repairs needed including, but not limited to, walls, bathroom tiles, ceilings, and fixtures. Items in need of repair were completed. An audit was completed by the Maintenance Director	

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F 584	Continued From page 10 in bed and an interview was conducted. R97 stated to look at the wall in the bathroom and the wall had been in disrepair for a year. Observation of the wall across from the toilet in the bathroom revealed three light yellow tiles duct taped to three white tiles. One of the light yellow tiles was broken and caved inwards, exposing a hole in the wall. R97 stated they were not happy about the bathroom wall. R97 stated they had to look at the wall every time they go into the bathroom. R97 stated the facility staff put a piece of tape on the wall instead of tearing out the wall and fixing it like they were supposed to. On 6/6/22 at 8:37 a.m., R97's bathroom wall remained in disrepair. On 6/6/22 at 4:00 p.m., an interview was conducted with OSM (other staff member) #1 (the maintenance director at a sister facility). OSM #1 stated the facility currently does not have a maintenance director but does have two new maintenance assistants. OSM #1 stated the maintenance department is supposed to inspect every resident room/bathroom every month for any physical plant issues including painting, lighting, sinks, toilets, call bells and tiles. In addition to the monthly inspections, OSM #1 stated the management team conducts daily rounds and any staff can notify the maintenance department of any problems via a computer system. On 6/6/22 at 4:12 p.m., observation of R97's bathroom wall was conducted with OSM #1. OSM #1 stated the wall needed attention, was not homelike and was not acceptable. On 6/6/22 at approximately 4:44 p.m., OSM #1	F 584	to ensure the package terminal air conditioner (PTAC) filters were clean and free from debris. An audit was completed by the Housekeeping Director to ensure that the privacy curtains were clean and rooms presented as a clean and homelike. 3. In Service/ Education was provided to housekeeping and the housekeeping staff in regard to the cleanliness of the facility including toilet stain removal, removal of dirt/cleanliness of facility floors and cleanliness of bathroom areas. In-service/education was provided to maintenance staff on properly maintaining resident areas and the general and routine maintenance in the facility to include responding timely to work order requests.	

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F 584	Continued From page 11 stated there was no documentation regarding R97's bathroom wall in the computer system. On 6/6/22 at approximately 5:20 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the assistant director of nursing) were made aware of the above concern. On 6/7/22 at 10:53 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that if a resident room/bathroom needs repairs, staff can put a request in the computer system but sometimes the password for the computer system doesn't work so staff can verbalize the request to the maintenance staff. The facility document titled, "VIRGINIA RESIDENT'S RIGHTS AND RESPONSIBILITIES" documented, "As a nursing facility resident, you have the following rights under federal and state law... A. To live a safe, clean, comfortable and homelike environment. B. To have housekeeping and maintenance services available to maintain a sanitary, orderly, and comfortable interior..." No further information was presented prior to exit. Complaint deficiency. 2. The facility staff failed to maintain Resident #45's (R45) privacy curtain in a clean and homelike manner. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/9/22, the resident scored 5	F 584	4. The Housekeeping director or designee will complete a random audit of 10 Rooms weekly x 3 months to ensure that they are clean homelike. All areas that are deficient will be corrected immediately and results will be communicated in the monthly QA meeting for review and suggestions. The Housekeeping director or designee will complete a random audit of 10 privacy curtains weekly to ensure cleanliness. All areas that are deficient will be corrected immediately and results will be communicated in the monthly QA meeting for review and suggestions.	7/12/22

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F 584	Continued From page 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely cognitively impaired for making daily decisions. On 6/5/22 at 5:03 p.m., and 6/6/22 at 2:40 p.m., observation of R45's privacy curtain was conducted. Light brown stains were observed on an approximate four foot (length) by four foot (width) area of the curtain. On 6/6/22 at 4:27 p.m., an interview was conducted with OSM (other staff member) #2 (the housekeeping manager), regarding the cleanliness of privacy curtains. OSM #2 stated the housekeepers check the privacy curtains on a daily basis and she conducts audits at least two to three times a week. OSM #2 stated that if a privacy curtain is dirty, the housekeepers are supposed to let either she or the floor tech know so a clean curtain can be obtained. On 6/6/22 at 4:34 p.m., observation of R45's privacy curtain was conducted with OSM #2. OSM #2 stated she could not comment on what the stain was but R45 does like to drink coffee. OSM #2 stated the privacy curtain was not homelike and the housekeeper should have reported the curtain to her or the floor tech. On 6/6/22 at approximately 5:20 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the assistant director of nursing) were made aware of the above concern. On 6/7/22 at 10:53 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated she looks at residents' rooms for cleanliness and reports dirty privacy curtains to the housekeepers.	F 584	The Maintenance director or designee will complete a random audit of 10 resident rooms weekly x 3 months to inspect for needed repairs. All areas that are deficient will be corrected and results will be communicated in the monthly QA meeting for review and suggestions.	7/12/22

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No further information was presented prior to exit.

Complaint deficiency.
3. Resident #52's (R52's) baseboard was pulled away from the wall approximately one inch. The space between the baseboard and wall contained dirt and debris.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/12/22, R52 was coded as being moderately impaired for making daily decisions, having scored 10 out of 15 on the BIMS (brief interview for mental status).

On the following dates and times, R52's room and bathroom were observed: 6/5/22 at 2:43 p.m.; 6/6/22 at 8:08 a.m., and 6/6/22 at 1:28 p.m. At each observation, the one inch wide space between the baseboard and the wall had debris and lint in it. The base of the inner bathroom door contained multiple chipped and gouged areas. Cracked tiles surrounded the toilet. The toilet was pulling away from the wall.

On 6/6/22 at 4:00 p.m., OSM (other staff member) #1, the maintenance director at a sister facility, was interviewed. He stated this facility does not currently have a maintenance director. He stated the two maintenance workers have been employed by the facility for only a short time. He stated the maintenance staff performs room audits, checking for paint, lighting, sinks, toilets, call bells, and any physical plant items. He stated these audits should be performed on each room every month. He stated he was not aware that the monthly audits were being completed for rooms at this facility in recent months. He stated

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any issues identified during a room audit should be addressed by either the maintenance or housekeeping staff. He stated the facility has the capacity to use a software system which tracks maintenance needs and maintenance completion. He stated the facility also utilizes paper forms staff members give to maintenance staff to report maintenance needs. He stated that when he performs room audits, his standard is whether or not the room or piece of equipment would be acceptable in his own home. He stated he is aware of several ongoing projects in the facility.

On 6/6/22 at 4:27 p.m., ASM (administrative staff member) #1, the executive director, stated the facility is in the middle of correcting some needed maintenance concerns. He stated: "It's like a plan of correction." When asked if the facility's plan was completed prior to surveyor entrance, he stated it was not.

On 6/6/22 at 4:27 p.m., OSM #2, the housekeeping manager, was interviewed. She stated she performs cleanliness audits in each room two or three times a week, depending on other things she has to oversee and complete. She stated housekeepers clean every resident room every day, and always are watching for additional housekeeping needs. She stated on her audits, she looks at resident beds, under beds, debris, furniture cleanliness, bathroom cleanliness, and room corner cleanliness. She stated rooms are cleaned every day, including weekends.

On 6/6/22 at 4:22 p.m., OSM #1 looked at R52's room and bathroom. He stated the dirty baseboard is both a housekeeping and a

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maintenance issue. He stated the space between the baseboard and the wall needs to be cleaned, then caulked. He stated R52's room was not homelike.

On 6/6/22 at 4:42 p.m., OSM #2 looked at R52's baseboard. She stated: "We only use a mop and a rag. There's a limit to how far we can go with cleaning.

On 6/7/22 at 2:44 p.m., ASM #1 and ASM #2, the assistant director of nursing, were informed of these concerns.

No further information was provided prior to exit.

Complaint deficiency.

4. Resident 31's (R31's) bathroom door base contained gouges and chips. The bathroom tiles had cracks and gouges. The toilet was pulling away from the wall in the bathroom.

