PRINTED: 06/28/2022
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. BUILDING _____ B. WING _____	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(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 6/13/22 through 6/15/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	The statements made in this plan of correction are not an admission of, or constitute an agreement with, the deficiencies alleged herein. To remain in compliance with all Federal and State regulations, the facility will take the actions described in this plan of correction. The following plan of correction constitutes the facility's allegation of compliance, that the alleged deficiencies, as described below, will be corrected by the date indicated.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/13/22 through 6/15/22. Nine complaints were investigated during the survey (VA00053043-substantiated with deficiency, VA00054249-substantiated with deficiency, VA00052197 unsubstantiated, VA00054160 substantiated with deficiency, VA00053123 substantiated with deficiency, VA00054834 unsubstantiated, VA00052979 substantiated without deficiency, VA00053249 substantiated with deficiency, VA00054928 unsubstantiated). Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 145 certified bed facility was 133 at the time of the survey. The survey sample included 48 current resident reviews and 11 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in	F 550	F550 Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with either the existence of the scope and severity of the cited deficiency or the conclusions set forth in the statement of deficiency. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7-8-2022

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

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F 550	Continued From page 1 this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff	F 550	Criteria 1 Resident #103 suffered no adverse outcomes related to wearing a hospital gown and plan to get out of bed. Upon notification from the surveyor regarding resident #103, staff on the unit were re-educated on ensuring residents clothing is changed after completing ADL care. Criteria 2 All current residents needing assistance with changing clothes and needing assistance getting out of bed have the potential to be affected by the alleged deficiency. Criteria 3 CNA's will be re-educated on changing clothing and ensuring residents are out of bed based on their preferences. Criteria 4 The DON or designee will conduct audits to ensure resident clothing is changed daily. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 550	Continued From page 2 failed to honor a resident and/or a resident family's choices for one of 59 residents in the survey sample, Resident #103 (R103). The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/13/2022, the resident scored 3 out of 15 on the BIMS (brief interview for mental status) assessment, which indicated the resident was severely impaired for making daily decisions. Section G documented R103 being totally dependent on two or more staff members for transfers and totally dependent of one person for dressing. On 6/13/2022 at approximately 12:15 p.m., an observation was made of R103 in their room. R103 was observed in bed wearing a hospital gown. R103 was observed to have their eyes open and respond by nodding yes or no to questions. R103 did not respond verbally. A handwritten note was observed to be written in a black marker on the bulletin board beside R103's bed on the right side and also on the bulletin board beside the doorway to the room. The note stated, "Please dress [R103] daily (needs total help) Please get [R103] out of the bed so she can participate in daily activities (needs total help). Please check [R103] for wetness as she will not just tell you. All of [R103] items are in her cabinets. Please leave TV on at night. Thank you, [R103] family. She can speak & understands what you are saying." When asked if they had been dressed or out of bed on 6/13/2022, R103 nodded "No." When asked if they had been bathed, R103 nodded "Yes."	F 550		

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F 550	Continued From page 3 Additional observations on 6/13/2022 at 2:12 p.m. and 4:25 p.m. revealed the findings as described above. On 6/14/2022 at 8:33 a.m., R103 was observed in a hospital gown in bed. On 6/14/2022 at 10:31 a.m., R103 was observed in bed in a hospital gown, when asked if they had a bath R103 nodded "Yes", when asked if they wanted to get dressed and out of bed today R103 nodded "Yes." On 6/14/2022 at 12:30 p.m. and 2:45 p.m., R103 was observed in bed in a hospital gown. The handwritten signs were observed to remain in place on R103's bulletin boards in the room. On 6/15/2022 at 9:15 a.m. and 10:30 a.m., R103 was observed in bed with a hospital gown on. The comprehensive care plan dated 4/5/2022 documented in part, "[R103] has an ADL (activities of daily living) self care performance deficit and requires assistance with ADL's and mobility r/t (related to): H/O (history of) CVA (cardiovascular accident) and decreased ability to do ADL's. Date initiated: 04/05/2022. Revision on: 04/08/2022..." The "Documentation Survey Report" (a report of CNA documentation for the month) for R103 dated 6/1/2022-6/30/2022 for "Transferring" for 6/13/2022 was observed to be blank for day and night shift and a "NA" was observed to be documented in the evening shift area. On 6/14/2022, the day and evening shift areas were observed to be blank and the night shift was observed to contain a "NA." On 6/14/2022 at 2:48 p.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 stated that R103 required a hoyer lift to get out of bed and required 2 staff members to	F 550		

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F 550	Continued From page 4 get out of bed. CNA #5 stated that when they worked with R103 they asked them what they wanted and had them dressed and out of bed each day. CNA #5 stated that all residents should be dressed every day and that the CNA assigned should wash them up and put clothes on them. CNA #5 stated that residents wear hospital gowns when they don't have anything else and their personal clothes make them feel more presentable. CNA #5 stated that they try their best to honor any family preferences for getting residents out of bed and their choices. CNA #5 stated that R103 was non-verbal but could communicate with their eyes and nodding. CNA #5 stated that they had not been assigned R103 on 6/14/2022 but had told the other CNA to get them up earlier that day but they had not done it. CNA #5 stated that the day shift CNA had already left for the day. On 6/14/2022 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that residents should be dressed and offered to get out of bed daily. LPN #9 stated that each resident had the right to be dressed in their own clothes and to get out of bed each day if they wanted to. LPN #9 reviewed the notes in R103's room written by R103's family and stated that they had asked the CNA that morning to get them out of bed for therapy to work with them but they had not done this. LPN #9 stated that they normally get R103 up and dressed by 10:00 a.m. On 6/15/2022 at 10:54 a.m., an interview was conducted with LPN #3, unit manager. LPN #3 stated that they had been at the facility for one week and were still learning the residents. LPN #3 stated that all residents had the right to get out of bed each day and should be dressed each day.	F 550		

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F 550	Continued From page 5 LPN #3 stated that each resident should be given the choice to get out of bed or stay in bed. LPN #3 observed R103 in their room who was observed to be in bed with a hospital gown on. LPN #3 stated that they were unaware of the handwritten notes from R103's family and it was observed the notes from R103's family had been taken down. The facility policy "Guest/Resident Rights" dated 9/1/2013 documented in part, "...Guests/residents have freedom of choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules and regulations affecting guest/resident conduct and those regulations governing protection of guest/resident health and safety...A facility must promote the exercise of rights for each guest/resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A guest/resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability..." The facility policy "Routine Guest/Resident Care" dated 3/1/2013 documented in part, "...Guests/residents are encouraged or assisted to dress in appropriate clothing and footwear daily (appropriate to season and weather, clean and in good repair)..." On 6/15/2022 at approximately 4:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator and ASM #4, the regional director of operations were made aware of the findings.	F 550		

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F 550	Continued From page 6 No further information was provided prior to exit.	F 550		
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, clinical record review and facility document review, it was determined that the facility staff failed to maintain the call bell in a position accessible to the resident for one of 59 residents in the survey sample, Resident #114 (R114). The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/23/2022, 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. Section G documented R114 having functional limitations in range of motion to both upper and lower extremities. The comprehensive care plan for R114 dated 2/25/2022 documented in part, "[R114] is at risk for fall related injury and falls R/T (related to): new admit, confusion, psychoactive medication. Date initiated: 02/25/2022. Revision on: 02/26/2022." Under "Interventions" it	F 558	F558 Criteria 1 Resident #114 suffered no adverse outcomes related to call bell allegedly being out of reach. Upon notification from the surveyors regarding resident #114, the call bell was placed in reach. Criteria 2 All current residents who need to use the call bell for assistance have the potential to be affected by this alleged deficiency. Audit of current residents was conducted to ensure call bells were within reach. Criteria 3 All staff will be re-educated on ensuring residents call bells are within reach. Criteria 4 The DON or designee will conduct audits to ensure resident call bells are in reach, these audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 558	Continued From page 7 documented in part, "...Put the resident's call light within reach and encourage him to use it for assistance as needed. Date Initiated: 02/26/2022..." On 6/13/2022 at 1:59 p.m., an observation was made of R114 in their room. R114 was observed lying in bed with a t-shirt on and asleep. R114's call light cord with push button was observed to be clipped onto the call light cord plugged into the wall at the center of the room. The call light was not in reach of R114 in the bed. Additional observations of R114 in their bed in the room on 6/13/2022 at 3:41 p.m. and 4:24 p.m. revealed the call light in the same position as described above. On 6/14/2022 at 8:45 a.m. and 1:45 p.m. the call light was observed in the same position as described above with R114 in the bed. On 6/14/2022 at 2:48 p.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 stated that the call bell should be clipped to the sheet or something in reach of the resident. CNA #5 stated that the purpose of this was to be within reach for them to call when they needed something. CNA #5 stated that R114 was able to use their call bell and the phone. CNA #5 observed R114 in the bed with the call bell clipped to the cord plugged into the wall at the center of the room at the patient station and stated that it was not in their reach and should not have been there because they could not reach it to call if needed. On 6/14/2022 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that the call bell should be placed within reach of the resident at all times for them	F 558		

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F 558	Continued From page 8 to be able to call. LPN #9 stated that staff should check the call bell placement during rounding every time they enter the room. The facility policy, "Routine Guest/Resident Care" dated 3/1/2013 documented in part, "...The call light should be easily accessible to the guests/residents at all times..." On 6/14/2022 at 4:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator and ASM #4, the regional director of operations were made aware of the findings. No further information was presented prior to exit.	F 558		
F 578 SS=E	Request/Refuse/Dscntinue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F578 F 578	Criteria 1 Resident #'s 90, #78, #114, #16 and #58 suffered no adverse outcomes related to allegedly not being provided written information regarding the formulation of advanced directives at the time of admission or during periodic reviews. Upon notification from the surveyors regarding residents, 90, 78, 114, 16 and 58 the facility has obtained their advance directive status if applicable. Admissions and Social Services were re-educated on obtaining advance directives and addressing them during periodic reviews. Criteria 2 All current residents have the potential to be affected by the alleged deficiency. Audit completed to ensure current residents have an active advanced directive. Criteria 3 Social Services, Admissions and nurse leadership will be re-educated regarding advanced directives and addressing them during periodic reviews.	

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F 578	Continued From page 9 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to evidence that residents and/or their RR (resident representative) were provided with written information and provided the opportunity to formulate advance directives at the time of admission and/or conduct a periodic review with the residents and/or their RRs if they wish to formulate one, or, if applicable, make changes to their existing advance directives or maintain them as written for 5 of 59 residents in the survey sample, Residents #90, #78, #114, #16, and #58. The findings include:	F 578	Criteria 4 The Administrator or designee will conduct audits on all new admissions monitoring advance directives. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. These results will be forwarded to the QAPI committee for review. The QAPI committee will determine the needs for further audits and action. Criteria 5 Date of compliance is 7/26/22.	

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F 578	Continued From page 10 1. The facility staff failed to provide Resident #90 (R90) or the RR written information and the opportunity to formulate advance directives (1) upon admission, and failed to conduct a periodic review of advance directives in 2021 and 2022. R90 was admitted to the facility on 5/25/18. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 2/14/22, the resident scored 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely cognitively impaired for making daily decisions. A review of R90's clinical record failed to reveal the resident and/or RR was provided with written information and provided the opportunity to formulate advance directives at the time of admission. Further review of R90's clinical record (to include social services notes, evaluations and care conference minutes for 2021 and 2022) failed to reveal evidence that the facility staff conducted a periodic review of all aspects of advance directives with R90 or the RR (excluding resuscitation status) during 2021 or 2022. On 6/15/22 at 12:21 p.m., an interview was conducted with OSM (other staff member) #1, the social worker. OSM #1 stated advance directives are reviewed with residents and/or their RRs by the admissions department upon admission to the facility. OSM #1 stated a review of residents' code (resuscitation) status is periodically conducted during care plan meetings and sometimes other aspects of advance directives are reviewed. OSM #1 stated a review of advance directives might be checked off on care plan meeting minutes but she wasn't sure how a review could be evidenced if it was not	F 578		

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	495109	A. BUILDING _____ B. WING _____	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 578	Continued From page 11 documented or checked off. On 6/15/22 at approximately 2:00 p.m., an interview was conducted with OSM (other staff member) #10, the admissions coordinator. OSM #10 stated residents and/or their RRs fill out an advance directive notification/acknowledgment form upon admission and this form is included in the admission contract. OSM #10 stated the admission contract is sent to the business office then sent to the medical records department after the admissions department is done with the contract. OSM #10 stated administrative staff were looking for requested advance directive notification/acknowledgment forms. On 6/15/22 at 2:32 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional clinical coordinator) and ASM #4 (the regional director of operations) were made aware of the above concern. The facility policy titled, "Federal & State-Guest/Resident Rights & Facility Responsibilities" documented, "12. Advance Directives. The facility must comply with the requirements specified in 42 CFR (code of federal regulations) part 489, subpart I (Advance Directives)...I. These requirements include provisions to inform and provide written information to all adult guests/residents concerning the right to accept or refuse medical or surgical treatment and, at the guest's/resident's option, formulate an advance directive...iv. If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		

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F 578	Continued From page 12 individual's resident representative in accordance with State law..." The facility policy titled, "Code Status" documented, "7. Review and Discussion of Advance Directives. I. Advance Directives and Code Status shall be reviewed with the resident, or the Patient Advocate/Health Care Representative (if properly invoked), or the Guardian/Conservator, or the patient surrogate (if the resident is terminally ill/permanently unconscious) at least once per year and documented in the medical record by Social Services..." No further information was presented prior to exit. Reference: (1) "What kind of medical care would you want if you were too ill or hurt to express your wishes? Advance directives are legal documents that allow you to spell out your decisions about end-of-life care ahead of time. They give you a way to tell your wishes to family, friends, and health care professionals and to avoid confusion later on. A living will tells which treatments you want if you are dying or permanently unconscious. You can accept or refuse medical care. You might want to include instructions on ·The use of dialysis and breathing machines ·If you want to be resuscitated if your breathing or heartbeat stops ·Tube feeding ·Organ or tissue donation A durable power of attorney for health care is a document that names your health care proxy. Your proxy is someone you trust to make health decisions for you if you are unable to do so." This	F 578		

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F 578	Continued From page 13 information was obtained from the website: https://medlineplus.gov/advancedirectives.html 2. The facility staff failed to conduct a periodic review of advance directives with Resident #78 (R78) or the RR (resident representative) in 2021 and 2022. Resident #78 was admitted to the facility on 1/5/18. On the most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 5/4/22, 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. A review of R78's clinical record (including social services notes, evaluations and care conference minutes for 2021 and 2022) failed to reveal evidence that the facility staff conducted a periodic review of all aspects of advance directives with R78 or the RR (excluding resuscitation status) during 2021 or 2022. On 6/15/22 at 10:20 a.m., an interview was conducted with R78. The resident stated staff had not discussed advance directives with the resident. On 6/15/22 at 12:21 p.m., an interview was conducted with OSM (other staff member) #1 (the social worker). OSM #1 stated advance directives are reviewed with residents and/or their RRs by the admissions department upon admission to the facility. OSM #1 stated a review of residents' code (resuscitation) status is periodically conducted during care plan meetings and sometimes other aspects of advance	F 578		

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F 578	Continued From page 14 directives are reviewed. OSM #1 stated a review of advance directives might be checked off on care plan meeting minutes but she wasn't sure how a review could be evidenced if it was not documented or checked off. On 6/15/22 at 2:32 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional clinical coordinator) and ASM #4 (the regional director of operations) were made aware of the above concern. No further information was presented prior to exit. 3. The facility staff failed to provide Resident #114 (R114) or R114's representative information on or an opportunity to formulate an advanced directive. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/23/2022, 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. Review of R114's clinical record failed to evidence documentation of advanced directive review or information on advanced directives provided to the responsible party. Review of the care plan meeting minutes dated 2/28/2022 and 3/8/2022 failed to evidence review of advanced directives. Review of the social service history evaluation dated 3/1/2022 failed to evidence review of advanced directives.	F 578		

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F 578	Continued From page 15 On 6/14/2022 at approximately 8:00 a.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of information provided or an opportunity to formulate an advanced directive for R 114. On 6/15/22 at 12:21 p.m., an interview was conducted with OSM (other staff member) #1, social worker. OSM #1 stated advance directives are reviewed with residents and/or their representatives by the admissions department upon admission to the facility. OSM #1 stated a review of resident's code status was periodically conducted during care plan meetings and sometimes other aspects of advance directives are reviewed. OSM #1 stated a review of advance directives may be checked off on care plan meeting minutes but she was not sure how a review could be evidenced if it was not documented or checked off. On 6/15/22 at approximately 2:00 p.m., an interview was conducted with OSM #10, the admissions coordinator. OSM #10 stated residents and/or their representatives fill out an advance directive notification/acknowledgment form upon admission and this form is included in the admission contract. OSM #10 stated the admission contract was sent to the business office and then sent to the medical records department after the admissions department was done with the contract. OSM #10 stated administrative staff were looking for the requested advance directive notification/acknowledgment forms. On 6/15/2022 at approximately 4:48 p.m., ASM (administrative staff member) #1, the administrator, was made aware of the findings.	F 578		

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F 578	Continued From page 16 ADM #1 stated that they did not have any evidence of advance directive information provided or reviewed for R114 to provide. No further information was presented prior to exit. 4. The facility staff failed to offer Resident #16 (R16) information on or an opportunity to formulate an advanced directive. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/14/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is not cognitively impaired for making daily decisions. On 6/13/2022 at approximately 2:15 p.m., an interview was conducted with R16 in their room. When asked about advanced directive information, R16 stated that they did not recall receiving any information from anyone regarding advanced directives when they were admitted to the facility about 3 months ago. Review of R16's clinical record failed to evidence documentation of advanced directive review or information on advanced directives provided. Review of the care plan meeting minutes dated 3/22/2022 failed to evidence review of advanced directives. Review of the social service history evaluation dated 3/10/2022 failed to evidence review of advanced directives. On 6/14/2022 at approximately 8:00 a.m., a	F 578		

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F 578	Continued From page 17 request was made to ASM (administrative staff member) #1, the administrator for evidence of information provided or an opportunity to formulate an advanced directive for R16. On 6/15/22 at 12:21 p.m., an interview was conducted with OSM (other staff member) #1, social worker. OSM #1 stated advance directives are reviewed with residents and/or their representatives by the admissions department upon admission to the facility. OSM #1 stated a review of resident's code status was periodically conducted during care plan meetings and sometimes other aspects of advance directives are reviewed. OSM #1 stated a review of advance directives may be checked off on care plan meeting minutes but she was not sure how a review could be evidenced if it was not documented or checked off. On 6/15/22 at approximately 2:00 p.m., an interview was conducted with OSM #10, the admissions coordinator. OSM #10 stated residents and/or their representatives fill out an advance directive notification/acknowledgment form upon admission and this form is included in the admission contract. OSM #10 stated the admission contract was sent to the business office and then sent to the medical records department after the admissions department was done with the contract. OSM #10 stated administrative staff were looking for the requested advance directive notification/acknowledgment forms. On 6/15/2022 at approximately 4:48 p.m., ASM (administrative staff member) #1, the administrator was made aware of the findings. ASM #1 stated that they did not have any	F 578		

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F 578	Continued From page 18 evidence of advance directive information provided or review for R16 to provide. No further information was presented prior to exit. 5. The facility staff failed to obtain or discuss an advance directive upon admission for Resident # 58 (R58). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 04/17/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. A review of (R58's) clinical record failed to evidence an advance directive or discussion of an advance directive. The comprehensive care plan for (R58) dated 04/13/2022 failed to evidence documentation of an advance directive. The current physician's order sheet dated April 2022 documented, "Code Status: Do Not Resuscitate." On 6/15/22 at 12:21 p.m., an interview was conducted with OSM (other staff member) #1, social worker. OSM #1 stated advance directives are reviewed with residents and/or their representatives by the admissions department upon admission to the facility. OSM #1 stated a review of residents' code status is periodically conducted during care plan meetings and sometimes other aspects of advance directives are reviewed. OSM #1 stated a review of advance directives might be checked off on care plan meeting minutes but she wasn't sure how a	F 578		

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F 578	Continued From page 19 review could be evidenced if it was not documented or checked off. On 6/15/22 at approximately 2:00 p.m., an interview was conducted with OSM #10, admissions coordinator. OSM #10 stated residents and/or their representatives fill out an advance directive notification/acknowledgment form upon admission and this form is included in the admission contract. OSM #10 stated the admission contract is sent to the business office then sent to the medical records department after the admissions department is done with the contract. OSM #10 stated administrative staff were looking for (R58') advance directive notification/acknowledgment forms. On 06/15/22 at 3:40 p.m., an interview was conducted with (R58). When asked if the facility staff discussed or obtained an advance directive with them (R58) stated that they completed their own admission paperwork and that no one asked her about an advance directive. On 06/15/22 at approximately 4:48 p.m. ASM (administrative staff member) #1 stated that they did not have (R58's) advance directive notification/acknowledgment form. No further information was presented prior to exit.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584	F584 Criteria 1 Resident #134 suffered no adverse outcomes related to the bathroom allegedly not being clean. Upon notification from the surveyor regarding resident #134's dirty bathroom, it was immediately deep cleaned. Housekeeping staff re-educated on ensuring resident #134's bathroom is clean.	

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F 584	Continued From page 20 The facility must provide- §483.10(l)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (l) 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(l)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(l)(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 and clinical record review, the facility staff failed to maintain a clean, comfortable,	F 584	Criteria 2 All current residents have the potential to be affected by this alleged deficient practice. Audit of current resident bathrooms were completed to ensure they were clean and homelike. Criteria 3 Housekeeping staff will be re-educated on ensuring residents bathrooms are safe/clean/comfortable and homelike. Criteria 4 The Administrator or designee will conduct (5) random audits to ensure resident bathrooms are safe/clean/comfortable and homelike. these audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. These results will be forwarded to the QAPI committee for review. The QAPI committee will determine the needs for further audits and action. Criteria 5 Date of compliance is 7/26/22.	

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F 584	Continued From page 21 homelike environment for one of 59 residents in the survey sample, Resident #134. The facility staff failed to maintain Resident #134's (R134) bathroom in a clean and homelike manner. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/27/22, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. On 6/13/22 at 12:51 p.m., R134 was observed lying in bed. During an interview with R134, the resident stated the bathroom was dirty and the facility staff do not clean the floor in the bathroom. At that time, an observation of R134's bathroom was conducted. Small brown particles were observed on the floor in the right corner behind the toilet and in the corners under the sink; hair was observed around the trash can. On 6/14/22 at 3:05 p.m., another observation of R134's bathroom was conducted. The brown particles and hair remained on the floor. On 6/14/22 at 3:49 p.m., an interview was conducted with OSM (other staff member) #6 (a housekeeper). OSM #6 stated bathroom floors should be swept and mopped once every day and more than once if needed. OSM #6 stated the housekeeper responsible for cleaning R134's bathroom had left for the day. At that time, R134's bathroom was observed with OSM #6. OSM #6 stated the bathroom should have been	F 584		

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F 584	Continued From page 22 cleaned and was not clean or homelike. On 6/15/22 at 11:35 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional clinical coordinator) and ASM #4 (the regional director of operations) were made aware of the above concern. The facility policy titled, "Federal & State - Guest/Resident Rights & Facility Responsibilities" documented, "It is the facility's policy to abide by all guest/resident rights...i. Safe environment. The guest/resident has a right to a safe, clean, comfortable and homelike environment..." No further information was presented prior to exit.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and in the course of a complaint investigation, the facility staff failed to implement the facility abuse policy for 4 of 11 employee record reviews.	F 607	F607 Criteria 1 Employees #3, #4, #10 and #11 Licenses were verified. All had current licensure. Criteria 2 All current residents being cared for by licensed staff have the potential to be affected by the alleged deficiency. An audit was completed by the HR director and all licensed staff have current verified licenses. Criteria 3 HR director was reeducated to verify licensure when Job offer is extended. Criteria 4 The HR director/designees will conduct weekly audits on all new hires to assure license has been verified in is in personnel file. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. The results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(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 607	Continued From page 23 The facility staff failed to conduct certification and nursing license verifications upon hire for two CNAs)certified nursing assistant) #3 and #4, and two LPNs (licensed practical nurse) #10 and #11. The findings include: The facility abuse prohibition policy was reviewed and documented, "A. Screening Employees and Guests/Residents: 1. The facility will screen potential new employees for a history of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law...2. Without exception, all potential licensed and certified candidates must have their status confirmed with the appropriate boards to verify license/certification and to determine if any action has been taken against the license or certification." CNA #3 was hired on 8/25/21. CNA #4 was hired on 8/4/21. LPN #10 was hired on 8/18/21. LPN #11 was hired on 8/18/21. On 6/15/22 at 11:04 a.m., a review of certification and license verifications was conducted with OSM (other staff member) #9 (the accounts payable payroll coordinator). OSM #9 could not provide evidence that a license verification was conducted upon hire for CNA #3, CNA #4, LPN #10 or LPN #11. OSM #9 stated the nursing department was responsible for conducting license verifications when those employees were hired. OSM #9 stated she is now responsible for conducting license verifications. OSM #9 stated she conducts license verifications through the Virginia board of nursing website as soon as she receives potential employees' applications.	F 607		

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F 607	Continued From page 24 On 6/15/22 at 11:35 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional clinical coordinator) and ASM #4 (the regional director of operations) were made aware of the above concern. No further information was presented prior to exit.	F 607		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a	F 622	F622 Criteria 1 Resident #128 was discharged from the facility on 5/17/22. Criteria 2 All current residents who are discharged to the hospital have the potential affected by this alleged deficiency. Criteria 3 Nursing staff will be reeducated on the discharge to the hospital policy and the required documentation that is to be sent with resident when discharged to the hospital. Criteria 4 The DON or designee will conduct audits at morning clinical operations meeting regarding resident discharge, these audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 622	Continued From page 25 resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is	F 622		

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F 622	Continued From page 26 necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to evidence that all required documentation was provided to the receiving facility for a hospital transfer for 1 of 59 residents in the survey sample; Resident #128. The findings include: Resident #128 was transferred to the hospital on 5/17/22. There was no evidence that the comprehensive care plan goals, medication list, relevant progress notes or labs were provided to the hospital. Resident #128 was admitted to the facility on 9/10/21. On the most recent MDS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Date) of 5/30/22, the resident scored an 11 out of a possible 15 on the	F 622		

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F 622	Continued From page 27 BIMS (Brief Interview for Mental Status) indicating the resident was moderately impaired cognitively in ability to make daily life decisions. The resident was coded as requiring extensive assistance for eating and total care for all other areas of activities of daily living. A review of the clinical record revealed a nurse's note dated 5/17/22 that documented, "Nurse practitioner in facility observed resident not at [their] baseline, observed right facial droop and slow to respond. Able to follow directions. Vitals BP-128/78 (blood pressure), P-96 (pulse), T-97.4 (temperature), R-17 (respirations), 02-97% RA (oxygen saturation on room air). Resident has been transported to [name of hospital] via stretcher with EMT's (emergency medical technicians) for an evaluation. Report called into ER (emergency room) by N.P. (nurse practitioner) Resident is [their] own RP (responsible party). Emergency contact, [name] has been updated." A nurse practitioner note dated 5/17/22 documented, "Per staff pt (patient) has been acting unusual, having weakness, slow to respond. Today patient states "Something is not right." Pt having unequal grip strength, right sided facial drooping, and slurring of speech. NP (nurse practitioner) sending out to ER (emergency room) for further workup....pt having new onset right sided weakness, slurred speech, minimal right facial droop, pt being sent to ER for further evaluation of possible TIA/Stroke/UTI (transient ischemic attack (mini stroke), stroke, urinary tract infection.)" A review of the clinical record revealed a Hospital Transfer form completed on 5/17/22 (but dated 2/11/22) that documented resident demographic	F 622		

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F 622	Continued From page 28 information, vital signs (dated 5/17/22), reason for transfer (a fall, which was not accurate for 5/17/22) code status, and ongoing medical and care needs. Further review of the clinical record failed to reveal any evidence what documentation was provided to the hospital, including but not limited to comprehensive care plan goals, medication list, relevant progress notes or labs. On 6/14/22 at 3:00 PM an interview was conducted with LPN #4 (Licensed Practical Nurse). She stated that on a hospital transfer, the facility should send the hospital transfer form, face sheet, advance directives, medication list, progress notes, labs, bed hold and care plan. On 6/14/22 at approximately 4:00 PM ASM #1 (Administrative Staff Member) the Administrator, was provided a list of items needed, which included evidence of what documentation was provided to the hospital. On 6/15/22 at 9:40 AM, ASM #2, the Director of Nursing, stated there was no other documentation regarding what was sent to the hospital. She stated that the staff are supposed to document this information in the nurse's note. On 6/15/22 at 3:30 PM ASM #1 was provided with a list of policies requested, which included a request for one regarding admission, transfer, discharge, hospital transfer requirements. On 6/15/22 at 5:34 PM and 5:39 PM the facility sent emails with policies attached. None for admission, transfer, discharge, hospital transfer requirements was provided.	F 622		

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F 622	Continued From page 29 No further information was provided.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F 623	F623 Criteria 1 Resident # 128 was discharged to the hospital on 5/17/22 Criteria 2 All current residents discharged to the hospital have the potential to be affected by the alleged deficiency. Criteria 3 Licensed nurses will be educated on the policy for notification of Hospital Transfer to resident and or responsible party. Criteria 4 The DON/Designee will conduct audits monitoring resident and RP notification of hospital transfer. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. The results will be forwarded to the QAPI committee for review. The QAPI committee will determine the needs for further audits and action. Criteria 5 Date of compliance is 7/26/22.	

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F 623	Continued From page 30 (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 623		

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F 623	Continued From page 31 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to evidence that written notification of a hospital transfer was provided to the resident and/or responsible party for a hospital transfer for one of 59 residents in the survey sample; Resident #128. The findings include: Resident #128 was transferred to the hospital on 5/17/22. There was no evidence that written notification of a hospital transfer was provided to the resident and/or responsible party. Resident #128 was admitted to the facility on 9/10/21. On the most recent MDS (Minimum Data Set), a quarterly assessment with an ARD	F 623		

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F 623	Continued From page 32 (Assessment Reference Date) of 5/30/22, the resident scored an 11 out of a possible 15 on the BIMS (Brief Interview for Mental Status) indicating the resident was moderately impaired cognitively in ability to make daily life decisions. The resident was coded as requiring extensive assistance for eating and total care for all other areas of activities of daily living. A review of the clinical record revealed a nurse's note dated 5/17/22 that documented, "Nurse practitioner in facility observed resident not at [their] baseline, observed right facial droop and slow to respond. Able to follow directions. Vitals BP-128/78 (blood pressure), P-98 (pulse), T-97.4 (temperature), R-17 (respirations), 02-97% RA (oxygen saturation on room air). Resident has been transported to [name of hospital] via stretcher with EMT's (emergency medical technicians) for an evaluation. Report called into ER (emergency room) by N.P. (nurse practitioner) Resident is [their] own RP (responsible party). Emergency contact, [name] has been updated." A nurse practitioner note dated 5/17/22 documented, "Per staff pt (patient) has been acting unusual, having weakness, slow to respond. Today patient states "Something is not right." Pt having unequal grip strength, right sided facial drooping, and slurring of speech. NP (nurse practitioner) sending out to ER (emergency room) for further workup...:pt having new onset right sided weakness, slurred speech, minimal right facial droop, pt being sent to ER for further evaluation of possible TIA/Stroke/UTI (transient ischemic attack (mini stroke), stroke, urinary tract infection.)" A review of the clinical record revealed a Hospital	F 623		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 08/26/2022
FORM APPROVED
OMB NO. 0938-0391

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F 623	Continued From page 33 Transfer form completed on 5/17/22 (but for some reason dated 2/11/22) that documented resident demographic information, vital signs (dated 5/17/22), reason for transfer (a fall, which was not accurate for 5/17/22) code status, and ongoing medical and care needs. Further review of the clinical record failed to reveal any evidence of a written notification of a hospital transfer being provided to the resident and/or responsible party. On 6/14/22 at 3:00 PM an interview was conducted with LPN #4 (Licensed Practical Nurse). She stated that she was not sure about a written notification of a hospital transfer. On 6/14/22 at approximately 4:00 PM ASM #1 (Administrative Staff Member) the Administrator, was provided a list of items needed, which included evidence of a written notification of a hospital transfer being provided to the resident and/or responsible party. On 6/15/22 at 9:40 AM, ASM #2, the Director of Nursing, stated there was no evidence that a written notification of a hospital transfer was provided. On 6/15/22 at 3:30 PM ASM #1 was provided with a list of policies requested, which included a request for one regarding admission, transfer, discharge, hospital transfer requirements. On 6/15/22 at 5:34 PM and 5:39 PM the facility sent emails with policies attached. None for admission, transfer, discharge, hospital transfer requirements was provided. No further information was provided.	F 623		

PRINTED: 06/28/2022
FORM APPROVED
OMB NO. 0938-0391

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THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(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 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to evidence that written bed hold notice was provided to the resident and/or responsible party for a hospital transfer for 2 of 59 residents in the survey sample; Residents #128 and #76	F 625	F625 Criteria 1 Residents # 128 # 76 were discharged to the hospital. Criteria 2 All current residents being discharged to the hospital have the potential to be affected by this alleged deficient practice. Criteria 3 Licensed Nurses will be educated on the bed hold policy and documentation that it was given to resident and or RP. Criteria 4 The DON or designee will conduct audits to ensure residents discharged to the hospital have been given a copy of bed hold policy. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. The results will be forwarded to the QAPI committee for review. The QAPI committee will determine the needs for further audits and action. Criteria 5 Date of compliance is 7/26/22.	

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	495109	A. BUILDING _____ B. WING _____	C 06/16/2022

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F 625	Continued From page 35 The findings include: 1. Resident #128 was transferred to the hospital on 5/17/22. There was no evidence that written bed hold notice was provided to the resident and/or responsible party. Resident #128 was admitted to the facility on 9/10/21. On the most recent MDS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Date) of 5/30/22, the resident scored an 11 out of a possible 15 on the BIMS (Brief Interview for Mental Status) indicating the resident was moderately impaired cognitively in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 5/17/22 that documented, "Nurse practitioner in facility observed resident not at [their] baseline, observed right facial droop and slow to respond. Able to follow directions. Vitals BP-128/78 (blood pressure), P-96 (pulse), T-97.4 (temperature), R-17 (respirations), 02-97% RA (oxygen saturation on room air). Resident has been transported to [name of hospital] via stretcher with EMT's (emergency medical technicians) for an evaluation. Report called into ER (emergency room) by N.P. (nurse practitioner) Resident is [their] own RP (responsible party). Emergency contact, [name] has been updated." A review of the clinical record revealed a Hospital Transfer form completed on 5/17/22 (but for some reason dated 2/11/22) that documented resident demographic information, vital signs (dated 5/17/22), reason for transfer (a fall, which was not accurate for 5/17/22) code status, and ongoing medical and care needs.	F 625		

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F 625	Continued From page 36 Further review of the clinical record failed to reveal any evidence of a written bed hold notice being provided to the resident and/or responsible party. On 6/14/22 at 3:00 PM an interview was conducted with LPN (Licensed Practical Nurse) #4 . She stated that on a hospital transfer, the facility should send the hospital transfer form, face sheet, advance directives, medication list, progress notes, labs, and bed hold. On 6/14/22 at approximately 4:00 PM ASM #1 (Administrative Staff Member) the Administrator, was provided a list of items needed, which included evidence of a written bed hold notice being provided to the resident and/or responsible party. On 6/15/22 at 9:40 AM, ASM #2, the Director of Nursing, stated there was no evidence that a written bed hold notice was provided. On 6/15/22 at 3:30 PM ASM #1 was provided with a list of policies requested, which included a request for one regarding admission, transfer, discharge, hospital transfer requirements. On 6/15/22 at 5:34 PM and 5:39 PM the facility sent emails with policies attached. None for admission, transfer, discharge, hospital transfer requirements was provided. No further information was provided. 2. The facility staff failed to evidence a bed hold was provided when Resident #76 was transferred to the hospital on 4/20/22. The facility's "Acute Care Transfer Document Checklist" did not evidence bed hold on the check list.	F 625		

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F 625	Continued From page 37 Resident #76 was admitted to the facility on 7/19/21. Resident #76's diagnoses included but were not limited to: ESRD (end stage renal disease), COPD (chronic obstructive pulmonary disease, diabetes mellitus and dementia. Resident #76's most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 3/19/22, coded the resident as scoring 9 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the eINTERACT (INTerventions to Reduce Acute Care Transfers) form dated 4/20/22 at 4:28 PM, revealed the following, "Mental confusion, weakness. Vital signs blood pressure-222/112, pulse-76, respirations-21, temperature-97.7, oxygen saturation-98% on room air. Emergency assistance arrived and transported resident to hospital. RP (responsible party) and NP (nurse practitioner) notified." On 6/13/22 at 3:32 PM, an interview was conducted with LPN (licensed practical nurse) #1. When asked what bed hold is provided when a resident is transferred to the hospital, LPN #1 stated, There is a form to check off, of what has been sent with the resident, there is a big envelope that we put the papers in. I do not know about the bed hold. On 6/13/22 at approximately 4:00 PM a request was made for the evidence of the bed hold policy when Resident #76 was transferred to the hospital on 4/20/22. On 6/14/22 at approximately 9:00 AM, SBAR	F 625		

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F 625	Continued From page 38 (situation background assessment recommendation) form for Resident #76 was provided. On 6/14/22 at 4:00 PM, request made again for bed hold for Resident #76. On 6/15/22 at 1:40 PM, ASM (administrative staff member) #1, the administrator, stated, "We do not have the bed hold for this resident." When ASM #1, the administrator and ASM #2, the director of nursing were asked who provides bed holds for residents, they stated, admissions does that but she is on vacation. On 6/15/22 at 3:40 PM, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional clinical coordinator and ASM #4, the regional director of operations were informed of the above concern. A request was made on 6/15/22 on 3:30 PM for any facility bed hold policy. On 6/15/22 at 6:20 PM, ASM #1 and ASM #2 stated, we do not have any policy related to bed holds. No further information was provided prior to exit.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation, it	F 641	F641 Criteria 1 Residents #'s 46, 114, and 701 suffered no adverse outcomes related to the alleged inaccurate coding of their MDS assessments. Residents #46 and #114 had their MDS's corrected and resident #701 is no longer in the facility so social services staff were re-educated on ensuring assessments are completed and coded accurately.	