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 3/18/22, R31 was coded as being cognitively intact for making daily decisions, having scored 13 out of 15 on the BIMS (brief interview for mental status).

On the following dates and times, R31's room and bathroom were observed: 6/5/22 at 2:50 p.m., 6/6/22 at 8:08 a.m. and 1:30 p.m. At each observation, the base of the bathroom door had chips and gouges. Several bathroom tiles were cracked and/or gouged, and the toilet was pulling away from the bathroom wall.

On 6/6/22 at 4:00 p.m., OSM (other staff

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member) #1, the maintenance director at a sister facility, was interviewed. He stated this facility does not currently have a maintenance director. He stated the two maintenance workers have been employed by the facility for only a short time. He stated the maintenance staff performs room audits, checking for paint, lighting, sinks, toilets, call bells, and any physical plant items. He stated these audits should be performed on each room every month. He stated he was not aware that the monthly audits were being completed for rooms at this facility in recent months. He stated any issues identified during a room audit should be addressed by either the maintenance or housekeeping staff. He stated the facility has the capacity to use a software system which tracks maintenance needs and maintenance completion. He stated the facility also utilizes paper forms staff members give to maintenance staff to report maintenance needs. He stated that when he performs room audits, his standard is whether or not the room or piece of equipment would be acceptable in his own home. He stated he is aware of several ongoing projects in the facility.

On 6/6/22 at 4:27 p.m., ASM (administrative staff member) #1, the executive director, stated the facility is in the middle of correcting some needed maintenance concerns. He stated: "It's like a plan of correction." When asked if the facility's plan was completed prior to surveyor entrance, he stated it was not.

On 6/6/22 at 4:24 p.m., OSM #1 looked at R31's bathroom. He stated the broken tiles in the bathroom needed to be replaced, the toilet needed to be repaired, and the door needed to be patched and painted. He stated R31's bathroom

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was not homelike.

On 6/7/22 at 2:44 p.m., ASM #1 and ASM #2, the assistant director of nursing, were informed of these concerns.

No further information was provided prior to exit.

Complaint deficiency.

5. Resident #1's (R1's) outer door frame had gouges and chips. R1's bathroom door had multiple gouges surrounding the outer door knob. R1's toilet base was sticky, and contained black specks and debris. R1's bathroom walls contained multiple gouges. In the area behind R1's bed, a television coaxial cable ran from under R1's bed and through a five inch by three inch rectangular hole in the wall, exposing the area behind the wall. The air conditioner was dirty behind the filter.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/30/22, R1 was coded as being moderately impaired for making daily decisions, having scored 11 out of 15 on the BIMS (brief interview for mental status).

On the following dates and times, R1's room and bathroom were observed: 6/5/22 at 2:54 p.m., 6/6/22 at 8:13 a.m. At each observation, the outer door frame had gouges and chips. The bathroom door had multiple gouges surrounding the outer door knob. The toilet base was sticky, and contained black specks and debris, and the bathroom walls contained multiple gouges. In the area behind R1's bed, a television coaxial cable ran from under R1's bed and through a five inch

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by three inch rectangular hole in the wall, exposing the area behind the wall. Behind the air conditioner filter, debris, dust, and dirt were visible.

On 6/6/22 at 4:00 p.m., OSM (other staff member) #1, the maintenance director at a sister facility, was interviewed. He stated this facility does not currently have a maintenance director. He stated the two maintenance workers have been employed by the facility for only a short time. He stated the maintenance staff performs room audits, checking for paint, lighting, sinks, toilets, call bells, and any physical plant items. He stated these audits should be performed on each room every month. He stated he was not aware that the monthly audits were being completed for rooms at this facility in recent months. He stated any issues identified during a room audit should be addressed by either the maintenance or housekeeping staff. He stated the facility has the capacity to use a software system which tracks maintenance needs and maintenance completion. He stated the facility also utilizes paper forms staff members give to maintenance staff to report maintenance needs. He stated that when he performs room audits, his standard is whether or not the room or piece of equipment would be acceptable in his own home. He stated he is aware of several ongoing projects in the facility.

On 6/6/22 at 4:27 p.m., ASM (administrative staff member) #1, the executive director, stated the facility is in the middle of correcting some needed maintenance concerns. He stated: "It's like a plan of correction." When asked if the facility's plan was completed prior to surveyor entrance, he stated it was not.

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On 6/6/22 at 4:29 p.m., OSM #1 looked at R1's room and bathroom. He stated all gouges needed to be repaired and painted in both the door frame and the bathroom door. He stated the television cable access is an open hole and must be filled and covered with an acceptable plate. He stated the housekeeping staff was responsible for cleaning the air conditioner. He stated neither R1's bedroom nor bathroom was homelike.

On 6/6/22 at 4:47 p.m., OSM #2 looked at R1's room and bathroom. She stated the dirty air conditioner "is a maintenance issue." She stated housekeepers are not allowed to remove the air conditioner covers to clean the air conditioners. She stated the base of the toilet was dirty, and needed to be cleaned. She stated: "We also have a problem with rust.

On 6/7/22 at 2:44 p.m., ASM #1 and ASM #2, the assistant director of nursing, were informed of these concerns.

No further information was provided prior to exit.

Complaint deficiency.
6. The facility staff failed to maintain a homelike environment in Resident #54's (R54) room.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/14/2022, the resident scored 13 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is not cognitively impaired for making daily decisions.

On 6/5/2022 at 3:23 p.m., an observation was

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F 584	Continued From page 20 made of R54's room. R54's room was observed to be a semi-private room with two beds separated by a privacy curtain. Observation of the wall area under the sink in the center of the room was observed to be unpainted with cracked white exposed sheetrock underneath the sink. Observation of the area along the edging of the wall and floor border revealed that the baseboards were removed exposing unpainted wall underneath. At this time, an interview was conducted with R54. When asked about the missing baseboards along the walls in the room and unpainted wall near the sink, R54 stated that it had been that way for about a year. When asked how they felt about the room R54 stated that they did not like it. Additional observations of R54's room on 6/5/2022 at 6:10 p.m., 6/6/2022 at 8:45 a.m., and 6/6/2022 at 1:15 p.m., revealed the findings as described above. On 6/6/2022 at 4:00 p.m., an interview was conducted with OSM (other staff member) #1, the maintenance director at a sister facility. OSM #1 stated that they currently did not have a maintenance director at the facility and had two new maintenance assistants in the building. OSM #1 stated that maintenance staff were supposed to perform room audits every month checking paint, lighting, sinks, toilets and call bells. OSM #1 stated that facility staff had a computer system they could put any maintenance issues in and the management team also did environmental rounds and gave them issues to fix. OSM #1 stated that the expectation of the room audits were to provide a homelike environment. OSM #1 stated that they were not aware of any resident rooms that were currently	F 584		

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under any renovation except for the empty wing that was shut down for roof repairs. OSM #1 stated that they had a lot of turnaround of staff in the facility and in their opinion it was behind to be brought up. OSM #1 stated that they did audits a month or two ago and found some areas to improve but had not been back through to see what had been completed. OSM #1 stated that they did not go into every room and found things that they could see from the doorways or halls. OSM #1 was asked to provide any work orders or audits for any repairs or concerns for R54's room.

On 6/6/2022 at approximately 4:10 p.m., an observation was made of R54's room with OSM #1. R54's floor was observed to be freshly wet with a sign in the doorway, vinyl baseboards were observed to be placed along the wall at this time. OSM #1 stated that maintenance had begun working on the room earlier that day.

On 6/7/2022 at 10:54 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that any repairs or environmental concerns were put into the computer system. LPN #2 stated that they also could call maintenance over the intercom for needs. LPN #2 stated that when they go into the residents rooms they look for cleanliness and any safety concerns. LPN #2 stated that the building was old and they focused on the resident more than the environment. LPN #2 stated that they would notice that all the baseboards were missing in a room because it would stand out and that it was not homelike.