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PRINTED: 06/28/2022
FORM APPROVED
OMB NO. 0938-0391

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F 641	Continued From page 39 was determined that the facility staff failed to accurately code the MDS (minimum data set) resident assessment for 3 of 59 residents in the survey sample, Resident #46, #114 and #701. The findings include: 1. The facility staff failed to accurately code Resident #46's (R46) quarterly MDS with an ARD (assessment reference date) of 6/4/2022 for falls sustained at the facility since the previous assessment. On the most recent MDS, a quarterly assessment with an ARD of 6/4/2022, 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. Section J1800 documented R46 not having any falls since admission/entry or reentry or prior assessment. Review of the clinical record revealed a list of R46's MDS assessments. The list revealed the prior assessment was an End of PPS Part A Stay with an ARD of 4/21/2022 and a quarterly MDS with an ARD of 4/11/2022. Review of the clinical record for R46 revealed documented falls on 5/5/2022 and 5/21/2022. The progress notes documented in part: "5/5/2022 10:03 (10:03 a.m.) Resident was found on the floor at 0025 (12:25 a.m.) in her room facing the door by her aid, her bed was behind her and wheelchair within 5 ft (feet) to her left. Resident stated that she was going to get some fish. Neuro (neurological) assessment conducted and her vital signs were within normal limits, alert	F 641	Criteria 2 All current residents have the potential to be affected by the alleged deficient practice. Audit completed to ensure current residents MDS's were coded correctly for falls and social services sections were coded accurately. Criteria 3 Social Services MDS coordinators will be re-educated on ensuring all MDS assessments are coded accurately. Criteria 4 MDS Director or designee will randomly audit five (5) MDS assessments to ensure assessments are coded accurately. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 641	Continued From page 40 able to answer to her name speech clear and typical, PERRLA (pupils, equal, round, reactive to light and accommodation) and able to move all extremities and grasp. No injuries or complaints of pain or discomfort..." "5/21/2022 20:23 (8:23 a.m.) Resident had an unwitnessed fall at 745 pm, resident was self propelling wheelchair in hallway and slid out of chair, resident noted with shoes intact. Resident was assessed with no injuries noted..." On 6/15/2022 at 9:44 a.m., an interview was conducted with RN (registered nurse) #1, MDS nurse. RN #1 stated that they used the RAI manual for guidance in completing the MDS assessments. RN #1 stated that they reviewed the look-back period for any falls when completing the MDS assessments. RN #1 stated that they reviewed the clinical record for falls. RN #1 stated that they would review R46's quarterly MDS with the ARD of 6/4/2022 and see if it should have been coded for falls. On 6/15/2022 at 2:03 p.m., RN #1 stated that they had reviewed the quarterly MDS for R46 and that it should have been coded for falls. RN #1 stated that R46 had falls in May of 2022 which should have been reflected on the quarterly MDS with the ARD of 6/4/2022. According to the RAI Manual, Version 1.16, dated October 2018, section J1800 documented in the steps for assessment, "...If this is not the first assessment/entry or reentry (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment. 3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in	F 641		

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F 641	Continued From page 41 an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment..." On 6/15/2022 at 2:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator and ASM #4, the regional director of operations were made aware of the findings. No further information was provided prior to exit. 2. The facility staff failed to accurately code Resident #114's (R114) quarterly MDS with an ARD (assessment reference date) of 5/23/2022 for falls sustained at the facility since the previous assessment. On the most recent MDS, a quarterly assessment with an ARD of 5/23/2022, 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. Section J1800 documented R114 not having any falls since admission/entry or reentry or prior assessment. Review of the clinical record revealed a list of R114's MDS assessments. The list revealed the prior assessment was an End of PPS Part A Stay MDS with an ARD of 4/18/2022 and an admission assessment with an ARD of 3/1/2022. Review of the clinical record for R114 revealed documented falls on 4/29/2022 and 5/15/2022. The progress notes documented in part: "4/29/2022 18:08 (6:08 p.m.) Resident observe	F 641		

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F 641	Continued From page 42 on bedroom via staff. On assessment, patient side lying lateral to bedroom with face down. Resident unable to note events leading up to fall...No injuries noted [sic] at this time..." "5/15/2022 21:00 (9:00 p.m.) Approx. (approximately) 1930 (7:30 p.m.), writer was called to residents room by staff, writer observed resident laying on his right side, on the floor, next to bed, last observed 15 minutes prior by writer, resting in low bed quietly, eyes closed, call bell and bedside table within reach, wearing non skid socks and facility gown, clean and dry, resident unable to explain how he fell, related to dementia diagnosis, moves upper extremities without pain, lower extremities contracted unable to move, neurochecks wnl (within normal limits), no new injuries noted, no swelling noted, denies all pain and discomfort..." On 6/15/2022 at 9:44 a.m., an interview was conducted with RN (registered nurse) #1, MDS nurse. RN #1 stated that they used the RAI manual for guidance in completing the MDS assessments. RN #1 stated that they reviewed the look-back period for any falls when completing the MDS assessments. RN #1 stated that they reviewed the clinical record for falls. RN #1 stated that they would review R114's quarterly MDS with the ARD of 5/23/2022 and see if it should have been coded for falls. On 6/15/2022 at 2:03 p.m., RN #1 stated that they had reviewed the quarterly MDS for R114 and that it should have been coded for falls. RN #1 stated that R46 had falls between the two MDS assessments which should have been reflected on the quarterly MDS with the ARD of 5/23/2022.	F 641		

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F 641	Continued From page 43 On 6/15/2022 at 2:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator and ASM #4, the regional director of operations were made aware of the findings. No further information was provided prior to exit. 3. For Resident #701, the facility staff failed to accurately complete the admission MDS for resident and staff interviews of sections C and D. Resident #701 was admitted to the facility on 8/17/21 and discharged to an assisted living facility on 9/25/21. The admission nursing assessment dated 8/18/21 documented the resident was alert and oriented to person only. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/21/21, the resident was coded as requiring supervision for eating and extensive assistance for all other areas of activities of daily living. On the above MDS, the resident interviews for Section C "Cognition" and Section D "Mood" were not attempted nor accurately completed. Each question response was documented with a dash. On 6/15/22 at 10:00 AM an interview was conducted with RN #1 (Registered Nurse) the MDS nurse. She stated that dashes are not encouraged and that resident interviews should be attempted, and if they could not be attempted, then that should have been documented. She stated that the staff member who was responsible for completing these sections was no longer at the facility. When asked what policy does the facility follow for completing the MDS, she stated	F 641		

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F 641	Continued From page 44 the RAI manual (Resident Assessment Instrument). Section B "Hearing, Speech, and Vision" of the above MDS was coded as follows: -Section B 0700 "Makes Self Understood" (Ability to express ideas and wants, consider both verbal and non-verbal expression. 0. Understood. 1. Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time. 2. Sometimes understood - ability is limited to making concrete requests. 3. Rarely/never understood.) Resident #128 was coded as a "2." -Section B 0800 "Ability to Understand Others" (Understanding verbal content, however able (with hearing aid or device if used). 0. Understands - clear comprehension. 1. Usually understands - misses some part/intent of message but comprehends most conversation. 2. Sometimes understands - responds adequately to simple, direct communication only. 3. Rarely/never understands.) Resident #128 was coded as a "2." The coding of Section B as "Sometimes" understood and understands indicated that resident interviews for applicable sections below should have been attempted. Section C "Cognitive Patterns" was coded as follows: Section C 0100 Should Brief Interview for Mental Status (C0200-C0500) be Conducted? Attempt	F 641		

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F 641	Continued From page 45 to conduct interview with all residents. -0. No (resident is rarely/never understood) Skip to and complete C0700-C1000, Staff Assessment for Mental Status. -1. Yes Continue to C0200, Repetition of Three Words. The box for both above responses was filled in with a dash (-). Neither response was selected. As the resident was coded in Section B as being sometimes understood and understands, Section C for a resident interview for cognitive patterns should have been attempted. A review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, dated October 2019 was conducted as follows: Page C-1 documented: Most residents are able to attempt the Brief Interview for Mental Status (BIMS). A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance. (1) Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis. (2) Structured interviews will efficiently provide insight into the resident's current condition that will enhance good care...:. And on page C-2 was documented: Code 0, no: if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed	F 641		

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F 641	Continued From page 46 but not available. Skip to C0700, Staff Assessment of Mental Status. Code 1, yes: If the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.... If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items." A "Yes" was not coded for item C0100 as required by the RAI manual in order to dash out the interview responses. The resident interview was not attempted and item C0100 was not accurately completed. Section D "Mood" was coded as follows: D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents. 0. No (resident is rarely/never understood) Skip to and complete D0500-D0600, Staff Assessment of Resident Mood. 1. Yes Continue to D0200, Resident Mood Interview. The box for both above responses was filled in with a dash (-). Neither response was selected. As the resident was coded in Section B as being sometimes understood and understands, Section D for a resident interview for mood should have been attempted.	F 641		

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F 641	Continued From page 47 A review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, dated October 2019 was conducted as follows: Page D-1 documented: Most residents who are capable of communicating can answer questions about how they feel. Obtaining information about mood directly from the resident, sometimes called "hearing the resident's voice, is more reliable and accurate than observation alone for identifying a mood disorder. And on page D-2 was documented: Code 0, no: if the interview should not be conducted because the resident is rarely/never understood or cannot respond verbally, in writing, or using another method, or an interpreter is needed but not available. Skip to item D0500, Staff Assessment of Resident Mood. Code 1, yes: if the resident interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Continue to item D0200, Resident Mood Interview. And on page D-3 was documented: If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item D0100 must be coded	F 641		

PRINTED: 06/28/2022
FORM APPROVED
OMB NO. 0938-0391

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F 641	Continued From page 48 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items. A "Yes" was not coded for item D0100 as required by the RAI manual in order to dash out the interview responses. The resident interview was not attempted and item D0100 was not accurately completed. On 6/15/22 at approximately 4:00 PM, ASM #1 (Administrative Staff Member), the Administrator, ASM #2, the Director of Nursing, and ASM #4, the Regional Director of Operations were made aware of the findings. No further information was provided by the end of the survey.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental 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	F 645	F645 Criteria 1 Resident #19 suffered no adverse outcomes related to the alleged inaccurate or incomplete level I PASARR. Resident #19 has an updated and corrected PASARR. Criteria 2 All current residents needing PASARRs completed have the potential to be affected by the alleged deficient practice. Audit completed to ensure current residents have an up to date PASARR. Criteria 3 Social Services will be re-educated on ensuring PASARR's are completed and accurate.	

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F 645	Continued From page 49 (k)(3)(II) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (I)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (II) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual 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	F 645	Criteria 4 Administrator or designee will complete five (5) random audits of current resident's charts to ensure PASARR's are completed and accurate. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. The results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 645	Continued From page 50 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 and clinical record review, the facility staff failed to ensure a complete and accurate level I PASRR (preadmission screening and resident review) to determine if a level 2 PASRR was required for one of 59 residents in the survey sample, Resident #19. The facility staff failed to entirely complete section 2 of Resident #19's (R19) PASRR and inaccurately documented the resident as not having a serious mental illness. The findings include: On the most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 4/18/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), which indicated the resident was not cognitively impaired for making daily decisions. R19's diagnoses included bipolar disorder (1), borderline personality disorder (2) and dissociative identity disorder (3). R19's level 1 PASRR, completed on 9/14/21 documented, "2. DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)? "No" was circled. "2.a. Is this major mental disorder diagnosable under DSM (Diagnostic and	F 645		

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F 645	Continued From page 51 Statistical Manual of Mental Disorders) (e.g. schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or other mental disorder that may lead to a chronic disability)? Neither "yes" nor "no" was circled. The employee who completed R19's PASRR was not available for interview during the survey. On 6/14/22 at 9:03 a.m., an interview was conducted with OSM (other staff member) #1 (the social worker). OSM #1 stated the admissions department completes PASRRs but she has completed them and is familiar with the process. OSM #1 stated PASRRs are completed based on residents' medical records. OSM #1 stated she knew R19 had some psychiatric diagnoses including bipolar disorder and borderline personality disorder. OSM #1 reviewed R19's PASRR and stated the PASRR was not accurate and one wouldn't know if a level 2 PASRR was needed if the level 1 is not accurate. On 6/15/22 at 11:35 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional clinical coordinator) and ASM #4 (the regional director of operations) were made aware of the above concern. On 6/15/22 at 6:20 p.m., ASM #1 and ASM #2 stated the facility did not have a policy regarding PASRRs. No further information was presented prior to exit. References: (1) "Bipolar disorder is a mood disorder that can cause intense mood swings." This information was obtained from the website:	F 645		

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F 645	Continued From page 52 https://medlineplus.gov/bipolardisorder.html (2) "Borderline personality disorder (BPD) is a mental condition in which a person has long-term patterns of unstable or turbulent emotions. These inner experiences often result in impulsive actions and chaotic relationships with other people." This information was obtained from the website: https://medlineplus.gov/ency/article/000935.htm (3) "Dissociative identity disorder. Formerly known as multiple personality disorder, this disorder is characterized by 'switching' to alternate identities. You may feel the presence of two or more people talking or living inside your head, and you may feel as though you're possessed by other identities." This information was obtained from the website: https://www.mayoclinic.org/diseases-conditions/dissociative-disorders/symptoms-causes/syc-20355215?p=1	F 645		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656	F656 Criteria 1 Residents #'s 14 ,96,701 had no adverse outcomes related to the alleged implementation of resident care plan for medication administration. The physician and RP were notified of alleged medication errors by the nurse. No new orders received. Resident #94 Had no ill effects from O2 of 1.5. liters and O2 sats remained within normal limits. O2 was increased to 3L as per MD order. Resident #58 did not have non- pharmacological interventions prior to administering pain medication. She had no ill effects from alleged deficient practice. Resident #87 had no ill effect from not having hand splint in place. Hand splints were placed on guest and added to C.N.A task list. Pressure ulcer treatment was reinstituted per MD orders. Resident #76 dialysis communication sheets were reimplemented immediately. Dialysis contacted to send communication forms back to the facility. Dialysis catheter site checked and there were no ill effects from the catheter /dialysis. Resident #61's O2 flow was corrected at the time it was noted.	

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F 656	Continued From page 53 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 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for 2 of 3 residents in the medication administration observation task (Residents #14 and #96); and for 6 of 59 residents in the survey sample (Residents #701, #94, #58, #87, #76, and #61).	F 656	Criteria 2 All current residents have the potential to be affected by the alleged deficient practice of implementation of Care Plans. Criteria 3 Licensed nurses will be reeducated on Physician orders, medication administration, development and implementation of resident care plan, Reading the O2 concentrators and validating order, dialysis communication sheets, non-pharmacological interventions for pain management, splint donning and doffing medication pass, and Medication administration. Criteria 4 DON/Designee will randomly audit five Nurses for medication administration, following MD orders, following MD orders, dialysis communication forms, O2 documentation, and following the residents care plan for splinting. These audits will be completed 5 days a week for four weeks; Then one day a week for four weeks; then twice in the last month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 656	Continued From page 54 The findings include: 1. For Resident #14, the facility staff failed to implement the comprehensive care plan for administering medication as ordered. Resident #14 was admitted to the facility on 3/12/21. On the annual MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 3/11/22, Resident #14 scored a 15 out of a possible 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact in ability to make daily life decisions. A review of the comprehensive care plan revealed one dated 3/23/21 for "[Resident #14] is at risk for constipation R/T (related to): decreased mobility, medications side effects." This care plan included the intervention, dated 3/23/21 for "Administer medications as ordered and observe for ineffectiveness/side effects. Report abnormal findings to the physician." On 6/14/22 at 8:17 AM, LPN #5 (Licensed Practical Nurse) was observed to prepare and administer the following medications for Resident #14: Methimazole 5 mg (milligrams), 1 tab. Buspar 10 mg, 1 tab Aspirin 81 mg, 1 tab Magnesium Oxide 400 mg, 1 tab On 6/14/22 at 11:16 AM, reconciliation of the medications was conducted compared with the physician's orders. An order dated 9/8/21 for a lidocaine 4% patch (1) to the left knee every morning was noted. It was noted that LPN #5	F 656		

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F 656	Continued From page 55	F 656		

signed out for a lidocaine patch to left knee as being administered when it had not been administered.

On 6/14/22 at 12:40 PM an interview was conducted with Resident #14. When asked if they received their pain patch on their knee this morning, they stated that they did not.

On 6/14/22 at 12:40 PM an interview was attempted with LPN #5 regarding the missed medication. He refused to answer any questions, denied doing anything wrong and walked away from the surveyor.

On 6/14/22 at 12:45 PM the above concern was reported to ASM #1 (Administrative Staff Member) the Administrator and ASM #4, the Regional Director of Operations.

On 6/14/22 at 3:00 PM, an interview was conducted with LPN #4 (Licensed Practical Nurse) regarding medication administration. She stated that if a resident was not administered medications and there was no parameters to hold it, then the care plan to administer medications as ordered was not being followed.

On 6/15/22 at 9:03 AM, an interview regarding the purpose of care plans was conducted with LPN #6. LPN #6 stated that the purpose of the care plan was so that staff know what the resident is doing and what staff need to do to care for the resident.

A review of the facility policy, "Care Planning" was conducted. The policy documented, "Every resident in the facility will have a person-centered Plan of Care developed and implemented that is

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F 656	Continued From page 56 consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs identified in the comprehensive assessments and prepared by an interdisciplinary team who includes but not limited to; attending physician, a registered nurse who is responsible for the resident, a nurse aide, a member of food/nutrition services, the resident or resident representative, therapy staff as required and any other ancillary staff. Additional resources will also be utilized to ensure that any additional needs or risk areas are identified..." On 6/15/22 at approximately 4:00 PM, ASM #1 (Administrative Staff Member), the Administrator, ASM #2, the Director of Nursing, and ASM #4, the Regional Director of Operations were made aware of the findings. No further information was provided by the end of the survey. References: (1) Lidocaine - is used to treat pain Information obtained from https://medlineplus.gov/druginfo/meds/a603026.html 2. For Resident #96, the facility staff failed to implement the comprehensive care plan for administering medication as ordered. Resident #96 was admitted to the facility on 2/15/20. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/11/22, Resident #96 scored a 13 out of a possible 15 on the BIMS (brief interview for mental status) indicating the resident was	F 656		

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F 656	Continued From page 57 cognitively intact in ability to make daily life decisions. The resident was coded as supervision for eating and extensive to total care for other areas of activities of daily living. A review of the comprehensive care plan revealed one dated 5/12/21 for "[Resident #96] is at risk for abnormal bleeding/bruising R/T (related to): medication use..." The care plan included an intervention dated 5/12/21 for "Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician." Another care plan, dated 7/22/21 was for "[Resident #96] is at risk for constipation R/T: decreased mobility, diminished appetite, Hx (history) of constipation, medications side effects." This care plan included the intervention, dated 7/22/21 for "Administer medications as ordered and observe for ineffectiveness/side effects. Report abnormal findings to the physician." On 6/14/22 at 8:28 AM, LPN #5 (Licensed Practical Nurse) was observed to prepare and administer the following medications for Resident #96: Dulera 100 mcg (micrograms) / 5 mcg inhaler Aspirin 325 mg (milligrams), 1 tab Vitamin D3 25 mcg, 1 tab Colace 100 mg, 1 tab Glipizide 5 mg, 1 tab Genvoya 150 mg/150 mg/200 mg/10 mg, 1 tab Risperdone 0.5 mg, 1 tab Prednisone 10 mg, 1 tab Senna 8.6 mg, 1 tab Acetaminophen 325 mg, 1 tab Spiriva 18 mcg	F 656		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 58 On 6/14/22 at 11:15 AM, reconciliation of the medications was conducted compared with the physician's orders. An order dated 6/30/21 for Alaway (1) eye drops and an order dated 1/18/21 for Pepcid (2) were noted. It was noted that LPN #5 signed out these medications as being administered when they had not been administered. On 6/14/22 at 12:40 PM an interview was attempted with LPN #5 regarding the missed medication. He refused to answer any questions, denied doing anything wrong and walked away from the surveyor. On 6/14/22 at 12:45 PM the above concern was reported to ASM #1 (Administrative Staff Member) the Administrator and ASM #4, the Regional Director of Operations. On 6/14/22 at 3:00 PM, an interview was conducted with LPN #4 (Licensed Practical Nurse) regarding medication administration. She stated that if a resident was not administered medications and there was no parameters to hold it, then the care plan to administer medications as ordered was not being followed. On 6/15/22 at 9:03 AM, an interview regarding the purpose of care plans was conducted with LPN #6. LPN #6 stated that the purpose of the care plan was so that staff know what the resident is doing and what staff need to do to care for the resident. A review of the facility policy, "Care Planning" was conducted. This policy documented, "Every resident in the facility will have a person-centered Plan of Care developed and implemented that is	F 656		

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F 656	Continued From page 59 consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs identified in the comprehensive assessments and prepared by an interdisciplinary team who includes but not limited to; attending physician, a registered nurse who is responsible for the resident, a nurse aide, a member of food/nutrition services, the resident or resident representative, therapy staff as required and any other ancillary staff. Additional resources will also be utilized to ensure that any additional needs or risk areas are identified..." On 6/15/22 at approximately 4:00 PM, ASM #1 (Administrative Staff Member), the Administrator, ASM #2, the Director of Nursing, and ASM #4, the Regional Director of Operations were made aware of the findings. No further information was provided by the end of the survey. References: (1) Alaway is used for the treatment of allergy symptoms of the eyes Information obtained from https://medlineplus.gov/druginfo/meds/a604033.html (2) Pepcid is used for the treatment of reflux and ulcers Information obtained from https://medlineplus.gov/druginfo/meds/a687011.html 3. For Resident #701, the facility staff failed to implement the comprehensive care plan for	F 656		

PRINTED: 06/28/2022
FORM APPROVED
OMB NO. 0938-0391

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F 656	Continued From page 60 administering medication as ordered. Resident #701 was admitted to the facility on 8/17/21 and discharged to an assisted living facility on 9/25/21. The admission nursing assessment dated 8/18/21 documented the resident was alert and oriented to person only. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/21/21, the resident was coded as requiring supervision for eating and extensive assistance for all other areas of activities of daily living. A review of the comprehensive care plan for Resident #701 revealed one dated 9/2/21 for "[Resident #701] is at risk for abnormal bleeding/bruising R/T: medication use..." The interventions included one dated 9/2/21 for "Administer medications as ordered...." A review of the clinical record revealed a nurse's note dated 9/20/21 at 7:20 AM (note actually created on 9/22/21 at 3:05 PM) that documented, "[Resident #701] and another resident was put to bed in the wrong beds. on med pass [Resident #701] received the medication of the resident of who bed (they) was put into during the night. (They) received Levothyroxine (1). (They) was monitored and (their) brother was notified about the medication error. [Resident #701] ate (their) breakfast and responded back when being talked to. No S/S (signs or symptoms) of an (sic, a) reaction noted." A nurse's note dated 9/21/21 documented, "notified brother of med event on 9-21-21, also notified np (nurse practitioner) and md (medical doctor) of med event n.n.o (no new orders) at this time will cont (continue) to monitor."	F 656		

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F 656	Continued From page 61 A review of the "Incident Report" about the medication error, dated 9/20/21, included a written statement dated 9/21/21 from the nurse that made the medication error, documented, "On 9/21/21 I administered to [Resident #701] two Tylenol (2) and synthroid (same as 1); When I administered [Resident #701] (their) medication I did not ask (their) name, I looked at (their) picture in the electronic record and thought it was the person laying in the bed. I was asked by the aide why [Resident #701] wasn't in (their) bed approximately seven in the morning. I then went to the computer and, identified in the computer the picture and calling out the guest name to clearly identify the MD. the aide (name) stated that she placed [Resident #701] in the wrong room around approximately three A.M. Vital signs were taken and no distress noted - same level of cognitive level." Further review of the incident report included a copy of the facility policy, "Medication Administration" which documented, "Medications are administered in accordance with written orders of the attending physician....Verify the medication label against the medication administration record for the guest/resident name, time, drug, dose, and route....Never administer medications supplied for one guest/resident to another guest/resident...." The above policy addressed steps for preparing medications accurately at the medication cart but identified no criteria for verifying the resident being administered the medication at the bedside was the correct resident (i.e. ask their name, check for ID band if applicable.)	F 656		

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F 656	Continued From page 62 The nurse who made the medication error was no longer at the facility and could not be interviewed. On 6/14/22 at 3:00 PM, an interview was conducted with LPN #4 (Licensed Practical Nurse) regarding medication administration. She stated that if a resident was not administered medications and there was no parameters to hold it, then the care plan to administer medications as ordered was not being followed. On 6/15/22 at 9:03 AM, an interview regarding the purpose of care plans was conducted with LPN #6. LPN #6 stated that the purpose of the care plan was so that staff know what the resident is doing and what staff need to do to care for the resident. A review of the facility policy, "Care Planning" was conducted. This policy documented, "Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs identified in the comprehensive assessments and prepared by an interdisciplinary team who includes but not limited to; attending physician, a registered nurse who is responsible for the resident, a nurse aide, a member of food/nutrition services, the resident or resident representative, therapy staff as required and any other ancillary staff. Additional resources will also be utilized to ensure that any additional needs or risk areas are identified..." On 6/15/22 at approximately 4:00 PM, ASM #1 (Administrative Staff Member), the Administrator,	F 656		

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F 656	Continued From page 83 ASM #2, the Director of Nursing, and ASM #4, the Regional Director of Operations were made aware of the findings. No further information was provided by the end of the survey. References: (1) Levothyroxine - is used to treat hypothyroidism Information obtained from https://medlineplus.gov/druginfo/meds/a682461.html (2) Tylenol - is used to treat mild to moderate pain Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html COMPLAINT DEFICIENCY 4. For Resident #94, the facility staff failed to implement the comprehensive care plan for the use of oxygen. Resident #94 was admitted to the facility on 3/30/20. On the most recent MDS (Minimum Data Set) an annual assessment with an ARD (Assessment Reference Date) of 5/10/22, Resident #94 scored an 11 out of a possible 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living, except for eating which only required supervision. A review of the clinical record revealed a physician's order dated 1/25/22 for oxygen at 3	F 656		

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F 656	Continued From page 64 liters per minute continuously. A review of the comprehensive care plan revealed one dated 10/10/20 for "[Resident #94] has a potential for difficulty breathing and risk for respiratory complications..." This care plan included the intervention, dated 3/15/21 for "Administer medication and treatments per physician orders....oxygen per order..." On 6/13/22 at 1:13 PM and 6/14/22 at 9:04 AM, Resident #94 was observed in bed with oxygen on. The flow meter reflected an oxygen rate of 1.5 liters per minute as evidenced by the line for the 1.5 liter mark crossing through the middle of the flow meter ball. On 6/14/22 at 3:00 PM, an interview was conducted with LPN #4 (Licensed Practical Nurse). She stated that the resident's oxygen rate should be 3 liters per minute. When asked if the rate was set at 1.5 liters, was the oxygen being administered as ordered, she stated that it was not. When asked was the care plan being followed, she stated that it was not. On 6/15/22 at 9:03 AM, an interview regarding the purpose of care plans was conducted with LPN #6. LPN #6 stated that the purpose of the care plan was so that staff know what the resident is doing and what staff need to do to care for the resident. A review of the facility policy, "Care Planning" was conducted. The policy documented, "Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes	F 656		

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F 656	Continued From page 65 measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs identified in the comprehensive assessments and prepared by an interdisciplinary team who includes but not limited to; attending physician, a registered nurse who is responsible for the resident, a nurse aide, a member of food/nutrition services, the resident or resident representative, therapy staff as required and any other ancillary staff. Additional resources will also be utilized to ensure that any additional needs or risk areas are identified..." On 6/15/22 at approximately 4:00 PM, ASM #1 (Administrative Staff Member), the Administrator, ASM #2, the Director of Nursing, and ASM #4, the Regional Director of Operations were made aware of the findings. No further information was provided by the end of the survey. 6. Facility staff failed to implement Resident #58's (R58's) comprehensive care plan for attempting non-pharmacological interventions prior to the administration of a PRN [as needed] pain medication tramadol (1). (R58) was admitted to the facility with a diagnosis that included by not limited to: rheumatoid arthritis. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 04/17/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section J0300 "Pain Presence" coded (R58) as having frequent pain in the past 5 (five) days. Section J0600 "Pain Intensity" coded (R58) as having a pain level of five out of ten with tem	F 656		

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F 656	Continued From page 66 being the worse pain. The physician's order for (R58) documented in part, "Tramadol HCl (hydrochloride) Tablet 50 MG (milligram). Give 1 tablet by mouth every 6 (six) hours as needed for pain. Complete NPI (non-pharmacological interventions) with use. Order date: 4/18/2022." The eMAR (electronic medication administration record) for (R58) dated June2022 documented the physician's order as stated above and "Pain-Non-Pharmacological Interventions: Document Non Pharmacological interventions used: 1)Massage. 2) Meditation/Relaxation. 3)Positioning. 4) Ice/cold pack. 5)Diversional Activity. 6) Guided Imagery. 7) Rest. 8)Social Interaction. as needed Document NonPharmacological Interventions using the corresponding number. Start Date04/12/2022." Review of the eMAR failed to evidence documentation of non-pharmacological interventions as stated above from 06/01/2022 through 06/12/2022. The eMAR revealed that (R58) received 50 mgs of tramadol on the following dates and times, with no evidence of non-pharmacological interventions being attempted on: 06/01/2022 at 7:06 a.m., 06/02/2022 at 10:48 a.m. and at 6:29 p.m., 06/03/2022 at 11:07 a.m., 06/04/2022 at 12:21 p.m., 06/06/2022 at 8:24 a.m., 06/07/2022 at 10:19 a.m. and at 9:59 p.m., 06/08/2022 at 5:20 p.m. and at 9:43 p.m., 06/09/2022 at 8:46 a.m. and at 8:26 p.m., 06/10/2022 at 5:50 a.m., 06/11/2022 at 9:38 p.m. and on 06/12/2022 at 4:32 a.m. and at 9:33 p.m. The comprehensive care plan for (R58)	F 656		

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F 656	Continued From page 67	F 656		

documented in part, "Focus. (R58) is at risk for pain and/or has acute/chronic pain r/t (related to) DX (diagnoses: RA (rheumatoid arthritis), DJD (degenerative joint disease), GERD (gastroesophageal reflux disease). Date Initiated: 04/13/2022." Under "Interventions" it documented in part, "Evaluate the effectiveness of pain interventions as given. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition as needed. Date Initiated: 04/13/2022."

Review of the facility's nurse's notes for (R58) dated 06/01/2022 through 06/12/2022 failed to evidence non-pharmacological interventions being attempted on the dates and times listed above.

On 06/15/22 at 8:00 a.m., an interview was conducted with LPN (licensed practical nurse) #7. When asked to describe the procedure when administering as needed pain medication LPN #7 stated that the nurse assesses the resident's pain by obtaining the severity of the resident's pain on a scale of zero to ten, with ten being the worse pain, the location of the pain and the type of pain such as throbbing or stabbing. LPN #7 stated that the nurse would then start with non-pharmacological interventions such as repositioning, ice pack, or heat, and if that does not alleviate the resident's pain, they would administer the prescribe medication. When asked how often non-pharmacological interventions LPN #7 stated that it should be attempted each time before the as needed pain medication is administered. When asked where it would be documented that the location of pain, type of pain and non-pharmacological

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F 656	Continued From page 68 interventions were attempted LPN #7 stated that it would be documented in the nurse's notes or the eMAR. After review of the eMAR for non-pharmacological interventions LPN #7 was asked about the missing documentation. LPN #7 stated that they could not say non-pharmacological interventions were attempted because it was not documented. After reviewing (R58's) comprehensive care plan, LPN #7 was asked to explain the intervention for (R58's) pain care plan as stated above. LPN #7 stated that the intervention referred to implementing non-pharm interventions. When asked if (R58's) care was implemented for the use and documenting of non-pharm interventions LPN #7 stated no. On 06/15/2022 at approximately 11:35 a.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 3, regional clinical coordinator, ASM# 4, regional director of operations. No further information was presented prior to exit. References: (1) Tramadol is used to relieve moderate to moderately severe pain. Tramadol extended-release tablets and capsules are only used by people who are expected to need medication to relieve pain around-the-clock. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html. 6. The facility staff failed to implement the comprehensive care plan for Resident #87 (R87) for (A) pressure ulcer treatments and (B) the use of hand splints.	F 656		

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F 658	Continued From page 69 On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/12/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is not cognitively impaired for making daily decisions. Section M documented R87 having 1 Stage 4 pressure ulcer and 1 Stage 3 pressure ulcer. A. On 6/14/2022 at 8:25 a.m., an interview was conducted with R87 in their room. R87 stated that the nurses had been in earlier that morning to change their wound dressing and had gotten better about doing the wound care as ordered. R87 stated that they had problems in the past with getting the wound dressing changed and their family had complained to the nurses about it. The comprehensive care plan for R87 documented in part, "Skin #2: [R87] has pressure ulcers to sacrum and right thigh. Stage 4, Being followed by wound doctor. Date Initiated: 07/17/2019. Revision on: 06/14/2022..." Under "Interventions" it documented in part, "...Treatments as ordered;..." The eTAR (electronic treatment administration record) for R87 dated 1/1/2022-1/31/2022 failed to evidence documentation of a treatment provided to the sacral wound 1/7/2022 through 1/17/2022. The progress notes documented in part, - "1/10/2022 22:38 (10:38 p.m.) Note Text: Sacral wound care provided during shift. Yellow/reddish discharge noted. Foul odor noted. No c/o pain/discomfort while providing wound care. Pain meds offered, declined per resident."	F 658		

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THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23238

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F 656	Continued From page 70 The progress notes failed to evidence documentation of treatment to the sacral wound 1/7/2022-1/9/2022 and 1/11/2022-1/17/2022. The physician orders reviewed from 1/1/2022 through 1/31/2022 documented in part, "Wound care: Sacral wound- clean with 1/4 Dakins solution- pack with Silver Calcium Alginate QD (every day) and PRN (as needed)- cover with dry dressing. Order Date: 01/07/2022, End Date: 01/17/2022..." The order failed to evidence a start date. The wound evaluation & management summary dated 1/7/2022 documented in part, "Stage 4 pressure wound sacrum full thickness...Wound progress: deteriorated, Additional wound detail: larger, d/c dakins packing, start Silver Alginate, dressing treatment plan, primary dressing(s), Sodium hypochlorite solution (dakins) apply once daily for 30 days: clean with 1/4 dakins solution; Alginate calcium w/silver apply once daily for 30 days. secondary dressing(s), gauze island (w/bdr) (with border) apply once daily for 30 days..." The wound evaluation & management summary dated 1/14/2022 documented in part, "Stage 4 pressure wound sacrum full thickness...Wound progress: improved, Additional wound detail: smaller, dressing treatment plan, primary dressing(s), Sodium hypochlorite solution (dakins) apply once daily for 23 days: clean with 1/4 dakins solution; Alginate calcium w/silver apply once daily for 23 days. secondary dressing(s), gauze island (w/bdr) apply once daily for 23 days..." The wound evaluation & management summary	F 656		

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F 656	Continued From page 71 dated 1/28/2022 documented in part, "Stage 4 pressure wound sacrum full thickness...Wound progress: improved, Additional wound detail: shorter, no longer with exposed bone, dressing treatment plan, primary dressing(s), Sodium hypochlorite solution (dakins) apply once daily for 9 days: clean with 1/4 dakins solution; Alginate calcium w/silver apply once daily for 9 days. secondary dressing(s), gauze island (w/bdr) apply once daily for 9 days..." On 6/14/2022 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that the care plan was to guide the staff on how to care for the resident. LPN #9 stated that the staff use the care plan to know what to do for the residents and were not implementing the care plan if they were not following the interventions. On 6/15/2022 at 9:56 a.m., a telephone interview was conducted with ASM (administrative staff member) #7, the wound physician. ASM #7 stated that R87 had a sacral wound they had been following for 956 days. ASM #7 stated that R87's wound was slow to heal due to medical comorbidities and noncompliance with offloading and turning and positioning. ASM #7 stated that there was a zinc barrier cream ordered for the skin around the wound but was not the primary treatment for the pressure ulcer. ASM #7 stated that there should be a continuous treatment in place for the Stage 4 pressure wound treatment. On 6/15/2022 at 10:54 a.m., an interview was conducted with LPN #3, the unit manager. LPN #3 stated that treatments were evidenced as completed by documenting them on the eTAR. LPN #3 stated that if there was no documentation	F 656		

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F 656	Continued From page 72 there was no evidence to support that anything was done. LPN #3 they were always taught that if it was not documented it was not done. LPN #3 reviewed the eTAR for R87 dated 1/1/2022-1/31/2022 and stated that they did not see any evidence that there was a treatment in place for the sacral pressure ulcer between 1/7/2022-1/17/2022. On 6/15/2022 at 1:29 p.m., an interview was conducted with LPN #2, wound nurse. LPN #2 stated that they were new to the wound nurse position. LPN #2 stated that R87's pressure ulcer was slow to heal due to non-compliance with offloading and turning and positioning off of the wound. LPN #2 stated that they round with the wound doctor and make any changes to treatment orders as needed when the physician rounds. LPN #2 reviewed the physician orders and the eTAR for R87 dated 1/1/2022-1/31/2022 and stated that they did not see any evidence of a treatment in place for the pressure ulcer from 1/7/2022-1/17/2022. On 6/15/2022 at approximately 4:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator and ASM #4, the regional director of operations were notified of the findings. No further information was provided prior to exit. Complaint deficiency B. On 6/14/2022 at 8:25 a.m., an interview was conducted with R87 in their room. R87 stated that they used to wear hand splints to keep their hands from getting stiff but had not worn them in	F 656		

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F 656	Continued From page 73	F 656		

months. R87 stated that they wanted to wear the hand splints and had asked about them but the nurses had told them that therapy had to evaluate for them. R87 stated that they did not know if the staff knew where they were or not and no one ever offered to apply them anymore.

Additional observations of R87 on 6/13/2022 at 2:45 p.m. and 4:30 p.m. and 6/14/2022 at 10:50 a.m., revealed them not wearing hand splints.

The comprehensive care plan for R87 documented in part, "[R87] is at risk for Contracture development, Date Initiated: 04/05/2022. Revision on: 04/05/2022..." Under "Interventions" it documented in part, "Pt (patient) to wear hand splints to both hands daily for contracture mgmt (management). Apply after morning ADL (activities of daily living) care and remove in the evening or as requested by pt. Date Initiated: 04/05/2022..."

The Occupational therapy OT discharge summary for R87 dated 12/7/2021 documented in part, "...Pt (patient) to wear B (bilateral) hand splints daily, on after ADL morning routine and off after lunch/before dinner. Pt has been tolerating 4 hour wear and is able to communicate to staff when she wants splints removed...Restorative aide trained in splint program and PROM (passive range of motion) to BUE (bilateral upper extremities) and hands..."