On 6/6/2022 at approximately 4:44 p.m., OSM #1 stated that they had reviewed their maintenance work orders and they had a work order in place

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for R54's room to repair the baseboards and the wall dated 2/15/2022. At this time a request was made to OSM #1 for a copy of the work order.

On 6/7/2022 at 7:30 a.m., ASM (administrative staff member) #1, the executive director, provided a copy of a work order dated 3/25/2022 for R54's room which documented a request, "door need to be painted."

On 6/6/2022 at 5:15 p.m., ASM #1, the executive director and ASM #2, the assistant director of nursing were made aware of the above concern.

No further information was presented prior to exit.

7. The facility staff failed to maintain a homelike environment in Resident #114's (R114) room.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/19/2022, the resident scored 3 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is severely impaired for making daily decisions.

On 6/5/2022 at 3:23 p.m., an observation was made of R114's room. R114's room was observed to be a semi-private room with two beds separated by a privacy curtain. Observation of the wall area under the sink in the center of the room was observed to be unpainted with cracked white exposed sheetrock underneath the sink. Observation of the area along the edging of the wall and floor border revealed that the baseboards were removed exposing unpainted wall underneath.

Additional observations of R114's room on

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6/5/2022 at 6:10 p.m., 6/6/2022 at 8:45 a.m., and 6/6/2022 at 1:15 p.m., revealed the findings as described above.

On 6/6/2022 at 4:00 p.m., an interview was conducted with OSM (other staff member) #1, the maintenance director at a sister facility. OSM #1 stated that they currently did not have a maintenance director at the facility and had two new maintenance assistants in the building. OSM #1 stated that maintenance staff were supposed to perform room audits every month checking paint, lighting, sinks, toilets and call bells. OSM #1 stated that facility staff had a computer system they could put any maintenance issues in and the management team also did environmental rounds and gave them issues to fix. OSM #1 stated that the expectation of the room audits were to provide a homelike environment. OSM #1 stated that they were not aware of any resident rooms that were currently under any renovation except for the empty wing that was shut down for roof repairs. OSM #1 stated that they had a lot of turnaround of staff in the facility and in their opinion it was behind to be brought up. OSM #1 stated that they did audits a month or two ago and found some areas to improve but had not been back through to see what had been completed. OSM #1 stated that they did not go into every room and found things that they could see from the doorways or halls. OSM #1 was asked to provide any work orders or audits for any repairs or concerns for R114's room.

On 6/6/2022 at approximately 4:10 p.m., an observation was made of R114's room with OSM #1. R114's floor was observed to be freshly wet with a sign in the doorway, vinyl baseboards were

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F 584	Continued From page 24 observed to be placed along the wall at this time. OSM #1 stated that maintenance had begun working on the room earlier that day. On 6/6/2022 at approximately 4:44 p.m., OSM #1 stated that they had reviewed their maintenance work orders and they had a work order in place for R114's room to repair the baseboards and the wall dated 2/15/2022. At this time a request was made to OSM #1 for a copy of the work order. On 6/7/2022 at 7:30 a.m., ASM (administrative staff member) #1, the executive director, provided a copy of a work order dated 3/25/2022 for R114's room which documented a request, "door need to be painted." On 6/7/2022 at 10:54 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that any repairs or environmental concerns were put into the computer system. LPN #2 stated that they also could call maintenance over the intercom for needs. LPN #2 stated that when they go into the residents rooms they look for cleanliness and any safety concerns. LPN #2 stated that the building was old and they focused on the resident more than the environment. LPN #2 stated that they would notice that all the baseboards were missing in a room because it would stand out and that it was not homelike. On 6/7/2022 at 5:15 p.m., ASM #1, the executive director and ASM #2, the assistant director of nursing were made aware of the above concern. No further information was provided prior to exit.	F 584		
F 645 SS=D	PASARR Screening for MD & ID	F 645		

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F 645	Continued From page 25 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 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	F 645	F645 1. The Level II screening for resident #90 was coordinated to be completed by the social worker. 2. An audit of all current residents was conducted on to ensure compliance with Level I and II screenings. All non-compliance corrections will be coordinated by the facility social worker/designee.	

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F 645	Continued From page 26 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 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 staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to complete a required PASRR (Preadmission Screening and Resident Review) (1) for one of 44 residents in the survey sample, Resident #90 (R90). The facility failed to complete a Level 2 PASRR as recommended on the resident's Level 1 PASRR dated 8/14/19.	F 645	3. Education was provided by the facility administrator to the admissions team on ensuring the appropriate pre-admission screenings according to federal/state guidelines are obtained on new admissions. Education was provided to the social services team on ensuring that appropriate coordination of services is completed upon identifying the need for level II screening after admission. 4. The Social Services director or designee will complete a weekly audit of all new admissions x 4 weeks then 10 per month x 2 months to ensure the appropriate pre-admission screenings according to federal/state guidelines are obtained. All non-compliance corrections will be coordinated by the facility social	

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F 645	Continued From page 27 The findings include: R90 was admitted to the facility with diagnoses that included bipolar disorder and depression. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/5/22, R90 was coded as being severely cognitively impaired for making daily decisions, having scored 4 out of 15 on the BIMS (brief interview for mental status). A review of R90's PASRR dated 8/14/19 (completed prior to admission to the facility) revealed, in part: "5 Recommendations (either 'a' or 'b' must be checked)...a. Refer for secondary assessment...MI (mental illness) or related condition: YES." All other questions in 5.a. and 5.b. were blank. On 6/7/22 at 9:03 a.m., OSM (other staff member) #11, the social services director, was interviewed. She stated when a resident is admitted, the admissions director is responsible for looking over a resident's PASRR to make sure all needed services for a resident are covered. She stated if a resident is admitted needing a Level 2 PASRR, someone should enter the resident's information into "the system" as a Level 2. When asked who is responsible for entering the information into the correct computer system to generate the required Level 2 screening, she stated: "Admissions." When asked to review the above referenced PASRR for R90, OSM #11 stated it appeared that R90 required a Level 2. She stated she could not find any evidence that the Level 2 screening had occurred. On 6/7/22 at 11:18 a.m., OSM (other staff	F 645	worker/designee and results will be communicated in the monthly QA meeting for review and suggestions	7/12/22

F 645 Continued From page 28 F 645

member) #10, the admissions director, was interviewed. When asked her role with PASRRs for newly admissions, she stated she makes sure the PASRRs are completed prior to a resident's admission. She stated she uploads the PASRR into the electronic medical record so other staff members can review it. She stated she does not have any role if the resident's PASRR recommends a resident receive a Level 2 screening.

On 6/7/22 at 2:44 p.m., ASM #1 and ASM #2, the assistant director of nursing, were informed of these concerns.

A review of the facility policy, "Preadmission Screening and Resident Review," revealed, in part: "The center will assure that all Serious Mentally Ill (SMI) and Intellectually Disabled (ID) residents receive appropriate pre-admission screenings according to Federal/State guidelines...The purpose is to ensure that the residents with SMI or are ID receive the care and services they need in the most appropriate setting...If it is learned after admission that a PASRR Level II screening is indicated, it will be the responsibility of Social Services to coordinate and/or inform the appropriate agency to conduct the screening and obtain the results."

No further information was provided prior to exit.

REFERENCE
(1) "PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care." This information is taken from the website https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/pread

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F 645	Continued From page 29 mission-screening-and-resident-review/index.html .	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656	F656 1. Resident #122 comprehensive care plan is being followed to be sure the resident's call light is within reach. 2. A Quality review of care plans for residents with intervention to place call bell within reach will be completed by the MDS or designee to ensure that the comprehensive care plans are being implemented as written. Follow up based on findings. 3. 3. The licensed nursing staff will be re- educated on implementing and following comprehensive care plan to reflect the resident's current status to include the call bell within reach.	

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F 656	Continued From page 30 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, staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for one of 44 residents in the survey sample, Resident #122 (R122). The facility staff failed to implement the comprehensive care plan for having R122's call bell within their reach for the prevention intervention for falls. The findings include: On the most recent MDS (minimum data set) assessment, a quarterly assessment with an assessment reference date of 5/23/2022, the resident scored a 7 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired for making daily decisions. The comprehensive care plan dated, 2/18/2022 documented in part, "Focus: (R122) is at risk for falls." The "Interventions" documented in part, "2/18/2022 - call bell encouraged. 4/6/2022 - Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed."	F 656	4. The interdisciplinary team will audit call bell within reach. Audit daily for 4 weeks, weekly x 4 and then monthly for 3 months. Results will be reviews will be discussed by the administrator and/or designee at the Quality Assurance Performance Improvement meetings monthly for three months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	7/12/22

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Observation was made on 6/5/2022 at 3:22 p.m. of R122 in their bed. The call bell was not within the resident's reach. A second observation was made on 6/6/2022 at 10:25 a.m. of R122 in their bed. The call bell was not within the resident's reach, it was located on a foot pedal, which had been removed from a wheelchair, sitting next to their bed. A third observation was made on 6/6/2022 at 4:48 p.m. The call bell was not within the resident's reach, it was located on a foot pedal, which had been removed from a wheelchair, sitting next to their bed.

An interview was conducted with LPN (licensed practical nurse) #6 on 6/6/2022 at 4:55 p.m. When asked if the care plan documents to keep the resident's call bell within reach and encourage the resident to use it, and the call bell has not been in place, is that following the care plan, LPN #6 stated no, since she observed it in the same place as the surveyor, it was not following the care plan.

ASM (administrative staff member) #1, the executive director, and ASM #2, the assistant director of nursing, were made aware of the above concern on 6/7/2022 at 2:54 p.m. A request was made for the policy on call bells on 6/7/2022 at approximately 5:00 p.m.

The facility policy, "Plans of Care" documented in part, "Develop and implement an Individualized Person-Centered comprehensive plan of care by the
Interdisciplinary Team that includes but is not limited to - the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and other

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F 656	Continued From page 32 appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident, and, to the extent practicable, the participation of the resident and the resident's representative(s) within seven (7) days after completion of the comprehensive assessment (MDS)." 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) §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	F 657	F657 1. Resident R122 comprehensive care plan will be revised with interventions for fall 2. Quality review of care plans for current residents with change of condition including falls will be completed by the MDS or designee to ensure that the comprehensive care plans have been updated with interventions to address the condition and are being implemented as written. Follow up based on findings.	

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F 657	Continued From page 33 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 comprehensive care plan after a fall, for one of 44 residents in the survey sample, Resident #122 (R122). The findings include: On the most recent MDS (minimum data set) assessment, a quarterly assessment with an assessment reference date of 5/23/2022, the resident scored a seven out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is severely cognitively impaired for making daily decisions. In Section J - Health Conditions, the resident was coded as having had falls since their last admission/entry/readmission/prior assessment. R 122 was coded as having had two or more falls during the look back period. The nurse's note dated 4/2/2022 at 12:49 p.m. documented, "Resident awake and alert can make needs known denied pain/discomfort when writer was giving medication to roommate resident was observed sitting in bathroom in wheelchair she was cursing out loud as she was trying to get closer to the toilet, when writer attempted to redirect resident began yelling and rocking back and forth and slid out of the wheelchair. Resident was assessed head to toe with no obvious external injuries noted no change in ROM (range of motion) to right upper/lower extremities and left lower extremity, her left upper extremity had previous deficits."	F 657	3. The licensed nursing staff will be re-educated by DCS/designee on implementing and following comprehensive care plan to reflect the resident's current status to revise after a fall. 4. DCS/designee will audit revise of care plan after fall daily for 4 weeks, weekly x 4 and then monthly for 3 months. Results will be reviews will be discussed by the administrator and/or designee at the Quality Assurance Performance Improvement meetings monthly	

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F 657	Continued From page 34 The "Report of Resident Fall" dated 4/2/2022 at 9:00 a.m. documented in part, "While giving B bed medication observed resident wheeling self into bathroom was attempting to get closer to toilet and while trying to redirect her she slid to the floor from wheelchair into sitting position. Witnessed fall. Location of Event: resident restroom. Where was the resident's last known location? In wheelchair at sink brushing teeth. Footwear was in use at the time of event? Shoes. Activity at time of event - going to bathroom unassisted. Was the resident assessed for fall prior to event - yes. Did the president's Plan of Care include falls prevention - yes." A checkmark was placed next to: A new Plan of Care/Intervention has been completed to prevent further events. NOTE: A new Plan of Care/Intervention MUST be completed to prevent further events and these new changes communicated to staff." The comprehensive care plan dated, 2/18/2022, documented in part, "Focus: (R122) is at risk for falls." The "Interventions" were reviewed. There was no new intervention put in place for the fall noted above on 4/2/2022. LPN An interview was conducted with ASM (administrative staff member) #2, the assistant director of nursing, on 6/7/2022 at 8:31 a.m. When asked who is responsible for updated the care plan, ASM #2 stated the unit managers and MDS is the gate keeper and does most of it. When a resident has a fall, who updates the care plan, ASM #2 stated the unit managers. An interview was conducted with LPN (licensed practical nurse) #7, the unit manager, on	F 657	for three months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	7/12/22

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6/7/2022 at 8:35 a.m. When asked who updates the care plans, LPN #7 stated the nurses, unit managers, and MDS does most of the care plans but social workers, ADON (assistant director of nursing) and DON (director of nursing) update them too. If a resident has a fall, who updates the care plan, LPN #7 stated the nurse on the floor and the unit manager follows up on it to make sure the care plan was updated. LPN #7 reviewed the care plan for R112 for the fall of 4/2/2022. LPN #7 stated she did not see where it had been updated for the fall of 4/2/2022. LPN #7 stated she could not tell me she updated it, only thing she could say is that it may not have been care planned on that day but someone could have gone back and updated it. When asked the purpose of the care plan, LPN #7 stated it's to identify the resident and when they go out a copy of it goes with them so the people responsible for caring for them know what is going on with the resident. LPN #7 stated the care plan is a picture of how the resident is reacting, falls, therapy etc.

On 6/7/2022 at 9:23 a.m. ASM #2 stated that all nurses can update the care plan and it's supposed to be updated at the time of a fall.

The facility policy, "Fall Management" documented in part, "Post Fall Strategies: 5. Update Care plan and Nurse Aide Kardex with intervention(s)...8. Update plan of care with new interventions as appropriate."

ASM (administrative staff member) #1, the executive director, and ASM #2, the assistant director of nursing, were made aware of the above concern on 6/7/2022 at 2:54 p.m.

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 684 SS=D	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 staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services in accordance with professional standards and the comprehensive care plan for the treatment of wounds for one of 44 residents in the survey sample, Resident #180 (R180). The findings include: The facility staff failed to administer treatments for a diabetic foot wound and a lateral ankle infectious wound. R180 was admitted to the facility with diagnoses that included but were not limited to: diabetes, history of venous thrombosis, congestive heart failure, bullous pemphigoid, atrial fibrillation, osteoarthritis, and chronic kidney disease. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/23/2021, the resident scored a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions. In Section M - Skin	F 684	F684 1. Resident #180 no longer resides in the facility 2. A quality review of current residents has been completed to ensure the physician has been notified of residents' changes in skin condition and treatment orders are being administered per the Physician's orders, along with documentation by the Licensed nurse on the TAR (Treatment Administration Record).	