On 6/14/2022 at 2:48 p.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 stated that they perform passive range of motion exercises on residents during ADL care. CNA #5 stated that they were not aware of any residents that had splints on their

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F 656	Continued From page 74 hallway. CNA #5 stated that they thought the nurses or the therapist applied the splints because the CNAs did not. On 6/14/2022 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that therapy evaluated and recommended splint use for residents. LPN #9 stated that the nurses would follow up and make sure the splint is being applied by the CNAs or the nurse. LPN #9 stated that the care plan was to guide the staff on how to care for the resident. LPN #9 stated that the staff use the care plan to know what to do for the residents and were not implementing the care plan if they were not applying the splints as directed in the care plan. LPN #9 stated that they thought they remembered R87 having hand splints and that the CNAs should apply them after morning care. LPN #9 went to R87's room and found two hand splints in the drawer of the nightstand. R87 stated to LPN #9, "Oh, you found them, I am glad because no one knew where they were." LPN #9 proceeded to apply the splints to R87's hands. On 6/16/2022 at approximately 4:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator and ASM #4, the regional director of operations were notified of the findings. No further information was provided prior to exit. 7. The facility staff failed to implement the comprehensive care plan for dialysis care for Resident #76. Resident #76 was admitted to the facility on	F 656		

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F 656	Continued From page 75 7/19/21. Resident #76's diagnoses included, but were not limited to, ESRD (end stage renal disease) and dementia. Resident #76's most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 3/19/22, coded the resident as scoring 9 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of Resident #76's comprehensive care plan revised 9/9/21, revealed the following, "NEED: Resident is at risk for complications related to needs for dialysis due to: End Stage Renal Disease. dialysis cath replaced 1/6/21. Hemodialysis Tuesday, Thursday, Saturday. INTERVENTIONS: Observe for signs/symptoms of infection to access site: Redness, Swelling, warmth or drainage/bleeding and other signs of infection: fever, generalized malaise, complaints of abdominal pain, chills. Document and report abnormal findings to the physician. For Hemodialysis: Facility will utilize the Dialysis Communication form to communicate with the dialysis center. Send the dialysis communication book to the dialysis center with each appointment. Upon return from the dialysis center review the communication book including any progress notes and provide an update to the physician and any staff member/disciplines as needed. A review of the physician's orders dated 8/9/21 renewed 5/2/22, revealed the following, "Hemodialysis Tuesday, Thursday, Saturday. Monitor dialysis catheter Right Chest for signs/symptoms of infection. May reinforce dressing if needed. Monitor every shift."	F 656		

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F 656	Continued From page 76 A review of the dialysis binder for Resident #76 on 6/14/22, revealed the following, the facility's "Hemodialysis Communication Form" was completed on the following dates, 6/14/22, 4/22/22, 4/7/22, 3/29/22, 3/28/22 and 3/24/22. The facility failed to provide communication to the dialysis facility for 10 of 14 visits in March 2022, the missing dates in March 2022 were: 3/1, 3/3, 3/8, 3/10, 3/12 3/15, 3/17, 3/19, 3/22 and 3/31. The facility failed to provide communication to the dialysis facility for 11 of 13 visits in April 2022, the missing dates in April 2022 were: 4/2, 4/5, 4/9, 4/12, 4/14, 4/16, 4/19, 4/23, 4/26, 4/28 and 4/30. The facility failed to provide communication to the dialysis facility for 13 of 13 visits in May 2022, the missing dates in May 2022 were: 5/3, 5/5, 5/7, 5/10 5/12, 5/14, 5/17, 5/19, 5/21, 5/24, 5/26, 5/28 and 5/31. The facility failed to provide communication to the dialysis facility for 5 of 5 visits in June 2022, the missing dates in June 2022 were: 6/2, 6/4, 6/7, 6/9 and 6/11. A review of the TAR (treatment administration record) for March 2022, revealed the following, "Monitor dialysis catheter Right Chest for signs/symptoms of infection. May reinforce dressing if needed. Monitor every shift." The reviewed evidenced that 25 out of 93 shifts/opportunities were missing documentation. Missing dates were day shift: 3/1, 3/2, 3/4, 3/5, 3/6, 3/7, 3/12, and 3/15; evening shift 3/3, 3/6, 3/8, 3/9, 3/24 and 3/26 and night shift 3/1, 3/4, 3/6, 3/7, 3/9, 3/10, 3/11, 3/14, 3/15, 3/22 and	F 656		

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F 656	Continued From page 77 3/29. A review of the TAR for April 2022, revealed the following, "Monitor dialysis catheter Right Chest for signs/symptoms of infection. May reinforce dressing if needed. Monitor every shift." The review evidenced that 6 out of 61 shifts/opportunities were missing documentation. Missing dates were day shift: 4/1, 4/9, 4/10 and 4/21; evening shift 4/8 and night shift 4/4. A review of the TAR for May 2022, revealed the following, "Monitor dialysis catheter Right Chest for signs/symptoms of infection. May reinforce dressing if needed. Monitor every shift." The review evidenced that 8 out of 90 shifts/opportunities were missing documentation. Missing dates were day shift: 5/8, 5/17 and 5/23; evening shift: 5/23, 5/25, 5/26 and 5/28 and night shift 5/11. A review of the TAR for June 2022, revealed the following, "Monitor dialysis catheter Right Chest for signs/symptoms of infection. May reinforce dressing if needed. Monitor every shift." The review evidenced that 6 of 42 shifts were missing documentation. Missing dates were day shift: 6/5, 6/8, 6/10 and 6/11; evening shift: 6/10 and night shift 6/8. On 6/13/22 at 3:25 PM, an interview was conducted with Resident #76. When asked if she had a dialysis binder, Resident #76 stated, I have one. I believe I left it at the dialysis center. When asked if they check the dialysis catheter site every shift, Resident #76 stated, I do not think so. An interview was conducted on 6/14/22 at 3:00 PM with LPN (licensed practical nurse) #3. When	F 656		

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F 656	Continued From page 78 asked the purpose of the care plan, LPN #3 stated, the purpose of the care plan is to identify the needs of each resident and what actions need to be taken for those needs. When asked if not having the dialysis communication sheets sent with the resident indicated the care plan was being followed, LPN #3 stated, no, it would not be followed in that case. When asked if there were blanks on the TAR, what that indicated, LPN #3 stated, if there are blanks, then I have always been taught, if it was not documented it was not done. When asked if dialysis catheter care was not documented, was the care plan being followed, LPN #3 stated, no, it was not. On 6/14/22 at 4:20 PM, ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator were informed of the above concern. A review of the facility's "Care Planning" policy dated 6/21, which reveals, "In addition to care plans based on admission orders, goals for admission and desired outcomes, interdisciplinary team assessments, physician orders. No further information was provided prior to exit. 8. The facility staff failed to implement the comprehensive care plan for oxygen therapy for Resident #61. Resident #61 was admitted to the facility on 4/23/21 with diagnoses that included, but not limited to, COPD (chronic obstructive pulmonary disease). Resident #61's most recent MDS (minimum data set) assessment, a quarterly assessment, with an	F 656		

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assessment reference date of 4/22/22, coded the resident as scoring 7 out of 15 on the BIMS (brief interview for mental status score), indicating the resident was severely cognitively impaired. The resident was coded as requiring extensive assistance in bed mobility, transfers, dressing; total dependence with toileting, bathing and personal hygiene and supervision with eating.

Resident #61's care plan dated 4/24/21 with no revision date, revealed the following, "Need: Resident has a potential for difficulty breathing and risk for respiratory complications related to: COPD. Interventions: Elevate head of bed, encourage cough & deep breathing, Oxygen as ordered via nasal cannula every shift for SOB (shortness of breath), COPD oxygen per order."

A review of the physician's orders dated 4/4/22, revealed the following, "Oxygen 2l/min via nasal cannula for SOB.
every shift for SOB."

Resident #61 was observed with oxygen via nasal cannula at 3 liters per minute on 6/13/22 at 1:09 PM, 6/14/22 at 9:00 AM and 6/14/22 at 2:50 PM. The oxygen concentrator is the Invacare Perfecto2.

An interview was unable to be conducted with Resident #61 due to cognitive impairment.

On 6/14/22 at 2:55 PM, LPN (licensed practical nurse) #3 was asked to observe the oxygen setting on Resident #61.

An interview was conducted on 6/14/22 at 3:00 PM with LPN (licensed practical nurse) #3. When asked the purpose of the care plan, LPN #3

PRINTED: 08/26/2022
FORM APPROVED
OMB NO. 0938-0391

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F 656	Continued From page 80 stated, the purpose of the care plan is to identify the needs of each resident and what actions need to be taken for those needs. When asked the oxygen setting observed, LPN #3 stated, it is set on 3 liters nasal cannula. When asked if the oxygen being set at 3 liters nasal cannula, indicated that the care plan was being followed, LPN #3 stated, "No, it is not." On 6/14/22 at 4:20 PM, ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator were informed of the above concern. According to the instruction manual for the Invacare Perfecto2 oxygen concentrator, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow know until the ball rises to the line. Now center the ball on the liters per minute line prescribed." The facility's "Physician orders" policy dated 6/24/21, revealed the following, "Treatment rendered to a guest/resident must be in accordance with the specific standing, written, verbal, or telephone order of a physician or other licensed health professional ordering within their scope of practice and clinical privileges." No further information was provided prior to exit.	F 656		
F 657 SS=E	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.	F 657	F657 Criteria 1 Resident # 114 had her care plan updated with Splint to RU arm splint and use of fall mats. Splint was applied to resident # 114. Fall mats were care planned and put in place for resident #114. Resident # 87 and Resident 25's care plans were updated to reflect the altercation and prevention of further confrontations. Resident # 336 was discharged from the facility on 10/21/21.	

PRINTED: 06/28/2022
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OMB NO. 0938-0391

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F 657	Continued From page 81 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, clinical record review, facility document review and in the course of a complaint investigation it was determined that the facility staff failed to review and/or revise the comprehensive care plan for 4 of 59 residents in the survey sample. Resident #114, #87, #25, #336. The findings include: 1. The facility staff failed revise Resident #114's comprehensive care plan for (A) the use of a splint to the right upper arm and (B) the use of fall mats.	F 657	Criteria 2 All current residents have the potential to be affected by the alleged deficient practice. Criteria 3 Licensed nurses will be re- educated on fall policy, updating plan of care for the use of devices (brace/splint), resident-to-resident incidents, and after a fall. Criteria 4 DON/Designee will randomly audit five Nurses for care plan updates related to falls. These audits will be completed 5 days a week for four weeks; Then one day a week for four weeks; then twice in the last month. The results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 82 On the most recent MDS, a quarterly assessment with an ARD of 5/23/2022, the resident scored 3 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section J1800 documented R114 not having any falls since admission/entry or reentry or prior assessment. A. On 6/13/2022 at 1:59 p.m., an observation was made of R114 in their room. R114 was observed lying in bed with a t-shirt on and asleep. R114 was observed not wearing a splint on the right upper arm. Additional observations of R114 in their room on 6/13/2022 at 3:41 p.m. and 4:24 p.m. and 6/14/2022 at 8:45 a.m. and 1:30 p.m. revealed R114 not wearing a splint on the right upper arm. The comprehensive care plan for R114 documented in part, "[R114] is at risk for contracture development. Has contractures to all 4 extremities. Date Initiated: 03/10/2022. Revision on: 03/10/2022." The care plan failed to evidence an intervention for the right wrist extension brace. The physician orders for R114 documented in part, - "Pt (patient) to wear R (right) wrist extension brace RUE (right upper extremity) during the day as tolerated. Perform skin inspections daily. one time a day. Order Date: 04/02/2022." The clinical record failed to evidence documentation of R114 refusing to wear the RUE wrist extension brace on 6/13/2022 or 6/14/2022.	F 657		

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F 657	Continued From page 83 On 6/14/2022 at 2:48 p.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 stated that they perform passive range of motion exercises on residents during ADL care. CNA #5 stated that they were not aware of any residents that had splints on their hallway. CNA #5 stated that they thought the nurses or the therapist applied the splints because the CNAs did not. On 6/14/2022 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that therapy evaluated and recommended splint use for residents. LPN #9 stated that the nurses would follow up and make sure the splint is being applied by the CNAs or the nurse. LPN #9 stated that the care plan was to guide the staff on how to care for the resident. LPN #9 stated that the staff use the care plan to know what to do for the residents and were not implementing the care plan if they were applying the splints as directed in the care plan. LPN #9 stated that they thought they remembered R114 having a splint on their arm when they were on the other unit. LPN #9 went to R114's room and found a splint in the closet. LPN #9 proceeded to apply the splint to R114 right arm. On 6/15/2022 at 9:44 a.m., an interview was conducted with RN (registered nurse) #1, MDS nurse. RN #1 stated that the care plan was used to guide the staff on how to care for the patient. RN #1 stated that anything that required a physician order was placed on the care plan. RN #1 stated that splints were placed on the care plan so the staff would know to use them. On 6/15/2022 at 11:31 a.m., RN #1 stated that	F 657		

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F 657	Continued From page 84 they had reviewed R114's care plan and the splint was not included but should have been. RN #1 stated that they had corrected the care plan. The facility policy, "Care Planning" dated 9/1/2011 documented in part, "...The care plan must be specific, resident centered, individualized and unique to each resident and may include: It should be oriented toward preventing avoidable declines. How to manage risk factors. Address/include resident strengths. Utilize current standards of practice...The care plan and resident kardex will be updated on Admission, Quarterly, Annually and with significant changes. This includes adding new focuses, goals, and interventions and resolving ones that are no longer applicable as needed..." The facility policy, "Brace and Splint Program" dated 1/1/2012 documented in part, "...a. A care plan will be developed that has measurable objectives and interventions and that include the following: b. Applying the brace/splint: Resident applies the brace with staff that provide verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for the appliance. c. Staff has a scheduled program of applying and removing the appliance that includes: d. Scheduled hours to be worn and when skin will be inspected for signs and symptoms of pressure areas, irritations; rashes, etc. and will be reported to charge nurse and attending physician. e. Communicate individualized interventions to the direct care providers. Provide specific directions and training as needed (e.g., correct splint application, range of motion tech, skin integrity). Update Care plan and Kardex. 6. Documentation: a. Document resident daily participation, including actual	F 657		

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F 657	Continued From page 85 number of minutes participating in Point of Care..." On 6/15/2022 at approximately 4:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator and ASM #4, the regional director of operations were notified of the findings. No further information was provided prior to exit. B. On 6/13/2022 at 1:59 p.m., an observation was made of R114 in their room. R114 was observed lying in bed with a t-shirt on and asleep. R114's bed was observed to be pushed against the wall in the room with a fall mat placed on the floor to the right side of the bed. Additional observations of R114 in their room on 6/13/2022 at 3:41 p.m. and 4:24 p.m. and 6/14/2022 at 8:45 a.m. and 1:30 p.m. revealed the fall mat in place to the right side of the bed. The physician orders for R114 documented in part, - "Fall mat at bedside- check placement and function every shift for safety. Order Date: 05/16/2022." The progress notes documented in part: - "4/29/2022 18:08 (6:08 p.m.) Resident observe on bedroom via staff. On assessment, patient side lying lateral to bedroom with face down. Resident unable to note events leading up to fall...No injuries noted [sic] at this time..." - "5/15/2022 21:00 (9:00 p.m.) Approx. (approximately) 1930 (7:30 p.m.), writer was called to residents room by staff, writer observed	F 657		

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F 657	Continued From page 86 resident laying on his right side, on the floor, next to bed, last observed 15 minutes prior by writer, resting in low bed quietly, eyes closed, call bell and bedside table within reach, wearing non skid socks and facility gown, clean and dry, resident unable to explain how he fell, related to dementia diagnosis, moves upper extremities without pain, lower extremities contracted unable to move, neurochecks wnl (within normal limits), no new injuries noted, no swelling noted, denies all pain and discomfort...nsg (nursing) intervention bedside mat..." On 6/14/2022 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that fall mats were on the care plans for residents. LPN #9 stated that the care plan was to guide the staff on how to care for the resident. LPN #9 stated that the staff use the care plan to know what to do for the residents and that the care plan should be reviewed after a fall. LPN #9 stated that the care plan was reviewed to determine if any new interventions were needed or if the current plan was adequate and it should be done as soon as possible after a fall. LPN #9 stated that the interventions were updated so that all staff were able to see what needed to be in place. On 6/15/2022 at 9:44 a.m., an interview was conducted with RN (registered nurse) #1, MDS nurse. RN #1 stated that the care plan was used to guide the staff on how to care for the patient. RN #1 stated that the unit manager brought any resident falls to the daily meetings and they would update the care plans then. RN #1 stated that after a fall the care plan was updated with any new interventions that were added. RN #1 stated that anything that required a physician order was	F 657		

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F 657	Continued From page 87 placed on the care plan. RN #1 stated that fall mats were placed on the care plan so the staff would know to use them. On 6/15/2022 at 11:31 a.m., RN #1 stated that they had reviewed R114's care plan and the fall mats were not included but should have been. RN #1 stated that they had corrected the care plan. On 6/15/2022 at 2:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator and ASM #4, the regional director of operations were made aware of the findings. No further information was provided prior to exit. 2. The facility staff failed to review and/or revise the comprehensive care plan for Resident #87 (R87) after a resident to resident incident with their roommate on 11/10/2021. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/12/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was not cognitively impaired for making daily decisions. On 6/14/2022 at 8:25 a.m., an interview was conducted with R87 in their room. When asked about any incident with their previous roommate on 11/10/2021, R87 stated that they got along well with their current roommate. R87 stated that they had hallucinations at times and did not remember any problems with a previous	F 657		

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F 657	Continued From page 88 roommate. R87 stated that they felt safe at the facility. A FRI (facility reported incident) dated 11/10/2021 for R87 was reviewed. The follow up and summary dated 11/17/2021 documented in part, "This is a follow-up and summary to Facility Reported Incident in which it was reported that Resident [R25] got out of bed on November 10, 2021 and placed a pillow over her roommates [R87]'s head...A little after midnight on November 10, 2021 [R87] was heard calling out for nurse who immediately responded and found [R25] at [R87]'s bedside with a pillow over [R87]'s face. The nurse immediately removed the pillow and directed [R25] back to bed and placed certified nursing assistant [Name of CNA] at the door of the room to monitor [R25] for the rest of the night. [CNA] provided comfort to [R87] who reported that she was fine...[R25] was sent to the hospital for psychiatric evaluation on November 10, 2021...Upon her return she was transferred to a private room [Room number]. [R25] was seen by the nurse practitioner, [Name of NP] upon return...Resident was also seen by psychiatric nurse practitioner, [Name of NP] who agreed with these changes in medication. [R87] continues to receive supportive care and continues to state that she is fine. Impression and findings: The incident did occur..." The progress notes for R87 documented in part, - "11/10/2021 09:40 (9:40 a.m.) Note Text: made call to rp (responsible party) and made her aware of resident confusion during the night , made rp aware that roommate was removed to a different room, skin check is in progress, writer spoke with resident this morning and resident stated that she was fine no c/o (complaints of) pain or discomfort	F 657		

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F 657	Continued From page 89 noted will cont (continue) to monitor." - "11/10/2021 10:08 (10:08 a.m.) Note Text: Guest noted talking to people who are not there. Guest stating, "stop sticking me with needles before I call my son". No one is in the room at this time. Writer was standing in the doorway observing guest. Guest observed saying, "I'm not ready yet Jesus"." - "11/10/2021 10:30 (10:30 a.m.) Nurse Practitioner note: CC (chief complaint): smothered by roommate, Seeing patient for recent altercation with roommate, patient states that her roommate attempted to smother her with a pillow last night , she states the pillow was not on her face for long because she moved the pillow away and screamed for help and then nursing came in and removed the pillow from the roommate. She states she feels fine , no Diff (difficulty) breathing, no pain, VSS (vital signs stable), oxygen stable. She does state that she is scared to sleep sec (secondary) to incident. No s/s (signs or symptoms) of acute distress, patient up in her wheelchair, following commands...Plan of care d/w (discussed with) staff on the floor: roommate removed , psych consult..." - "11/10/2021 13:03 (1:03 p.m.) Psychiatric Nurse practioner note: ...CC: shock from being assaulted during the previous night by roommate placing a pillow over her face. Information source: Resident, staff, records... Interval History: Severely frightened and currently anxious following assault previous night by her roommate. She states the roommate told her to be quiet then came to her bedside and placed a pillow over her face. She was able to push against it with her functional arm while shouting "Jesus help me! I'm not ready to go!" and nursing staff came to her rescue. States that this roommate has shouted at her before, and is relieved that she has been	F 657		

PRINTED: 06/28/2022
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F 657	Continued From page 90 permanently removed from being her roommate... Impression: Resident had a scare which her faith is helping her resolve quickly. No change in medication deemed appropriate at this time as the threatening situation was promptly dealt with to her satisfaction. Plan: Monitor for residual signs and symptoms of anxiety / PTSD (post traumatic stress disorder) for which medication would be appropriate..." - "11/17/2021 13:56 (1:56 p.m.) Swk (social worker) check with guest to see how she was doing since the incident with her room mate. Guest voiced she was fine she has another roommate and she is enjoying her company. Guest voiced she does not have any issues at this time." The comprehensive care plan for R87 failed to evidence a review and/or revision regarding the resident to resident incident on 11/10/2021. On 6/15/2022 at 12:20 p.m., an interview was conducted with OSM (other staff member) #1, social worker. OSM #1 stated that they were not in the building when the incident happened between R87 and R25 but spoke with R87 afterwards. OSM #1 stated that they had reviewed and updated R25's care plan after the incident but had not updated R87's care plan. OSM #1 stated that they normally would only review the care plan of the aggressor in a resident to resident incident. On 6/15/2022 at 2:07 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that the care plan was used to tell the staff how to care for the resident and was a person centered care directive for each resident in the facility. LPN #7 stated that any altercation	F 657		

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F 657	Continued From page 91 between two guests required both care plans to be updated. LPN #7 stated that both residents should have their care plan updated and reviewed even if only one was the aggressor. On 6/15/2022 at 2:14 p.m., a follow up interview was conducted with OSM #1, social worker. OSM #1 stated that the purpose of the care plan was to ensure that the nursing could follow what was going on with the guest. OSM #1 stated that nursing would need to monitor both residents after a resident to resident altercation. OSM #1 stated that R87 should be monitored for mood changes after an incident like the one on 11/10/2021 and the care plan probably should have been updated to reflect that. On 6/15/2022 at approximately 4:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator and ASM #4, the regional director of operations were notified of the findings. No further information was provided prior to exit. Complaint deficiency 3. The facility staff failed to review and/or revise the comprehensive care plan in a timely manner for Resident #25 (R25) after a resident to resident incident with their roommate on 11/10/2021. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/25/2022, the resident scored 5 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is severely impaired for making daily decisions.	F 657		

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F 657	Continued From page 92 On 6/14/2022 at 12:30 p.m., an observation was made of R25 in their room. R25 was observed in their private room sitting in a wheelchair. R25 was not observed displaying any aggressive behaviors during the dates of the survey. A FRI (facility reported incident) dated 11/10/2021 for R25 was reviewed. The follow up and summary dated 11/17/2021 documented in part, "This is a follow-up and summary to Facility Reported Incident in which it was reported that Resident [R25] got out of bed on November 10, 2021 and placed a pillow over her roommates [R87]'s head...A little after midnight on November 10, 2021 [R87] was heard calling out for nurse who immediately responded and found [R25] at [R87]'s bedside with a pillow over [R87]'s face. The nurse immediately removed the pillow and directed [R25] back to bed and placed certified nursing assistant [Name of CNA] at the door of the room to monitor [R25] for the rest of the night. [CNA] provided comfort to [R87] who reported that she was fine...[R25] was sent to the hospital for psychiatric evaluation on November 10, 2021...Upon her return she was transferred to a private room [Room number]. [R25] was seen by the nurse practitioner, [Name of NP] upon return...Resident was also seen by psychiatric nurse practitioner, [Name of NP] who agreed with these changes in medication. [R87] continues to receive supportive care and continues to state that she is fine. Impression and findings: The incident did occur..." The progress notes for R25 documented in part; - "11/10/2021 00:30 (12:30 a.m.) Late Entry: Note Text: Noted that resident got up and placed a pillow on her roommate's head. She kept getting	F 657		

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	495109	A. BUILDING _____ B. WING _____	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(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 657	Continued From page 93 out of her bed to try and place a pillow over [R87] head. Agency CNA (certified nursing assistant) had to sit in the door way to keep [R25] away from [R87] the entire shift. Nurse assumed responsibility until next shift." - "11/10/2021 00:48 (12:48 a.m.) Late Entry: Note Text: Guest was Not Admitted To [Name and phone number of Hospital]. She was transported back to the [Name of facility] this evening shift at approx. (approximately) 2130 (9:30 p.m.) via Ambulance. She appeared to be rested and no signs of distress..." - "11/10/2021 08:03 (8:03 a.m.) Note Text: Guest transferred to [Room number] from [Room number] with all belongings." - "11/10/2021 09:54 (9:54 a.m.) Note Text: spoke with resident rp (responsible party) r/t (related to) confusion and agitation during the night, notified rp that np (nurse practitioner) was made aware and resident has been placed in a different room temporarily until a permanent room can be determined, made rp aware that resident has calm down no distress noted at this time, will cont (continue) to monitor." - "11/10/2021 10:32 (10:32 a.m.) Note Text: notified rp (responsible party) of transfer to [Name of hospital] for a psych (psychiatric) eval (evaluation)." - "11/10/2021 10:50 (10:50 a.m.) Nurse practitioner note: ... Seeing patient per nursing patient found attempting trying to smother roommate with pillow, patient stated all she remembers is waking up to go pee, she doesn't remember anything else. No s/s (signs/symptoms) of acute distress, RP daughter notified. Psych to see patient today. Plan of care d/w (discussed with) staff on the floor: now in different room, stat CMP (comprehensive metabolic panel)..."	F 657		

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F 657	Continued From page 94 - "11/10/2021 12:07 (12:07 p.m.) Note Text: Call placed to [name and number of county non-emergency]. Spoke with dispatcher who took information. Per dispatcher, [name of county] officers is coming to facility to speak with DON (director of nursing) in reference to incident. And per dispatcher, someone is to return call to facility with how guest is going to be transported to [Name of hospital]. Waiting to be notified." The comprehensive care plan for R25 documented in part, "[R25] has a actual behavior problem R/T (related to): trying to smother her roommate with a pillow. Episodes of yelling/screaming out, physical behavioral symptoms directed towards others...Date Initiated: 03/17/2022. Revision on: 04/06/2022." The care plan failed to evidence a review or revision prior to 3/17/2022. On 6/15/2022 at 12:20 p.m., an interview was conducted with OSM (other staff member) #1, social worker. OSM #1 stated that they were not in the building when the incident happened between R87 and R25 but spoke with R87 afterwards. OSM #1 stated that R25 had behaviors of yelling out at times but had not had any aggressive behaviors prior to 11/10/2021. OSM #1 stated that R25 had not had any further aggressive behaviors towards any residents and remained in a private room. OSM #1 stated that they thought they had reviewed and updated R25's care plan after the incident. OSM #1 stated that they normally would only review the care plan of the aggressor in a resident to resident incident. OSM #1 reviewed the care plan for R25 dated 3/17/2022 and stated that they thought that it was reviewed/revised right after the incident on 11/10/2021 and was not sure where	F 657		

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	496109	A. BUILDING _____ B. WING _____	C 08/16/2022

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F 657	Continued From page 95 the 3/17/2022 date came from. OSM #1 stated that they would ask another staff member to review and see if they could pull the history on it. OSM #1 stated that the care plan should have been reviewed prior to 3/17/2022. On 8/15/2022 at 2:07 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that the care plan was used to tell the staff how to care for the resident and was a person centered care directive for each resident in the facility. LPN #7 stated that any altercation between two guests required both care plans to be updated as soon as possible. On 8/15/2022 at approximately 4:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator and ASM #4, the regional director of operations were notified of the findings. No further information was provided prior to exit. Complaint deficiency. 4. The facility staff failed to review or revise Resident #336's (R336) comprehensive care plan for falls the resident sustained on 8/16/21 and 9/16/21. On the most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 8/29/21, the resident scored 9 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately cognitively impaired for making daily decisions. A review of R336's clinical record (nurses' notes)	F 657		

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F 657	Continued From page 96 revealed the resident sustained falls on 8/16/21 and 9/16/21. A review of post fall evaluations dated 8/16/21 and 9/16/21 revealed a check box beside the words, "Care Plan/Kardex Updated." The check box was not marked. A review of R336's comprehensive care plan initiated on 3/16/21 failed to reveal evidence that the resident's care plan was reviewed or revised regarding those falls. On 6/15/22 at 8:02 a.m., an interview was conducted with RN (registered nurse) #2, regarding the purpose of the care plan. RN #2 stated the care plan is something to follow that kind of gives staff the guideline of what's going on with the resident and what the resident needs. RN #2 stated she does not review or revise care plans. On 6/15/22 at 10:14 a.m., an interview was conducted with RN #1 (the MDS coordinator). RN #1 stated she updates residents' care plans usually within 24 hours of being made aware of a resident's fall or when a new order for an intervention is obtained. RN #1 reviewed R336's care plan. The care plan documented for therapy to evaluate for proper fitting of shoes. The initiation date was 9/11/21 and the creation date was 9/22/21. RN #1 stated this was probably documented due to a new order and not from a review or revisions from R336's falls. RN #1 stated she would further review R336's care plan for any review or revisions for the 8/16/21 and 9/16/21 falls. On 6/15/22 at 1:56 p.m., RN #1 stated she could not find evidence that R336's care plan was reviewed or revised for either fall. On 6/15/22 at 2:32 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2	F 657		

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F 657	Continued From page 97 (the director of nursing), ASM #3 (the regional clinical coordinator) and ASM #4 (the regional director of operations) were made aware of the above concern. The facility policy titled, "Fall Management" documented, "3. When a fall occurs, the licensed nurse will evaluate the guest/resident for injury...4. The licensed nurse will complete: Review and /or revise care plan and guest/resident kardex..." No further information was presented prior to exit. COMPLAINT DEFICIENCY	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to follow professional standards of practice for 2 of 3 residents in the Medication Administration observation task, Residents #14 and #96; and for 2 of 59 residents in the survey sample; Residents #87 and #113. The findings include: 1. For Resident #14, the facility staff failed to follow professional standards of practice when	F 658	F658 Criteria 1 Resident #14,96, 87, and 113 had no adverse outcomes related to the alleged failure to Provide Services to Meet Professional Standards. All residents that were identified the RP and MD were notified. MD did not have new orders for the residents. Criteria 2 All current residents who rely on the facility to receive medication from the licensed staff at the facility have the potential to be affected be the alleged deficiency. Criteria 3 Licensed Nursing staff will be re-educated on ensuring physician orders are followed and that the standards of practice for medication administration are upheld.	

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PRINTED: 06/28/2022
FORM APPROVED
OMB NO. 0938-0391

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F 658	Continued From page 98 LPN #5 signed out for medication as given that was not administered. Resident #14 was admitted to the facility on 3/12/21. On the annual MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 3/11/22, Resident #14 scored a 15 out of a possible 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact in ability to make daily life decisions. On 6/14/22 at 8:17 AM, LPN #5 (Licensed Practical Nurse) was observed to prepare and administer the following medications for Resident #14: Methimazole 5 mg (milligrams), 1 tab. Buspar 10 mg, 1 tab Aspirin 81 mg, 1 tab Magnesium Oxide 400 mg, 1 tab On 6/14/22 at 11:16 AM, reconciliation of the medications was conducted and compared with the physician's orders. An order dated 9/8/21 for a lidocaine 4% patch (1) to the left knee every morning was noted. It was noted that LPN #5 signed out for a lidocaine patch to left knee as being administered when it had not been administered. On 6/14/22 at 12:40 PM an interview was conducted with Resident #14. When asked if they received their pain patch on their knee this morning, they stated that they did not. On 6/14/22 at 12:40 PM an interview was attempted with LPN #5 regarding the missed medication. He refused to answer any questions	F 658	Criteria 4 DON and/or designee will complete five (5) random audits of licensed nursing staff following physician's orders and following the standards of practice for medication administration. The DON and/or designee will also complete med pass audits on licensed nurses.Five random med pass audits will be conducted. These audits will be completed weekly x four (4) weeks and monthly x two (2) months. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 658	Continued From page 99 and denied doing anything wrong and walked away from the surveyor. On 6/14/22 at 12:45 PM the above concern was reported to ASM #1 (Administrative Staff Member) the Administrator and ASM #4, the Regional Director of Operations. On 6/14/22 at 3:00 PM, an interview was conducted with LPN #4 (Licensed Practical Nurse) and medication administration was discussed. She stated that staff should not sign out for medications that were not given. A review of the comprehensive care plan revealed one dated 3/23/21 for "[Resident #14] is at risk for constipation R/T (related to): decreased mobility, medications side effects." This care plan included the intervention, dated 3/23/21 for "Administer medications as ordered and observe for ineffectiveness/side effects. Report abnormal findings to the physician." A review of the facility policy, "Medication Administration" was conducted. This policy documented, "Medications are administered in accordance with written orders of the attending physician...Record the dose, route, and time of the medication on the Medication/Treatment Administration Record. Document if the guest/resident refused." The policy did not address not signing out for medications that were not given. According to Fundamentals of Nursing, 5th edition, Lippincott, Williams & Wilkins, page 577, "The most common medication errors include documentation errors....charting medication that was not given."	F 658		

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F 658	Continued From page 100 On 6/15/22 at approximately 4:00 PM, ASM #1 (Administrative Staff Member), the Administrator, ASM #2, the Director of Nursing, and ASM #4, the Regional Director of Operations were made aware of the findings. No further information was provided by the end of the survey. References: (1) Lidocaine - is used to treat pain Information obtained from https://medlineplus.gov/druginfo/meds/a603026.html 2. For Resident #96, the facility staff failed to follow professional standards of practice when LPN #5 signed out for medication as given that was not administered. Resident #96 was admitted to the facility on 2/15/20. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/11/22, Resident #96 scored a 13 out of a possible 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact in ability to make daily life decisions. On 6/14/22 at 8:28 AM, LPN #5 (Licensed Practical Nurse) was observed to prepare and administer the following medications for Resident #96: Dulera 100 mcg (micrograms) / 5 mcg Inhaler Aspirin 325 mg (milligrams), 1 tab Vitamin D3 25 mcg, 1 tab Colace 100 mg, 1 tab Glipizide 5 mg, 1 tab	F 658		

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F 658	Continued From page 101 Genvoya 150 mg/150 mg/200 mg/10 mg, 1 tab Risperdone 0.5 mg, 1 tab Prednisone 10 mg, 1 tab Senna 8.6 mg, 1 tab Acetaminophen 325 mg, 1 tab Spiriva 18 mcg On 6/14/22 at 11:15 AM, reconciliation of the medications was conducted and compared with the physician's orders. An order dated 6/30/21 for Alaway (1) eye drops and an order dated 1/18/21 for Pepcid (2) were noted. It was noted that LPN #5 signed out these medications as being administered when they had not been administered. On 6/14/22 at 12:40 PM an interview was attempted with LPN #5 regarding the missed medication. He refused to answer any questions and denied doing anything wrong and walked away from the surveyor. He displayed a hostile attitude. On 6/14/22 at 12:45 PM the above concern was reported to ASM #1 (Administrative Staff Member) the Administrator and ASM #4, the Regional Director of Operations. On 6/14/22 at 3:00 PM, an interview was conducted with LPN #4 (Licensed Practical Nurse). She stated that staff should not sign out for medications that were not given. A review of the comprehensive care plan revealed one dated 5/12/21 for "[Resident #96] is at risk for abnormal bleeding/bruising R/T (related to): medication use..." This care plan included an intervention dated 5/12/21 for "Administer medications as ordered. Observe for	F 658		

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F 658	Continued From page 102	F 658		

ineffectiveness and side effects, report abnormal findings to the physician." Another care plan, dated 7/22/21 was for "[Resident #96] is at risk for constipation R/T: decreased mobility, diminished appetite, Hx (history) of constipation, medications side effects." This care plan included the intervention, dated 7/22/21 for "Administer medications as ordered and observe for ineffectiveness/side effects. Report abnormal findings to the physician."

A review of the facility policy, "Medication Administration" was conducted. This policy documented, "Medications are administered in accordance with written orders of the attending physician...Record the dose, route, and time of the medication on the Medication/Treatment Administration Record. Document if the guest/resident refused." The policy did not address not signing out for medications that were not given.

According to Fundamentals of Nursing, 5th edition, Lippincott, Williams & Wilkins, page 577, "The most common medication errors include documentation errors....charting medication that was not given."

On 6/15/22 at approximately 4:00 PM, ASM #1 (Administrative Staff Member), the Administrator, ASM #2, the Director of Nursing, and ASM #4, the Regional Director of Operations were made aware of the findings. No further information was provided by the end of the survey.

References:

(1) Alaway is used for the treatment of allergy

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F 658	Continued From page 103 symptoms of the eyes Information obtained from https://medlineplus.gov/druginfo/meds/a604033.html (2) Pepcid is used for the treatment of reflux and ulcers Information obtained from https://medlineplus.gov/druginfo/meds/a687011.html 3. The facility staff failed to follow medication administration standards of practice during medication administration to Resident #87 (R87). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/12/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is not cognitively impaired for making daily decisions. On 6/14/2022 at 10:55 a.m., an interview was conducted with R87 in their room. During the interview with R87, at 10:59 a.m., an observation was made of LPN (licensed practical nurse) #5 entering R87's room. LPN #5 entered the room with two medication cups, one in the right hand and one in the left hand. LPN #5 proceeded to R87's roommate's (Resident 113) side of the room and placed the cup on the overbed table and stated, "Here are your meds" to Resident #113 (R113) who was in the bed. LPN #5 proceeded to come over to R87 and stated, "Here are your meds" handing a cup of medication to R87. LPN #5 assisted R87 to place the pills in their mouth and then left the room at that time leaving R113 with the cup of pills still sitting on	F 658		

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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 658	Continued From page 104 the overbed table. On 6/14/2022 at approximately 11:08 a.m., an interview was attempted with LPN #5. LPN #5 stated that the medications were the residents "morning meds" and that they always gave two residents medications at the same time and had never made a mistake doing it this way. LPN #5 stated that they put A bed medications in the left hand and B bed medications in the right hand. LPN #5 stated that they did not work at the facility normally and had already been followed by a surveyor that morning and did not have time to talk. On 6/14/2022 at approximately 3:08 p.m., an interview was conducted with LPN #9. LPN #9 stated that medications were administered to one resident at a time. LPN #9 stated that errors could be made by administering to multiple residents at the same time and there were also infection control concerns. LPN #9 stated, "You just don't do that." During the entrance conference on 6/13/2022 at approximately 1:30 p.m., ASM (administrative staff member) #1, the administrator stated the facility used Lippincott as their nursing standard of practice. The facility policy "Medication Administration" dated 3/1/2013 documented in part, "...Guest/resident medications are administered in an accurate, safe, timely, and sanitary manner..." Fundamentals of Nursing, Lippincott, Williams & Wilkins 5th edition; page 557 under the section "Nurse Practice Acts", "Nurses are also expected	F 658		

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PRINTED: 06/28/2022
FORM APPROVED
OMB NO. 0938-0391

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	495109	A. BUILDING _____ B. WING _____	C 06/15/2022

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F 658	Continued From page 105 to practice in a safe and prudent manner ....It is the nurse's legal domain to administer medications in a safe and timely manner. "Page 588, "Procedure 29-1; Administering Oral Medications". Procedure: 1. Wash hands. 2. Arrange MAR next to medication supply. 3. Prepare medications for only one client at a time. 4. Remove ordered medications from supply ....5. Calculate correct drug dosage ....6. Prepare selected medications ...7. Take medication directly to client's room. Do not leave medication unattended..." On 6/14/2022 at 4:15 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator and ASM #4, the regional director of operations were made aware of the findings. No further information was presented prior to exit. 4. The facility staff failed to follow medication administration standards of practice during medication administration to Resident #113 (R113). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/21/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is not cognitively impaired for making daily decisions. On 6/14/2022 at 10:59 a.m., during an interview with another resident (Resident #87), an observation was made of LPN (licensed practical nurse) #5 entering R113's room. LPN #5 entered the room with two medication cups, one in the	F 658		

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F 658	Continued From page 106 right hand and one in the left hand. LPN #5 proceeded to R113's side of the room and placed the cup on the overbed table stating "here are your meds" to R113 who was in the bed. LPN #5 proceeded to come over to R87 and stated "here are your meds", handing a cup of medication to R87. LPN #5 assisted R87 to place the pills in their mouth and then left the room at that time leaving R113 with the cup of pills still sitting on the overbed table. At this time, R113 was observed to get out of bed and get in the wheelchair stating that the nurse forgot their pain pills. R113 was observed to exit the room and go to LPN #5 at the medication cart to request pain medication. R113 returned to the room with a second medication cup with two tablets inside. On 6/14/2022 at approximately 11:08 a.m., an interview was attempted with LPN #5. LPN #5 stated that the medications were the residents "morning meds" and that they always gave two residents medications at the same time and had never made a mistake doing it this way. LPN #5 stated that they put A bed medications in the left hand and B bed medications in the right hand. LPN #5 stated that they did not work at the facility normally and had already been followed by a surveyor that morning and did not have time to talk. LPN #5 stated that they thought they had watched both residents swallow their medication in the room, stated that they do not leave medications at the bedside and walked away from the surveyor into a residents room. On 6/14/2022 at approximately 3:08 p.m., an interview was conducted with LPN #9. LPN #9 stated that medications were administered to one resident at a time. LPN #9 stated that errors could be made by administering to multiple	F 658		

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F 658	Continued From page 107 residents at the same time and there were also infection control concerns. LPN #9 stated, "You just don't do that." LPN #9 stated that medications were not left at the bedside and that the nurse stayed to make sure the resident swallowed the medication. LPN #9 stated that anyone could come in and take the medication or they could get lost. On 6/13/2022 at approximately 1:30 p.m., during entrance ASM (administrative staff member) #1, the administrator stated the facility used Lippincott as their nursing standard of practice. The facility policy "Medication Administration" dated 3/1/2013 documented in part, "...Observe that the guest/resident swallows the oral medications. Do not leave medications with the guest/resident to self-administer unless the guest/resident is approved for self-administration of the medication..." On 6/14/2022 at 4:15 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator and ASM #4, the regional director of operations were made aware of the findings. No further information was presented prior to exit.	F 658	F677 Criteria 1 R40 in the facility was noted to have long fingernails and without palm protectors. R40 nails were trimmed, and protectors placed on guest.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677	R10 in the facility was noted as failed to honor resident preference for showers instead of a bed bath. R10 has received showers as per guests' preference. R87 in the facility was noted as failed to provide bathing/showers, incontinence care, personal hygiene and ADL care. R87 has received thorough ADL care to include incontinence care, personal hygiene and bathing/showering as per guests' preferences.	