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F 684	Continued From page 37 conditions, the resident was coded as having infection of the foot and diabetic foot ulcers. For left lateral ankle: The physician order dated, 10/14/2021 documented, "Cleanse left lateral ankle with NS (normal saline) pat dry apply Santyl and cover with dry dressing every day every day shift." The October 2021 TAR (treatment administration record) documented the above order. There were no signatures documented to indicate the treatment was completed on 10/16/2021 and 10/20/2021. The physician order dated, 10/23/2021 documented, "Santyl Ointment: apply to (L) (left) lateral ankle topically every day shift for wound care. Cleanse (L) lateral ankle w/ (with) NS, pat dry, apply Santyl, calcium alginate and dry DSG (dressing) Q (every) day," The October TAR documented the above order. There were no signatures documented to indicate the treatment was completed on 10/28/2021. The physician order dated, 11/11/2021 documented, "Cleanse (L) lateral ankle w/ NS, pat dry, apply Manuka Honey, calcium alginate and dry Dsg Q day." The November 2021 TAR documented the above order. There were no signatures documented to indicate the treatment was completed on 11/12/2021. The physician order dated, 11/18/2021 documented, "Santyl Ointment: Apply to (L) lateral ankle topically every day shift for wound care. Cleanse (L) lateral ankle w/ NS, pat dry, apply Santyl, Calcium Alginate and dry DSG." The November TAR documented the above order.	F 684	3. Licensed Nurses re-educated by DCS/Designee regarding notifying the physician of resident's changes in skin condition and treatment orders are being administered per the Physician's orders, along with documentation by the Licensed nurse on the TAR (Treatment Administration Record). 4. DCS/Designee to conduct quality monitoring regarding notifying the physician of resident's changes in	

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F 684	Continued From page 38 There were no signatures documented to indicate the treatment was completed on 11/19/2021 and 11/25/2021. The December 2021 TAR documented the above order. There were no signatures documented to indicate the treatment was completed on 12/9/2021 and 12/14/2021. For right heel: The physician order dated, 10/28/2021 documented, "Santyl Ointment: apply to (R) (right) heel topically every day and evening shift for wound care. Cleanse (R) heel w/ NS, pat dry, apply Santyl Calcium alginate and dry DSG Q day. The October TAR documented the above order. There were no signatures documented to indicate the treatment was completed on 10/29/2021. The physician order dated 10/28/2021 documented, "Santyl Ointment: apply to (R) heel topically every day and evening shift for wound care. Cleanse (R) heel w/ NS, pat dry, apply Santyl Calcium alginate and dry DSG Q day." The November TAR documented the above order. There were no signatures documented to indicate the treatment was completed on 11/8/2021 in the morning and on 11/10/2021 in the evening. The physician order dated, 11/11/2021 documented, "Cleanse (R) heel w/ NS, pat dry, apply calcium alginate Silver and dry Dsg Q day." The November TAR documented the above order. There were no signatures documented to indicate the treatment was completed on 11/12/2021. The physician order dated, 11/18/2021 documented, "Santyl Ointment; Apply to (R) heel	F 684	skin condition and treatment orders are being administered per the Physician's orders, along with documentation by the Licensed nurse on the TAR (Treatment Administration Record). Audit daily for 4 weeks, weeklyx4 and then monthly for 3 months weeks and turn results into the Administrator and/or designee for review. Results will be reviewed/ discussed by the administrator and/or designee at the Quality Assurance Performance Improvement meetings monthly for three months.	

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F 684	Continued From page 39 topically every day shift for Wound Care. Cleanse (R) heel w/ NS, pat dry, apply Santyl, calcium alginate and dry Dsg Q day." The November TAR documented this order. There were no signatures documented to indicate the treatment was completed on 11/19/2021 and 11/25/2021. The December TAR documented the above order. There were no signatures documented to indicate the treatment was completed on 12/9/2021 and 12/14/2021. The comprehensive care plan dated 8/23/2021, documented in part, "Focus: (R180) has (L) lateral ankle infection wound." The comprehensive care plan dated, 7/7/2021, documented in part, "Focus: The resident has diabetic ulcer of the (R) heel r/t (related to) diabetes, renal disease." An interview was conducted with LPN (licensed practical nurse) #8 on 6/7/2022 at 12:58 p.m. When asked what it indicates when there are blanks on the TAR, LPN #8 stated the nurse did not sign it off. When asked how do you know that the treatment was done, LPN #8 stated, "You don't know if it was completed or not." An interview was conducted with ASM (administrative staff member) #2, the assistant director of nursing, on 6/7/2022 at 2:14 p.m. ASM #2 was asked to review the above TARs for October, November and December 2021 for R180. When asked what the blanks indicated, ASM #2 stated more than likely the nurse forgot to click it off. When asked how you know they did the treatment, ASM #2 stated, if it's not documented, not sure if it was done. A policy was requested for following physician	F 684	The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	7/12/22

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F 684	Continued From page 40 orders on 6/7/2022 at approximately 4:30 p.m. The facility presented on 6/6/2022 at 9:19 a.m., a copy of their standard of practice reference: Clinical Nursing Skills & Techniques, Perry and Potter. In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients." ASM (administrative staff member) #1, the executive director, and ASM #2, the assistant director of nursing, were made aware of the above concern on 6/7/2022 at 2:54 p.m. No further information was provided prior to exit.	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.	F 686	686 1. Resident #180 no longer resides in the facility 2. A quality review of current residents with pressure ulcers has been performed. 3. Licensed Nurses re-educated by DCS/Designee regarding following Physician orders on documenting on Treatment Administration Records	

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F 686	Continued From page 41 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 provide care and services in accordance with professional standards and the comprehensive care plan for the treatment of pressure injuries for one of 44 residents in the survey sample, Resident #180 (R180). The findings include: The facility staff failed to administer treatments for a pressure injury on R180's left foot, big toe and treatment to the right lateral malleolus for prevention of pressure injuries. R180 was admitted to the facility with diagnoses that included but were not limited to: diabetes, history of venous thrombosis, congestive heart failure, bullous pemphigoid, atrial fibrillation, osteoarthritis, and chronic kidney disease. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/23/2021, the resident scored a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions. In Section M - Skin conditions, the resident was coded as having one unstageable pressure injury with slough and/or eschar and one unstageable wound that was a deep tissue injury. The physician order dated, 10/28/2021 documented, "Derma Prep (L) (left) foot anterior 1st digit BID (twice a day) every day and evening shift for wound care." The November TAR (treatment administration record) documented	F 686	4. DCS/Designee to conduct quality monitoring regarding physician orders being followed as written for the administration of treatments, to include documentation by the licensed nurse in the TAR (Treatment Administration Record). Audit weekly daily 4 weeks, weeklyx4 and then monthly for 3 months weeks and turn results into the Administrator and/or designee for review. Results will be reviewed/ discussed by the administrator and/or designee at the Quality Assurance Performance Improvement meetings monthly for three	

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F 686	Continued From page 42 this order. There were no signatures documented to indicate the treatment was completed on 11/8/2021 during the day shift and 11/10/2021 on the evening shift. The December 2021 TAR documented the above order. There were no signatures documented to indicate the treatment was completed on 12/1/2021 evening shift and 12/14/2021 day shift. The physician order dated, 11/17/2021 documented, "Skin prep right lateral malleolus for prevention of pressure ulcer every morning and at bed time." The November TAR documented this order. There were no signatures documented to indicate the treatment was completed on 11/22/2021 day shift and on 11/29/2021 day shift. The December TAR documented this order. There were no signatures documented to indicate the treatment was completed on 12/1/2021 day shift, 12/18/2021 day shift and 12/20/2021 day shift. The comprehensive care plan dated, 3/19/2021 documented in part, "Focus: The resident has SDTI (suspected deep tissue injury) 1st digit or potential for pressure injury development r/t (related to) Hx (history) of ulcers, DM (diabetes mellitus)." The "Interventions" documented in part, "Administer medications as ordered. Monitor/document for side effects and effectiveness. Follow facility policies/protocols for the prevention/treatment of skin breakdown." The Braden Scale for Predicting Pressure Sore Risk dated, 101/3/2021, documented the resident had a score of 18, indicating the resident was "at risk" for developing pressure injuries.	F 686	months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	7/12/22

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F 686	Continued From page 43	F 686		

The wound care specialist notes dated 12/29/2021 documented the left foot anterior 1st digit wound as an unstageable DTI (deep tissue injury), anterior, first toe. This wound was resolved on 12/29/2021.

An interview was conducted with LPN (licensed practical nurse) #8 on 6/7/2022 at 12:58 p.m. When asked what it indicates when there are blanks on the TAR, LPN #8 stated the nurse did not sign it off. When asked how do you know that the treatment was done, LPN #8 stated, "You don't know if it was completed or not."

An interview was conducted with ASM (administrative staff member) #2, the assistant director of nursing, on 6/7/2022 at 2:14 p.m. ASM #2 was asked to review the above TARs for October, November and December 2021 for R180. When asked what the blanks indicated, ASM #2 stated more than likely the nurse forgot to click it off. When asked how you know they did the treatment, ASM #2 stated, if it's not documented, not sure if it was done.

The facility policy, "Clinical Guideline Skin & Wound" documented in part, "To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/ prevention of pressure injury...Licensed Nurse to document presence of skin impairment/new skin impairment when observed and weekly until resolved. Licensed Nurse to report changes in skin integrity to the physician/practitioner and resident/responsible party and document in the medical record. Develop individualized goals and interventions and document on the care plan and

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F 686	Continued From page 44	F 686		

the CNA (certified nursing assistant) Kardex...Monitor residents' response to treatment and modify treatment as indicated. Evaluate the effectiveness of interventions, and progress towards goals during the care management meeting and as needed."

The facility presented on 6/6/2022 at 9:19 a.m., a copy of their standard of practice reference: Clinical Nursing Skills & Techniques, Perry and Potter.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

ASM (administrative staff member) #1, the executive director, and ASM #2, the assistant director of nursing, were made aware of the above concern on 6/7/2022 at 2:54 p.m.

No further information was provided prior to exit.

Pressure Injury:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (1)

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F 686	Continued From page 45 Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.(1) Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.(1). (1) This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf.	F 686		
F 745 SS=D	Provision of Medically Related Social Service	F 745		

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F 745	Continued From page 46 CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide medically related social services for one of one of 44 residents in the survey sample, Resident #90 (R90). The facility failed to complete a Level 2 PASRR (Preadmission Screening and Resident Review) (1) as recommended on the resident's Level 1 PASRR dated 8/14/19. The findings include: R90 was admitted to the facility with diagnoses that included bipolar disorder and depression. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/5/22, R90 was coded as being severely cognitively impaired for making daily decisions, having scored 4 out of 15 on the BIMS (brief interview for mental status). A review of R90's PASRR (Preadmission Screening and Resident Review) dated 8/14/19 (completed prior to admission to the facility) revealed, in part: "5 Recommendations (either 'a' or 'b' must be checked)...a. Refer for secondary assessment...MI (mental illness) or related condition: YES." All other questions in 5.a. and 5.b. were blank. On 6/7/22 at 9:03 a.m., OSM (other staff	F 745	F745 1.) The Level II screening for resident #90 was coordinated to be completed by the social worker. 2. An audit of all current residents was conducted on to ensure compliance with Level I and II screenings. All non-compliance corrections will be coordinated by the facility social worker/designee. 3. Education was provided by the facility administrator to the admissions team on ensuring the appropriate pre-admission screenings according to federal/state guidelines are	

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F 745	Continued From page 47 member) #11, the social services director, was interviewed. She stated when a resident is admitted, the admissions director is responsible for looking over a resident's PASRR to make sure all needed services for a resident are covered. She stated if a resident is admitted needing a Level 2 PASRR, someone should enter the resident's information into "the system" as a Level 2. When asked who is responsible for entering the information into the correct computer system to generate the required Level 2 screening, she stated, "Admissions." When asked to review the above referenced PASRR for R90, OSM #11 stated it appeared that R90 required a Level 2. She stated she could not find any evidence that the Level 2 screening had occurred. When asked whether or not facilitating the completion of a Level 2 PASRR is a medically related social service, she stated: "Yes, it is." On 6/7/22 at 11:18 a.m., OSM (other staff member) #10, the admissions director, was interviewed. When asked her role with PASRRs for newly admissions, she stated she makes sure the PASRRs are completed prior to a resident's admission. She stated she uploads the PASRR into the electronic medical record so other staff members can review it. She stated she does not have any role if the resident's PASRR recommends a resident receive a Level 2 screening. On 6/7/22 at 2:44 p.m., ASM #1 and ASM #2, the assistant director of nursing, were informed of these concerns. A review of the facility policy, "Preadmission Screening and Resident Review," revealed, in part: "The center will assure that all Serious	F 745	obtained on new admissions. Education was provided to the social services team on ensuring that appropriate coordination of services is completed upon identifying the need for level II screening after admission. 4. The Social Services director or designee will complete a weekly audit of all new admissions x 4 weeks then 10 per month x 2 months to ensure the appropriate pre-admission screenings according to federal/state guidelines are obtained. All non-compliance corrections will be	

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F 745	Continued From page 48 Mentally Ill (SMI) and Intellectually Disabled (ID) residents receive appropriate pre-admission screenings according to Federal/State guidelines...The purpose is to ensure that the residents with SMI or are ID receive the care and services they need in the most appropriate setting...If it is learned after admission that a PASRR Level II screening is indicated, it will be the responsibility of Social Services to coordinate and/or inform the appropriate agency to conduct the screening and obtain the results." A review of the facility policy, "Social Services," revealed, in part: "Medically-related social services will be provided to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident...Social Service personnel will identify the medically related social and emotional needs of residents and their families and provide for those needs by...Facilitating access to community resources/supports." No further information was provided prior to exit. REFERENCE (1) "PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care." This information is taken from the website https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/preadmission-screening-and-resident-review/index.html .	F 745	coordinated by the facility social worker/designee and results will be communicated in the monthly QA meeting for review and suggestions	7/12/22
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors.	F 759		

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F 759	Continued From page 49 The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; 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 ensure a medication error rate less than five percent for two of four residents observed during the medication administration observation. During the medication administration observation, 2 errors out of 27 opportunities occurred, resulting in a 7.41 percent medication error rate. The findings include: 1. The facility staff failed to administered the correct physician prescribed dose of 500 mg (milligrams) of an antacid medication to Resident #37 (R37). Instead, LPN (licensed practical nurse) #1 administered 750 mg of the medication on 6/6/22. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/31/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. A review of R37's clinical record revealed a physician's order dated 3/11/22 for a chewable calcium carbonate antacid- 500 mg- one tablet by mouth after meals for low calcium. A review of R37's June 2022 medication administration record revealed documentation of the physician's order for a 500 mg tablet of	F 759	F759 1. Resident # 37 was administered the wrong dose of medication. LPN #1 was educated per facility policy on medication administration. Resident # 33 was administered the wrong dose of medication. LPN #1 was educated per facility policy on medication administration. 2. Quality review of nursing medication pass for all license nurses was conducted by DON/ designee to ensure that Medication passes are being performed per facility policy on medication administration.	