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F 677	Continued From page 108 Based on observation, resident interview, staff interview, facility document review and in the course of a complaint investigation, the facility staff failed to provide ADL (activities of daily living) care for 3 of 59 residents in the survey sample, Residents #40, #10 and #87. The findings include: 1.a. The facility staff failed to trim Resident #40's (R40) fingernails. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/6/22, 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. Section G coded R40 as being totally dependent on one staff with personal hygiene. On 6/14/22 at 3:10 p.m., an observation of R40's fingernails was conducted with LPN (licensed practical nurse) #8. R40's fingers were contracted and bent in towards the resident's palms; however, LPN #8 was able to move the resident's fingers out from the palms for the observation. R40's right thumb nail was approximately one forth inch long. All nails on R40's left hand, excluding the pinky finger, were approximately one half inch long. R40 stated staff had not trimmed the resident's nails in two to three months. R40's comprehensive care plan last reviewed on 4/15/22 documented, "(R40) requires assistance with adl's r/t (related to) impaired mobility diagnosis of quadriplegia, muscle weakness, chronic pain. Guest will state that he needs his	F 677	Criteria 2 All residents who are dependent for ADL care have the potential to be affected by the alleged deficiency. Criteria 3 Nursing staff will be re-educated on providing ADL care to include nail trimming, orthotic and bathing/shower preferences. Criteria 4 DON/designee or designee will complete five (5) random audits of documentation for residents who are dependent for ADL care. These audits will be completed 5 days a week for four weeks; Then one day a week for four weeks; then twice in the last month. The results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

PRINTED: 06/28/2022
FORM APPROVED
OMB NO. 0938-0391

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F 677	Continued From page 109 nails trimmed and then decline when offered by staff. BATHING: Check nail length and trim and clean on bath day and as necessary..." However, a review of R40's clinical record (including nurses' notes and ADL records for March 2022 through June 2022) failed to reveal documentation that R40 was offered a fingernail trim and refused. On 6/15/22 at 8:02 a.m., an interview was conducted with CNA (certified nursing assistant) #2 and RN (registered nurse) #2 (a CNA and nurse who has cared for R40). CNA #2 stated she recently wanted to cut R40's fingernails but it was difficult to get the clippers under the resident's nails and she didn't know how to do so. CNA #2 stated she had not reported this to any other facility employee. CNA #2 stated she was going to ask the podiatrist if there was anything that could be done but the podiatrist was busy during the last visit. RN #2 stated she had recognized R40's fingernails and how his hands were formed (contracted fingers). RN #2 stated she had not attempted to trim R40's fingernails because she wasn't comfortable doing so. RN #2 stated had not found out what could be done to trim the resident's nails. On 6/15/22 at 8:54 a.m., an interview was conducted with LPN #6 (a unit manager). LPN #6 stated she observed R40's fingernails Wednesday or Thursday of the previous week. LPN #6 stated R40's fingers were hard to open. LPN #6 stated she was now trying to see how R40's nails could be trimmed and maybe a hand towel could be rolled into the resident's hands. LPN #6 stated she spoke with someone from the therapy department regarding this two weeks ago but she could not remember who she spoke to.	F 677		

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F 677	Continued From page 110 On 6/15/22 at 10:27 a.m., R40 was observed lying in bed. A palm protector was on the resident's right hand. The fingernails on both of R40's hands were trimmed. R40 stated a therapist, nurse and CNA had been in the room and trimmed the resident's nails. On 6/15/22 at 10:44 a.m., an interview was conducted with OSM (other staff member) #8 (the rehab therapy director). OSM #8 stated no employee had come to him or the therapy staff regarding R40's fingernails until this morning when the unit manager asked if he could evaluate the resident. On 6/15/22 at 11:35 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional clinical coordinator) and ASM #4 (the regional director of operations) were made aware of the above concern. The facility policy titled, "Routine Guest/Resident Care" documented, "Guests/residents receive the necessary assistance to maintain good grooming and personal/oral hygiene...3. Daily personal hygiene minimally includes assisting or encouraging guests/residents with washing their face and hands, shaving, nail care, combing their hair each morning, and brushing their teeth and/or providing denture care. Any concerns will be reported to the nurse." No further information was presented prior to exit. Complaint Deficiency. 1.b. The facility staff failed to assist Resident #40 (R40) with eating assistance on 8/30/21 and	F 677		

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F 677	Continued From page 111 8/31/21. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/6/22, 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. Section G coded R40 with requiring extensive assistance of one staff with eating. R40's comprehensive care plan last reviewed on 4/15/22 documented, "(R40) requires assistance with adl's r/t (related to) impaired mobility diagnosis of quadriplegia, muscle weakness, chronic pain. EATING: Resident requires extensive set-up one staff assistance to eat." A complaint submitted to the SA (state agency) on 9/9/21 documented concern that R40 was not assisted with eating on either 8/30/21 or 8/31/21. A review of R40's point of care ADL (activities of daily living) records for 8/30/21 and 8/31/21 failed to reveal documentation of R40's meal intake or documentation that the resident was assisted with eating breakfast and lunch on those dates. On 6/13/22 at 3:12 p.m., an interview was conducted with R40. R40 stated there are times when the resident does not receive a meal tray. R40 stated the staff keeps the "feeders" meal trays on the cart and feeds them after they pass the other meal trays. R40 stated the facility contracts agency staff and sometimes they forget to assist the resident with meals. On 6/15/22 at 8:02 a.m., an interview was conducted with CNA (certified nursing assistant) #2 (a CNA who has cared for R40.) CNA #2	F 677		

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F 677	Continued From page 112 stated the CNAs are supposed to document meal assistance and intake in the point of care system. CNA #2 stated R40 must be fed and has voiced concerns about not being fed. CNA #2 stated meal trays for the residents who require assistance stay on the tray cart until the residents can be fed. CNA #2 stated sometimes R40 gets irritated by the time he is fed and then states he does not want the tray. A review of R40's clinical record (including ADL records and nurses' notes) for 8/30/21 and 8/31/21 failed to reveal documentation that R40 was offered assistance with eating and refused breakfast and lunch. On 6/15/22 at 11:35 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional clinical coordinator) and ASM #4 (the regional director of operations) were made aware of the above concern. The facility policy titled, "Routine Guest/Resident Care" failed to reveal documentation regarding assistance with feeding. No further information was presented prior to exit. Complaint Deficiency. 2. The facility staff failed to provide showers per the resident's preference for Resident #10 (R10). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/8/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident is not cognitively impaired for making daily decisions.	F 677		

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F 677	Continued From page 113 Section G documented R10 being totally dependent on one person for personal hygiene and totally dependent on one person for bathing. On 6/13/2022 at 3:44 p.m., an interview was conducted with R10 in their room. R10 stated that they were supposed to get showers on Tuesdays and Thursdays but were lucky to get one every 3 weeks. R10 stated that they preferred to have at least one shower a week because it made them feel cleaner than a bed bath. R10 stated that the staff often gave bed baths on their shower days and never offered a shower. R10 stated that the staff often told them that they were short staffed or gave no reason why they could not give the shower. On 6/15/2022 at 12:00 p.m., a follow up interview was conducted with R10. R10 stated that they did not receive their shower on 6/14/2022 as scheduled. R10 stated that they did not refuse it and was not offered a shower. R10 stated that the CNA (certified nursing assistant) just came in and gave them a bed bath. The physician orders for R10 documented in part, "If patient refuses shower or is agitated call daughter to calm patient and encourage patient do not let pt (patient) miss shower days. Order Date: 3/25/2022." The progress notes dated 4/1/2022-6/15/2022 failed to evidence documentation of R10 refusing showers. The "Shower/Bath" documentation for 4/1/2022-4/30/2022 documented a shower/bath/bed bath given on 4/15/2022. The document failed to evidence documentation of a	F 677		

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F 677	Continued From page 114	F 677		

shower/bath/bed bath given on 4/5/2022, 4/8/2022, 4/22/2022, 4/26/2022 and 4/29/2022. The document contained an "NA" in the area for the shower/bath/bed bath on 4/1/2022, 4/4/2022, 4/12/2022 and 4/19/2022.

The "Shower/Bath" documentation for 5/1/2022-5/31/2022 documented a shower/bath/bed bath given on 5/6/2022, 5/13/2022, 5/24/2022 and 5/27/2022. The document failed to evidence documentation of a shower/bath/bed bath given on 5/3/2022, 5/10/2022, and 5/17/2022. The document contained an "NA" in the area for the shower/bath/bed bath on 5/31/2022. The document contained evidence of R10's refusal of a shower/bath/bed bath on 5/20/2022.

The "Shower/Bath" documentation for 6/1/2022-6/30/2022 documented a shower/bath/bed bath given on 6/3/2022, 6/7/2022 and 6/10/2022. The document failed to evidence documentation of a shower/bath/bed bath given on 6/14/2022.

The comprehensive plan for R10 documented in part, "[R10] has an ADL (activities of daily living) self care performance deficit and requires assistance with ADL's and mobility r/t (related to): limited mobility and weakness. Date Initiated: 07/16/2020. Revision on: 07/21/2020."

On 6/15/2022 at approximately 8:30 a.m., a request was made to ASM (administrative staff member) #1 for the shower sheets for R10 from 4/1/2022-6/15/2022.

On 6/15/2022 at approximately 1:30 p.m., ASM #2, the director of nursing provided a

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F 677	Continued From page 115 Shower/Skin Observation document for R10 dated 6/14/2022 which documented in part, "Bed bath given..." On 6/14/2022 at 2:48 p.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 stated that showers were given twice a week. CNA #5 stated that they had a schedule they followed with certain room numbers to receive showers on certain days. CNA #5 stated that if the resident refused their shower they let the nurse know and attempted later in the day. CNA #5 stated if the resident continued to refuse the shower they offered a bed bath or documented the refusal. CNA #5 stated that they did not have any problems getting their scheduled showers completed during their shift. CNA #5 stated that resident preferences regarding showers or bed baths should be honored and they were asked which they wanted on their shower days. CNA #5 stated that showers/bed baths were documented in the computer as completed or refused. On 6/14/2022 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that resident showers were given twice a week. LPN #9 stated that the CNA's documented the showers in the computer and on shower sheets in a book. LPN #9 stated that if a resident refused their shower the CNA notified the nurse and they spoke to the resident to try to convince them. LPN #9 stated that if they still refused they notified the responsible party and documented it in the medical record. On 6/15/2022 at 8:15 a.m., an interview was conducted with CNA #2. CNA #2 stated that showers/bed baths were documented in the	F 677		

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	495109	A. BUILDING _____ B. WING _____	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 116 computer and on shower sheets. CNA #2 stated that there should not be any blank areas in the shower/bath/bed bath documentation because you could not say whether it was done or not and if there was an "NA" it meant not applicable so it did not happen. On 6/15/2022 at 10:54 a.m., an interview was conducted with LPN #3. LPN #3 stated that showers were given twice a week and documented in the shower book and in the computer. LPN #3 stated that if a resident refused the shower it was documented in the medical record and the family was notified. LPN #3 stated that they always learned that if it was not documented it was not done and could not say that showers were given if there was no documentation to support it. The facility policy "Routine Guest/Resident Care" dated 3/1/2013 documented in part, "...Showers, tub baths, and/or shampoos are scheduled according to person centered care or state specific guidelines [sic]; Bed linens are changed at this time. Additional showers are given as requested..." On 6/15/2022 at 2:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator and ASM #4, the regional director of operations were made aware of the findings. No further information was provided prior to exit. 3. The facility staff failed to provide bathing/showers, incontinence care, personal hygiene and ADL (activities of daily living) care to Resident #87 (R87).	F 677		

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F 677	Continued From page 117 On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/12/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section E documented no rejections of care observed. Section G documented R87 requiring extensive assistance from one staff member for bed mobility, transfers, personal hygiene and toilet use and totally dependent on one person for bathing. On 6/14/2022 at 10:50 a.m., an interview was conducted with R87. R87 stated that there were times when there was a delay getting their brief changed when soiled but they knew the staff were busy with other residents. R87 stated that there were days when they did not get their bath until after lunch and they preferred to get washed up in the morning so they could get out of bed between 10:00 a.m. and 12:00 p.m. R87 stated that there were days when they did not get washed up at all but the staff did come in and change their brief. The complaint allegations related to 12/2021-1/2022 timeframe, clinical records and ADL records for those dates were reviewed. The "Documentation survey report" for R87 dated 12/1/2021-12/31/2021 failed to evidence toilet use and incontinence care for R87 on day shift on 12/5/2021, 12/6/2021, 12/10/2021, 12/11/2021, 12/18/2021, 12/20/2021-12/24/2021, and 12/26/2021-12/31/2021. The report failed to evidence toilet use and incontinence care for R87 on evening shift on 12/5/2021, 12/6/2021, 12/9/2021, 12/16/2021, 12/23/2021, 12/24/2021,	F 677		

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F 677	Continued From page 118 12/26/2021, 12/30/2021 and 12/31/2021. The report failed to evidence toilet use and incontinence care for R87 on night shift on 12/7/2021-12/12/2021 and 12/15/2021-12/31/2021. The report failed to evidence a shower or bath on 12/10/2021, 12/14/2021, 12/21/2021, 12/24/2021, 12/28/2021 and 12/31/2021. The report failed to evidence ADL care for R87 on day shift on 12/5/2021, 12/6/2021, 12/10/2021, 12/11/2021, 12/13/2021, 12/14/2021, 12/18/2021, 12/20/2021-12/24/2021, 12/26/2021-12/31/2021. The report failed to evidence ADL care for R87 on evening shift on 12/5/2021, 12/6/2021, 12/9/2021, 12/11/2021, 12/16/2021, 12/23/2021, 12/24/2021, 12/26/2021, 12/30/2021, and 12/31/2021. The report failed to evidence ADL care for R87 on night shift on 12/7/2021-12/12/2021, and 12/15/2021- 12/31/2021. The report failed to evidence personal hygiene for R87 on day shift on 12/5/2021, 12/6/2021, 12/10/2021, 12/11/2021, 12/13/2021, 12/14/2021, 12/18/2021, 12/20/2021-12/24/2021, and 12/26/2021-12/31/2021. The report failed to evidence personal hygiene for R87 on evening shift for R87 for 12/5/2021, 12/6/2021, 12/9/2021, 12/16/2021, 12/23/2021, 12/24/2021, 12/26/2021, 12/30/2021 and 12/31/2021. The report failed to evidence personal hygiene for R87 on night shift for 12/7/2021-12/12/2021, and 12/15/2021-12/31/2021. The "Documentation survey report" for R87 dated 1/1/2022-1/31/2022 failed to evidence toilet use and incontinence care for R87 on day shift on 1/2/2022 and 1/3/2022, 1/6/2022, 1/8/2022, 1/11/2022-1/13/2022, 1/15/2022-1/23/2022,	F 677		

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F 677	Continued From page 119 1/25/2022-1/27/2022 and 1/30/2022. The report failed to evidence toilet use and incontinence care for R87 on evening shift on 1/2/2022-1/6/2022, 1/9/2022-1/11/2022, 1/14/2022 and 1/15/2022, 1/18/2022 and 1/19/2022, 1/21/2022-1/24/2022, 1/28/2022 and 1/31/2022. The report failed to evidence toilet use and incontinence care for R87 on night shift on 1/1/2022-1/12/2022, 1/14/2022-1/25/2022 and 1/28/2022-1/31/2022. The report failed to evidence a shower or bath on 1/11/2022, 1/18/2022, 1/21/2022 and 1/25/2022. The report failed to evidence ADL care for R87 on day shift on 1/1/2022-1/3/2022, 1/6/2022, 1/8/2022, 1/11/2022-1/13/2022, 1/15/2022-1/23/2022, 1/25/2022-1/27/2022 and 1/30/2022. The report failed to evidence ADL care for R87 on evening shift on 1/2/2022-1/6/2022, 1/9/2022-1/11/2022, 1/14/2022 and 1/15/2022, 1/18/2022 and 1/19/2022, 1/21/2022-1/24/2022, 1/28/2022 and 1/31/2022. The report failed to evidence ADL care for R87 on night shift on 1/1/2022-1/12/2022, 1/14/2022-1/25/2022 and 1/28/2022-1/31/2022. The report failed to evidence personal hygiene for R87 on day shift on 1/1/2022-1/3/2022, 1/6/2022, 1/8/2022, 1/11/2022-1/13/2022, 1/15/2022-1/23/2022, 1/25/2022-1/27/2022 and 1/30/2022. The report failed to evidence personal hygiene for R87 on evening shift for R87 for 1/2/2022-1/6/2022, 1/9/2022-1/11/2022, 1/14/2022 and 1/15/2022, 1/18/2022 and 1/19/2022, 1/21/2022-1/24/2022, 1/28/2022 and 1/30/2022. The report failed to evidence personal hygiene for R87 on night shift for 1/1/2022-1/12/2022, 1/14/2022-1/26/2022 and	F 677		

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F 677	Continued From page 120 1/28/2022-1/31/2022. The comprehensive care plan for R87 documented in part, "Incontinence: [R87] is incontinent of bowel. Needs assistance in incontinent care r/t (related to) functional deficit and underlying comorbidity. Use of indwelling foley r/t neurogenic bladder. Date Initiated: 07/17/2019. Revision on: 08/19/2021." The care plan further documented, "Adl: [R87] has an ADL Self Care Performance Deficit and requires assistance with ADL's and mobility r/t dx (diagnoses) of MS (multiple sclerosis), gerd (gastro-esophageal reflux disease), htn (hypertension), ams (altered mental status), paraplegic, and blindness. Date Initiated: 07/17/2019. Revision on: 08/19/2021..." Under "Interventions" it documented in part, "BED MOBILITY: Resident requires extensive assistance of one staff to reposition and turn in bed. Date Initiated: 08/02/2019..." The care plan further documented, "[R87] chooses not to follow treatment regimen R/T: declines to have wedge removed. Declines to have to of the bed to be lowered. Declines to be repositioned in the bed. Date Initiated: 05/19/2022, Revision on: 05/19/2022." On 6/14/2022 at 2:46 p.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 stated that showers were given twice a week. CNA #5 stated that they had a schedule they followed with certain room numbers to receive showers on certain days. CNA #5 stated that if the resident refused their shower they let the nurse know and attempted later in the day. CNA #5 stated if the resident continued to refuse the shower they offered a bed bath or documented the refusal. CNA #5 stated that	F 677		

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F 677	Continued From page 121	F 677		

showers/bed baths were documented in the computer as completed or refused. CNA #5 stated that incontinence care was provided every 2 hours and as needed and personal hygiene was completed every shift. CNA #5 stated that all residents were given a bed bath each day in the morning to get them ready for the day. CNA #5 stated that the bed bath included the full body. CNA #5 stated that these were documented in the computer. CNA #5 stated that R87 had a catheter and they emptied the catheter bag each shift. CNA #5 stated that they turned and repositioned R87 every two hours and used a wedge to help position them and provided incontinence care at that time. CNA #5 stated that R87 liked to stay on their back most of the time and often refused to turn off of their back and use the wedge for positioning but often let them use pillows. CNA #5 stated that R87 got out of the bed most days and there were days when they refused to get out of bed. CNA #5 stated that they informed the nurse when R87 refused turning and positioning and getting out of bed.

On 6/15/2022 at 8:15 a.m., an interview was conducted with CNA #2. CNA #2 stated that showers/bed baths were documented in the computer and on shower sheets. CNA #2 stated that there should not be any blank areas in the shower/bath/bed bath documentation because you could not say whether it was done or not and if there was an "NA" it meant not applicable so it did not happen. CNA #2 stated that all residents were given a bed bath each day in the morning prior to getting up and dressed.