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F 759	Continued From page 50 calcium carbonate antacid and the medication was scheduled for each day at 9:00 a.m., 1:00 p.m. and 5:00 p.m. On 6/6/22 at 8:25 a.m., LPN #1 was observed preparing and administering medications for R37. LPN #1 administered 750 mg of the (store-brand name) calcium carbonate to the resident. On 6/6/22 at 2:12 p.m., an interview was conducted with LPN #1, regarding the process for ensuring the correct medication is administered. LPN #1 stated she pulls up the resident's name (in the computer system), looks at the physician's orders and looks at the medication sleeve to make sure she has the correct resident name, medication name, dose and time. LPN #1 stated she does this three times then calls out the resident's name when she enters the resident's room. At this time, LPN #1 was made aware of the above observation. On 6/6/22 at 2:18 p.m., LPN #1 called the nurse practitioner and made her aware of the medication error. On 6/6/22 at approximately 5:20 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the assistant director of nursing) were made aware of the above concern. The facility policy titled, "Medication- Oral Administration of" documented, "Review physician's order... Review the MAR (medication administration record) or EMAR (electronic medication administration record) should there be any uncertainties verify the MAR or EMAR with the Physician's Order Sheet (POS) and seek clarification as indicated... Compare the medication unit/dose label against	F 759	3. The licensed nursing staff re- educated on the five rights of medication administration per facility policy. 4. DON/designee to conduct quality review of random Med passes weekly for 4 weeks to validate implementation of the five rights to medication administration. Results will be reviewed and discussed by the administrator and/or designee at the Quality Assurance Performance Improvement meetings monthly for three months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	7/12/22

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F 759	Continued From page 51 the MAR or EMAR prior to returning the medication container or card to the medication cart or disposing of the empty container; and prior to supporting the resident to accept and ingesting the medication..." No further information was presented prior to exit. 2. The facility staff failed to administer prescribed Fluticasone nasal spray as ordered to Resident #33 (R33) during the medication administration observation on 6/6/2022. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/28/2022, the resident scored 5 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired for making daily decisions. On 6/6/2022 at 8:13 a.m., an observation was made of LPN (licensed practical nurse) #4 who was administering medications at the facility. LPN #4 prepared R33's medications which included oral medications and Fluticasone propionate 50 mcg nasal spray. With permission from R33 an observation was made of LPN #4 administering the medication. LPN #4 administered R33's oral medication followed by administering two consecutive sprays of the Fluticasone prop. nasal spray into R33's left nostril and then the right nostril. The physician orders for R33 documented the medications listed above. The physician order for the Fluticasone propionate nasal spray documented, "Fluticasone Propionate Suspension 50 mcg/act 1 (one) spray in both nostrils every 12 hours related to Allergic Rhinitis,	F 759		

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F 759	Continued From page 52 unspecified. Order Date: 03/17/2022." On 6/6/2022 at approximately 8:20 a.m., an interview was conducted with LPN #4. When asked about the number of sprays ordered for the Fluticasone prop. nasal spray for R33, LPN #4 stated that R33 was supposed to receive one spray in each nostril. LPN #4 stated that they often had to spray twice to get the sprayer to prime and get the medication to go into the nostril. LPN #4 removed the Fluticasone prop. nasal spray and sprayed it into the air which misted medication with the first spray and stated that it was working now that it was primed. On 6/6/2022 at 5:15 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the assistant director of nursing were made aware of the findings. No further information was provided prior to exit.	F 759		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, it was determined that the facility staff failed to serve food in a palatable manner	F 804	F804 1. The Food Palatability finings during survey are duly noted. 2. Current residents can be affected by the alleged deficiency. 3. Education and Review of policies and procedures related to Nutritive Value, Appearance & Palatability and re-education of Dietary Services Manager and Dietary Staff on was completed on by the Dietary Services District Manager.	

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F 804	Continued From page 53 from one of one kitchen. The findings include: On 06/05/2022 during individual interviews with residents, complaints were voiced about the facility's meals not being hot and not having any flavor. On 06/05/2022 at approximately 6:30 p.m. a test tray consisting of chicken tenders, french fries, chopped spinach, pureed chicken, mashed potatoes and carrots were placed on a cart in the kitchen, sent to the North-east section of unit two and placed in the food cart. The cart was followed by this and another surveyor, OSM (other staff member) #3, account manager (facility's title for dietary manager) and OSM # 4, cook. At approximately 6:54 p.m., the last dinner tray was served to a resident on the North-east section of unit two and OSM # 4 was asked to remove the test tray from the food cart. OSM #4 placed it on top of a cart then proceeded to take the temperatures of the food. OSM #4 was observed obtaining the test tray food temperatures using a facility thermometer. All of the pureed food was above 133 degrees F (Fahrenheit). The chicken tenders were 117 degrees F and the french fries were 108 degrees F. The test tray was sampled by two surveyors, OSM # 3 and OSM # 4 for appropriate appetizing temperatures and palatable taste. When asked to describe the taste of the pureed food and the chopped spinach OSM # 3 and OSM # 4 stated that it was warm enough and palatable. After tasting the chicken tenders and french fries OSM # 3 and OSM # 4 stated that the items should	F 804	4. The Dietary Services Manager or Designee will complete a random customer service audit of 10 alert & oriented residents weekly x 12 weeks to assess palatability, nutritive value and appearance of meals. The Dietary Manager will complete a test tray audit rotating through breakfast, lunch, and dinner 3x week x 12 weeks. Results will be communicated in the monthly QA meeting for review and recommendations.	7/12/22

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F 804	Continued From page 54 have been hotter and did not taste good due to the low temperature. On 06/06/2022 at approximately 5:00 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, assistant director of nursing, were made aware of the above findings. No further information was provided prior to exit.	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review it was determined that the facility staff failed to honor reasonable food preferences and choices for one of 44 residents in the survey sample, Resident #24. The findings include: On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 3/13/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment,	F 806	1. The dietary manager met with resident #24 about her food choices and preferences and honoring reasonable requests. 2. All current resident has the potential to be affected should the facility fail to honor reasonable food choices and preferences. 3. The Dietary Services District Manager completed education and a review of policies and procedures related to obtaining and honoring reasonable food choices and preferences for dietary staff.	

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F 806	Continued From page 55 indicating the resident was not cognitively impaired for making daily decisions. On 6/5/2022 at 5:05 p.m., an interview was conducted with Resident #24 (R24). R24 stated that they used to be able to order a salad from the kitchen for their dinner when they did not want a full meal but over the past two months the menus had changed and they did not receive salads anymore. R24 stated that it had been about 4 weeks since they had gotten a salad and the last one they received was with a meal as a side and was only lettuce with dressing on it. R24 stated that they were a diabetic and at times they only wanted to have a salad for dinner and then have a bedtime snack as an option. R24 stated that they had spoken to the dietary manager and they were told that they could not get salads. The physician orders for R24 documented in part, "Consistent Carbohydrates (CCD) diet, Regular texture, regular/thin liquids consistency, provide night time snack. Order Date: 5/4/2022..." The "Nutrition Evaluation Initial, Annual and Significant Change" for R24 dated 3/28/2022, documented in part, "...Liberalize diet to regular d/t (due to) weight loss. Review and update poc (plan of care)..." Review of the facility "Week-At-A-Glance" menus for Week 1 documented a tossed salad with dressing on the menu as a side dish for lunch on Saturdays. The menu for Week 2 documented a Caesar salad as a side dish for lunch on Tuesdays and a tossed salad with dressing as a side for dinner on Saturdays. The menu for Week 3 documented a Caesar salad as a side dish for lunch on Sundays. The menu for Week 4	F 806	4. The Dietary Services Manager or Designee will complete a random customer service audit of 10 alert & oriented residents weekly x 12 weeks to assess the facilities efforts to honor reasonable food choices and preferences. Results will be communicated in the monthly QA meeting for review and recommendations.	7/12/22

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F 806	Continued From page 56	F 806		

documented a tossed salad with dressing as a side for dinner on Sundays.

On 6/7/2022 at 12:55 p.m., an interview was conducted with OSM (other staff member) #3, the account manager. OSM #3 stated that they used to offer salads to residents but they stopped about a month ago. OSM #3 stated that they were told by their district manager that they were to follow their play sheet and salads were not on them. OSM #3 stated that they offered soup or a sandwich as an alternative. OSM #3 stated that they did not know why they were told not to offer salads anymore. OSM #3 stated that they spoke to all residents on admission to discuss food preferences and completed a food preference assessment. OSM #3 stated that they updated the assessment if the nurse called them and told them that something had changed but did not routinely go back and talk to the residents. OS #3 stated that they had spoken to R24 regarding requesting salads and had explained that if they fixed salads for them specially then they would have to offer them to all of the residents.

On 6/7/2022 at 1:53 p.m., an interview was conducted with OSM #13, the district manager. OSM #13 stated that any special requests by residents were honored as long as sufficient notice was provided. OSM #13 stated that occasionally residents preferred to have a salad for their meal rather than what was on the menu and that was honored as long as made in a reasonable time. OSM #13 stated that the same day would be a reasonable timeframe to request a salad for a meal. OSM #13 stated that they were not aware that the kitchen was not providing salads when requested by residents. At 1:58 p.m., OSM #3, the account manager joined the

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F 806	Continued From page 57 interview. OSM #3 advised OSM #13 that they were not offering salads to residents upon request and stated that they were not on the plate sheet. OSM #3 advised OSM #13 that the previous district manager had advised them that they were only allowed to serve salads when they were on the scheduled menu as posted. OSM #3 stated that the previous district manager advised them that when their new contract came along they were told to do what was on it and extra salads were not on it. OSM #13 stated that they were a contracted company and were working on an always available menu and that salads were going to be a part of it. OSM #13 stated that they were going to have OSM #3 conduct an updated food preference assessment for R24. The facility policy "Virginia Resident's rights and responsibilities" dated 01/07 documented in part, "...As a nursing facility resident, you have the following rights under federal and state law: ...To make choices about your life in the facility that are important to you..." On 6/7/2022 at 5:15 p.m., ASM (administrative staff member) #1, the executive director and ASM #2 the assistant director of nursing were made aware of the above concern. No further information was presented prior to exit.	F 806		
F 812 SS=E	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,	F 812	1. OSM #9 was educated on the importance of wearing the proper attire to include a hairnet to ensure hair is properly restrained. OSM #3 was educated on the facilities ware washing policy. 2. All residents are at risk should staff remain deficient with this practice. 3. The Dietary Services District Manager completed education on the facility's policy on staff attire for dietary staff and on ware washing.	

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F 812	Continued From page 58 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 the facility staff failed to prepare food in the facility's kitchen in a sanitary manner in one of one facility kitchens. The findings include: 1. The facility staff failed to wear a hair net while preparing residents dinner trays in the facility's kitchen. On 06/05/2022 at approximately 4:25 p.m., an observation of the dinner preparation was conducted in the facility's kitchen in the presence of OSM (other staff member) # 3, account manager. Observation of the tray line in the kitchen revealed OSM # 9 standing approximately half way down the tray line. The cook plated the food and place it on the tray opposite OSM # 9 and OSM # 9 placed beverages on the resident's meal trays before the plates were covered from 4:55 p.m. through 5:55 p.m. Observation of OSM	F 812	4. The Dining services manager/designee will conduct an audit of employee attire 5 days /week x 8 weeks then weekly x 4 weeks to ensure compliance with the policy. The dining services manager will randomly audit the ware washing process 3x per week x 12 weeks. Results will be communicated in the monthly QA meeting for review and recommendations.	7/12/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 59	F 812		

9 revealed that they did not have their hair covered during the observation time stated above.

On 06/05/2022 at approximately 6:00 p.m. an interview was conducted with OSM # 9. When asked about the use of a hair net when working in the kitchen OSM # 9 stated that they had a hair net and that it must have fallen off.

On 06/06/2022 at approximately 3:10 p.m. an interview was conducted with OSM # 3, account manager. When asked about OSM # 9 not wearing a hair net or head covering during the above observation OSM # 3 stated that they though OSM # 9 was wearing a hair net. When asked why a hair net or head covering is needed when working in the kitchen OSM # 3 stated that it keeps hair from falling into the food or drinks.

The facility's policy "Staff Attire" documented in part, "1. All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained."

On 06/06/2022 at approximately 5:00 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, assistant director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

2. On 06/05/2022 at approximately 6:05 p.m., an observation of the facility's dish room revealed OSM (other staff member) # 3, account manager removing and wiping dry, clean plate covers.

On 06/05/2022 at approximately 4:25 p.m., an observation of the dinner preparation was

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	495362	A. BUILDING ______ B. WING ______	C 06/07/2022

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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 812	Continued From page 60 conducted the facility's kitchen. At approximately 6:05 p.m., OSM # 3 was observed in the dish room area. A dietary staff member was unloading food carts that had come back to the kitchen with dirty dinner dishes, trays, silverware, palates and plate covers. Further observation revealed the dietary staff member removing only the plate covers and putting them through the automatic dishwasher. OSM # 3 was observed removing clean, wet plate covers that had just come out of the automatic dishwasher, and drying them with a towel. Further observation revealed that after hand drying the plate covers, they took them to the tray line and another dietary aide placed them over the resident's food and loaded into the food carts. The food carts were then taken out of the kitchen, into the hallways where other facility staff delivered the meal trays to the residents. On 06/06/2022 at approximately 3:10 p.m. an interview was conducted with OSM # 3, account manager. When asked about hand drying the plate covers OSM # 3 stated that the covers were not air drying fast enough. When asked about hand drying the plate covers OSM # 9 stated that they did not have enough of them and it would take to long for them to air dry. When asked if the cover should hand dried OSM # 3 stated that the covers should be air dried to prevent contamination. The facility's policy "Warewashing" documented in part, "4. All dishware will be air dried and properly stored." On 06/06/2022 at approximately 5:00 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, assistant director of nursing, were made aware of the above findings.	F 812		

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F 812	Continued From page 61 No further information was provided prior to exit.	F 812		
F 840 SS=D	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to evidence a current dialysis contract between the facility and the outpatient dialysis center providing services for 1 of 44 residents in the survey sample, Resident #29 (R29). The findings include: On the most recent MDS (minimum data set), a significant change assessment with an ARD	F 840	1. A contract for US Renal Services was obtained. 2. A list current dialysis patients was obtained to ensure that the facility had a contract services agreement in place. 3. Education was provided to the Executive director by the Regional Vice President of Ops on ensuring that the center has contracts to ensure the ability to provide necessary dialysis services. 4. Prior to the delivery of a new dialysis service the Executive Director or Designee will ensure that facility obtains a dialysis services contract. A monthly Audit x 3 months will be completed to ensure current dialysis contracts are held. Results will be forward to the monthly QAPI meeting for review.	7/12/22

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(assessment reference date) of 3/18/2022, the resident scored 8 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. Section O documented Resident #29 (R29) receiving dialysis while a resident.

On 6/5/2022 at approximately 3:30 p.m., during entrance conference a request was made to ASM (administrative staff member) #1, the executive director, to review the dialysis contracts held by the facility. Review of the facility dialysis contracts provided by ASM #1 failed to evidence a contract between the facility and [Name of dialysis center].

On 6/6/2022 at approximately 8:45 a.m., an observation was made of R29 in their room. R29 was observed dressed and sitting in a wheelchair in their room. At this time an interview was attempted with R29. When asked about dialysis R29 stated that they were going to dialysis that morning and showed a paper bag saying it was lunch to take with them. When asked how often they went to dialysis R29 was unable to answer the question appropriately.

The physician's orders for R29 documented in part, "Dialysis: [Name, address and phone number of dialysis center] 11am pick up time. Order Date: 3/13/2022."

The comprehensive care plan for R29 documented in part, "[Name of R29] needs Hemodialysis [Name and address of dialysis center] Monday, Wednesday and Friday. Pick up time 11 AM r/t (related to) renal failure. Right subclavian access. Date Initiated: 10/06/2020. Revision on: 03/13/2022..."

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F 840	Continued From page 63 On 6/6/2022 at approximately 2:30 p.m., a request was made to ASM #1 for the facility contract with [Name of dialysis center]. Additional request for the dialysis contract with [Name of dialysis center] were made to ASM #1 on 6/6/2022 at 5:10 p.m. and 6/7/2022 at 2:54 p.m. On 6/7/2022 at approximately 3:45 p.m., an interview was conducted with ASM #1. ASM #1 stated that they had been emailing the dialysis center and attempting to get the contract sent to them but did not have it at that time. ASM #1 stated that they were sure that they had a contract in place with them but did not have one for surveyor review. ASM #1 stated that they would continue attempting to get the contract from [Name of dialysis center]. On 6/7/2022 at 3:45 p.m., ASM #1, the executive director and ASM #2, the assistant director of nursing were made aware of the concern. No further information was provided prior to exit.	F 840		