On 6/15/2022 at 10:54 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that showers were given twice a

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PRINTED: 06/28/2022
FORM APPROVED
OMB NO. 0938-0391

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F 677	Continued From page 122 week and documented in the shower book and in the computer. LPN #3 stated that if a resident refused the shower it was documented in the medical record and the family was notified. LPN #3 stated that they always learned that if it was not documented it was not done and could not say that the care was provided if there was no documentation to support it. On 6/15/2022 at 4:05 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator and ASM #4, the regional director of operations were made aware of the findings. No further information was provided prior to exit. Complaint deficiency.	F 677		
F 684 SS=E	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 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 residents' highest level of well-being for 4 of 59 residents in the survey sample, Residents #19,	F 684	F684 Criteria 1 Resident #19 and resident #15 suffered no adverse outcomes related to the alleged failure of the facility to schedule their medical appointments. Resident #436 suffered no adverse outcomes related to the facility staff allegedly failing to follow physician orders for a physician appointment with the surgeon that was based on physician orders and plan of care. Facility re-educated ward clerk on scheduling appointments timely based on the resident's physician orders and plan of care. Resident #701 suffered no adverse outcomes related to the alleged medication error. At the time of the alleged incident, a medication error report was completed, nurse was re-educated regarding medication administration and the MD/RP were made aware. Nurses will be re-educated on following physician orders and standards of practice for medication administration.	

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F 684	Continued From page 123 #15, #436, #701. The findings include: 1. The facility staff failed to schedule a mammogram per Resident #19's (R19) plan of care. On the most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 4/18/22, 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 6/13/22 at 1:21 p.m., an interview was conducted with R19. R19 stated that about a year ago, the resident's sister was diagnosed with breast cancer and the resident had not had a mammogram in approximately 15 years so R19 requested to have a mammogram scheduled at that time. R19 stated she spoke to two nurse practitioners and still had not had a mammogram. A note signed by a nurse practitioner on 5/27/21 documented, "Patient concerned about her sister being dx (diagnosed) with breast cancer and would like to schedule a mammogram..."ASSESSMENT/PLAN OF CARE/MEDICAL DECISION-MAKING: Family hx (history) of breast cancer- will schedule mammogram..." A review of R19's clinical record failed to reveal a physician's order for a mammogram at this time. Further review of R19's clinical record revealed a physician's order signed by another nurse practitioner and dated 5/12/22 for a mammogram but failed to reveal a mammogram had ever been scheduled or	F 684	Criteria 2 All current residents who rely on the facility to schedule their medical appointments and receive medication from the licensed staff at the facility have the potential to be affected be the alleged deficiency. Criteria 3 Licensed Nursing staff will be re-educated on ensuring physician orders are followed and that the standards of practice for medication administration are upheld. Ward Clerk will be re-educated on scheduling medical appointments per resident's physician orders and plan of care. Criteria 4 DON and/or designee will complete five (5) random audits of licensed nursing staff following physician's orders and following the standards of practice for medication administration. The DON and/or designee will also complete five (5) random audits of resident's medical appointments to ensure the physician orders and plan of care are followed. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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PRINTED: 08/28/2022
FORM APPROVED
OMB NO. 0938-0391

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F 684	Continued From page 124 completed. The nurse practitioner who signed the 5/27/21 note and the nurse practitioner who signed the 5/12/22 physician's order were no longer employed at the facility and were not available for interview. On 8/14/22 at 8:47 a.m., an interview was conducted with CNA (certified nursing assistant) #1 (the ward clerk responsible for scheduling appointments). CNA #1 stated she keeps a book on all three units and the nurses and nurse practitioners are supposed to communicate needed appointments via those books. CNA #1 stated that sometimes, nurses and the nurse practitioners will email her with appointment needs but sometimes she isn't notified of needed appointments at all (via the communication book or email). CNA #1 stated R19 makes her own appointments most of the time then writes them down along with a confirmation number and gives the paper to CNA #1. CNA #1 stated she could not provide any documentation to evidence why R19 had not received the mammogram. On 8/14/22 at 9:41 a.m., another interview was conducted with R19. R19 stated that sometimes she does schedule appointments but she asked the nurse practitioners to schedule the mammogram appointment because R19 did not know who to contact to make the appointment. On 8/15/22 at 9:13 a.m., another interview was conducted with CNA #1. CNA #1 stated R19 has a lot of appointments and she was not aware of the nurse practitioner's documentation on 5/27/21 or the physician's order on 5/11/22. CNA #1 stated one of the nurse practitioners used to	F 684		

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F 684	Continued From page 125 make the statement that R19 "makes her own appointments so she's going to let her do it." CNA #1 could not provide any further information. On 6/15/22 at 11:35 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional clinical coordinator) and ASM #4 (the regional director of operations) were made aware of the above concern. The facility policy titled, "Physician's Order" documented, "Physician orders are obtained to provide a clear direction in the care of the guest/resident." On 6/15/22 at 6:20 p.m., ASM #1 and ASM #2 stated the facility did not have a policy for mammograms or scheduling appointments. No further information was presented prior to exit. 2. The facility staff failed to follow physician orders for a mammogram for Resident #15. Resident #15 was admitted to the facility on 1/13/21 with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), diabetes mellitus, CHF (congestive heart failure) and dementia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/14/22, coded the resident as scoring a 4 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the comprehensive care plan dated	F 684		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(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	Continued From page 126 12/1/21 documented in part, "NEED: Resident is at risk for impaired skin integrity/pressure injury. Resident is at risk for decline in condition. INTERVENTIONS: Observe and report to physician any changes in condition. Conduct weekly head to toe skin assessments." A review of the nurse practitioner's orders dated 10/12/21, revealed the following, "Set up ASAP (as soon as possible) appointment with Breast cancer center one time only for hx (history) of left breast cancer, new mass to right breast for 2 Days. A review of the nurse practitioner's orders dated 10/18/21, revealed the following, "Set up ASAP (as soon as possible) appointment for mammogram right breast mass/lump hx (history) of breast cancer. Call daughter and notify and see if able to set up and take to appointment one time only for right lump for 3 Day. A review of the nurse practitioner's orders dated 10/27/21, revealed the following, "If not already done set up appointment for ASAP (as soon as possible) MAMMOGRAM FOR MASS TO RIGHT BREAST WITH HX (history) OF BREAST CANCER -NEED DONE ASAP one time only for MAMMOGRAM ASAP for 2 Days. A review of the nurse practitioner's orders dated 11/3/21, revealed the following, "If not already done set up ASAP (as soon as possible) APPOINTMENT FOR MAMMOGRAM , RIGHT BREAST HARD MASS ORDER PLACED MULTIPLE TIMES IN OCC one time only for HX (history) BREAST CANCER, RIGHT BREAST MASS for 2 Days.	F 684		

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F 684	Continued From page 127 A review of the nurse practitioner's orders dated 11/8/21, revealed the following, "If not already done set up ASAP (as soon as possible) APPOINTMENT FOR MAMMOGRAM , RIGHT BREAST HARD MASS ORDER PLACED MULTIPLE TIMES IN OCC one time only for HX (history) BREAST CANCER, RIGHT BREAST MASS for 2 Days. A review of the nurse practitioner's orders dated 1/4/22, revealed the following, "Please schedule patient to see surgeon ASAP (as soon as possible) for right breast mass, hx (history) left breast cancer s/p (status/post) mastectomy. Try to schedule appointment on Wed, Thu, or Fri. Patient will need transport provided as daughter unable to transport. Notify daughter of date/time of appointment for her to be present. A review of the nurse practitioner's orders dated 2/4/22, revealed the following, "Referral to Breast surgeon for right breast mass/ hx (history) of breast cancer." A review of the nursing progress note dated 10/13/21 at 4:30 PM, revealed the following, "Dynamic mobile notified of US ultrasound to right breast. Lump noted to right breast. Guest denied pain/discomfort. Order/face sheet/and paper work has been completed. Someone is to call facility from Dynamic mobile with date and time of US. MD/RP aware." A review of the nursing progress note dated 10/14/21 at 3:29 PM, revealed the following, "Dynamic mobile notified facility that they would not be able to obtain US ultrasound to right breast, due 2 lumps. NP in facility and made aware."	F 684		

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F 684	Continued From page 128 A review of the nurse practitioner's note dated 11/3/21 at 10:50 AM, revealed the following, "Mass found to right breast patient has hx of breast cancer -order placed twice for appointment to be set up for mammogram ,patient denies pain on palpation, no s/s of acute distress." A review of the physician's note dated 1/4/22 at 10:15 AM, revealed the following, "Follow up right breast mass, history left breast cancer. Nursing documents on 10/14/21 that Dynamic mobile not able to obtain ultrasound to right breast due to 2 lumps. Nurse practitioner recertification 11/3 mention "order placed twice for appointment to be set up for mammogram." No result found in miscellaneous or results section in PCC (point click care). Spoke to daughter on phone, she was unaware of situation. Discussed whether or not she wishes to proceed with work up given patient's advance age and debility and would not be able to stand for mammogram. Daughter does want to pursue evaluation of right breast mass and indicated for preference to stay within Hospital system and previous doctor. She was unable to provide name of patient's treating doctors for her left breast cancer. A review of the physician's note dated 1/21/22 at 11:59 AM, revealed the following, "Right breast mass found around Oct/Nov 2021; history left breast cancer post mastectomy 2017. No work up done so far." A review of the nurse practitioner's note dated 2/3/22 at 7:11 PM, revealed the following, "Right breast mass found around Oct/Nov 2021. History left breast cancer post mastectomy 2017. No work up done so far. Spoke to RP (responsible	F 684		

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F 684	Continued From page 129 party) who would like further evaluation. Will refer to breast surgeon, daughter aware she will need to be present at appointment for decision making/consent. A review of the nurse practitioner's note dated 3/11/22 at 12:20 PM, revealed the following, "Appointment with breast cancer surgeon- patient s/p biopsy right breast cancer with possible mets per consult -patient to have PET scan on 3/24 at 8am -appointment placed in book for secretary." A review of the nurse practitioner's note dated 3/22/22 at 8:52 PM, revealed the following, "Patient post right breast biopsy 3/1, patient has breast cancer with Mets she is scheduled for pet scan 3/24." A review of the nurse practitioner note dated 3/28/22 at 2:12 PM, revealed the following, "Post right breast biopsy 3/1, + mets. Was scheduled for PET on 3/24, canceled due to Blood sugar on high side." A review of the physician note on dated 5/11/22 at 6:23 PM, revealed the following, "Discussed PET (positon emission tomography) scan result stage 3 CA (cancer), chemo was offered but family decided no chemo due to age/dementia. Due to above patient will not be a candidate for any cardiac procedure as well, we will manage HF (heart failure) in the facility. Per oncology, prognosis 6-18 months. Family agreeable for comfort/hospice once she will significantly decline." The nurse practitioners and nurses who documented notes are no longer employed at the facility.	F 684		

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F 684	Continued From page 130 An interview was conducted on 6/14/22 at 8:58 AM, with CNA (certified nursing assistant) #1. When ask her role in scheduling appointments for the residents, CNA #1 stated, I make appointments for the whole house except some residents might make their own. I have been here for 4-5 years. I round twice a day at 9:00 AM and 2:00 PM. I may get pulled to the floor to do AM care. I have an appointment book on all 3 units. On one side of the book, I have the appointment papers. I keep a copy and put on their unit, the resident name, date and time, who is picking up and time, doctors address. In that book, there is a piece of paper that is printed off from PCC and put on the left side of the book. The nurses let me know if there is an order in PCC and print off copy of the order. I go around every morning and check off all 3 books. If it is an agency nurse they do not make me aware of appointments. I have an email and the nurse practitioners sometimes email me. Some nurse practitioners will come up to me in the hall and give me appointments to make. Sometimes I schedule mammograms and they are so hard to get in. The nurse practitioner tells me where to call, sometimes they have the number. I do not document the follow up, I tell the nurses and I do not know if they write a note or not. Sometimes transportation does not show up at all and then we try to find out what happens. I call a day ahead of time to make sure they are coming, I will take the resident to the door myself and the transportation does not show up at times. When CNA #1 was asked for evidence of the appointments being made for the mammogram for Resident #15, CNA #1 stated, the previous administrator and DON (director of nursing) said to shred all the information monthly. I do not	F 684		

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OMB NO. 0938-0391

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F 684	Continued From page 131 have any written or documented evidence. When asked if she had discussed this process with the current administrator (started April 2022) or director of nursing (started May 2022), CNA #1 stated, no, I have not. An interview was conducted on 6/14/22 at 11:20 AM, with ASM (administrative staff member) #5, the physician. When asked if she knew the mammogram situation with Resident #15, ASM #5 stated, "Yes I do. We have changed our process, so that the physician spends more time with the long term care residents." When asked about the delay in implementation of orders for mammograms, ASM #5 stated, "If it's an outside procedure like a mammogram, we put the order in and let the nurses know and the agency nurses know. We try to let the unit manager know. It sometimes gets lost with the agency nurse. The CNA (CNA #1) schedules the test, each situation is unique. Some procedure are multiple calls back and forth. The family is notified, if patients cannot make decisions, we let them know. Family involved and sometimes wants to go with the resident, or to make sure they will go for the procedure." When asked if the delay in obtaining the mammogram for Resident #15 could have impacted the prognosis for the resident, ASM #5 stated, "I cannot say for 100%. I honestly believe that the prognosis was probably not impacted. Her dementia, comorbid conditions and functional status would all impact the prognosis." An interview was conducted on 6/14/22 at 3:00 PM with LPN (licensed practical nurse) #3. When asked if physician orders for appointments or tests are not completed as ordered, has the quality of care been maintained, LPN #3 stated, no, if we have not followed physician orders, we	F 684		

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F 684	Continued From page 132 are not maintaining quality of care. On 6/15/22 at 3:45 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional clinical coordinator and ASM #4, the regional director of operations were informed of the above concern. According to the facility's "Physician Orders" policy dated 6/24/21, which revealed the following, "Treatment rendered to a guest/resident must be in accordance with the specific standing, written, verbal, or telephone order of a physician or other licensed health professional ordering within their scope of practice and clinical privileges." No further information was provided prior to exit. Complaint Deficiency. 3. The facility staff failed to follow physician orders for a physician appointment with the surgeon for Resident #436. Resident #436 was admitted to the facility on 4/15/21 with diagnosis that included but were not limited to: dementia, falls, atrial fibrillation, chronic kidney disease. The most recent MDS (minimum data set) assessment, a Medicare 6 day admission assessment, with an ARD (assessment reference date) of 5/19/21, coded the resident as scoring a 6 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the comprehensive care plan dated	F 684		

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F 684	Continued From page 133 12/1/21 documented in part, "NEED: Resident has Actual Impairment to skin integrity related to surgical wound. INTERVENTIONS: Treatment to skin impairment per order." A review of the physician's orders dated 5/17/21, revealed the following, "Patient has an appointment with surgeon on 5/18/21 at 11 am." A review of the physician's note dated 5/17/21 at 12:32 PM, revealed the following, "He has an appointment on 18th of May with his surgeon." No progress note on 5/18/21 documenting the surgeon appointment. An interview was conducted on 6/14/22 at 8:58 AM, with CNA (certified nursing assistant) #1. When ask her role in scheduling appointments for the residents, CNA #1 stated, I make appointments for the whole house except some residents might make their own. I have been here for 4-5 years. I round twice a day at 9:00 AM and 2:00 PM. I may get pulled to the floor to do AM care. I have an appointment book on all 3 units. On one side of the book, I have the appointment papers. I keep a copy and put on their unit, the resident name, date and time, who is picking up and time, doctors address. In that book, there is a piece of paper that is printed off from PCC and put on the left side of the book. The nurses let me know if there is an order in PCC and print off copy of the order. I go around every morning and check off all 3 books. If it is an agency nurse they do not make me aware of appointments. I have an email and the nurse practitioners sometimes email me. Some nurse practitioners will come up to me in the hall and give me appointments to make. The nurse	F 684		

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F 684	Continued From page 134 practitioner tells me where to call, sometimes they have the number. I do not document the follow up, I tell the nurses and I do not know if they write a note or not. Sometimes transportation does not show up at all and then we try to find out what happens. I call a day ahead of time to make sure they are coming, I will take the resident to the door myself and the transportation does not show up at times. When CNA #1 was asked for evidence of the transportation being made for the surgeon appointment on 5/18/21 for Resident #436, CNA #1 stated, the previous administrator and DON (director of nursing) said to shred all the information monthly. I do not have any written or documented evidence. When asked if she had discussed this process with the current administrator (started April 2022) or director of nursing (started May 2022), CNA #1 stated, no, I have not. An interview was conducted on 6/14/22 at 11:20 AM, with ASM (administrative staff member) #5, the physician. When asked if she remembered Resident #436, ASM #5 stated, "I believe my partner cared for him" When asked if they knew he had missed his follow up surgical appointment, ASM #5 stated, "I do not see any documentation of that." An interview was conducted on 6/14/22 at 3:00 PM with LPN (licensed practical nurse) #3. When asked if physician orders for appointments or tests are not completed as ordered, has the quality of care been maintained, LPN #3 stated, no, if we have not followed physician orders, we are not maintaining quality of care. On 6/15/22 at 3:45 PM, ASM (administrative staff	F 684		

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F 684	Continued From page 135 member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional clinical coordinator and ASM #4, the regional director of operations were informed of the above concern. According to the facility's "Physician Orders" policy dated 6/24/21, which revealed the following, "Treatment rendered to a guest/resident must be in accordance with the specific standing, written, verbal, or telephone order of a physician or other licensed health professional ordering within their scope of practice and clinical privileges." No further information was provided prior to exit. Complaint Deficiency. 4. For Resident #701 the facility staff failed to follow physician's orders and standards of practice for medication administration, by administering another resident's medications to Resident #701. Resident #701 was admitted to the facility on 8/17/21 and discharged to an assisted living facility on 9/26/21. The admission nursing assessment dated 8/18/21 documented the resident was alert and oriented to person only. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/21/21, the resident was coded as requiring supervision for eating and extensive assistance for all other areas of activities of daily living. A review of the facility policy, "Medication Administration" was conducted. This policy documented, "Medications are administered in accordance with written orders of the attending	F 684		

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F 684	Continued From page 136 physician....Verify the medication label against the medication administration record for the guest/resident name, time, drug, dose, and route....Never administer medications supplied for one guest/resident to another guest/resident...." A review of the comprehensive care plan for Resident #701 revealed one dated 9/2/21 for "[Resident #701] is at risk for abnormal bleeding/bruising R/T: medication use..." The interventions included one dated 9/2/21 for "Administer medications as ordered...." A review of the clinical record revealed a nurse's note dated 9/20/21 at 7:20 AM (note actually created on 9/22/21 at 3:05 PM) that documented, "[Resident #701] and another resident was put to bed in the wrong beds. on med pass [Resident #701] received the medication of the resident of who bed (they) was put into during the night. (They) received Levothyroxine (1). (They) was monitored and (their) brother was notified about the medication error. [Resident #701] ate (their) breakfast and responded back when being talked to. No S/S (signs or symptoms) of an (sic, a) reaction noted." A nurse's note dated 9/21/21 documented, "notified brother of med event on 9-21-21, also notified np (nurse practitioner) and md (medical doctor) of med event n.n.o (no new orders) at this time will cont (continue) to monitor." A review of the "Incident Report" about the medication error, dated 9/20/21, included a written statement dated 9/21/21 from the nurse that made the medication error, documented, "On 9/21/21 I administered to [Resident #701] two Tylenol (2) and synthroid (same as 1); When I	F 684		

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F 684	Continued From page 137 administered [Resident #701] (their) medication I did not ask (their) name, I looked at (their) picture in the electronic record and thought it was the person laying in the bed. I was asked by the aide why [Resident #701] wasn't in (their) bed approximately seven in the morning. I then went to the computer and, identified in the computer the picture and calling out the guest name to clearly identify the MD. the aide (name) stated that she placed [Resident #701] in the wrong room around approximately three A.M. Vital signs were taken and no distress noted - same level of cognitive level." The nurse who made the medication error was no longer at the facility and could not be interviewed. On 6/14/22 at 3:00 PM, an interview was conducted with LPN #4 (Licensed Practical Nurse). She stated that the rights of medication administration were right resident, right medication, right dose, right route and right time. She stated that staff should not administer medications for one resident to another resident. On 6/15/22 at approximately 4:00 PM, ASM #1 (Administrative Staff Member), the Administrator, ASM #2, the Director of Nursing, and ASM #4, the Regional Director of Operations were made aware of the findings. No further information was provided by the end of the survey. References: (1) Levothyroxine - Is used to treat hypothyroidism Information obtained from https://medlineplus.gov/druginfo/meds/a682461.html	F 684		

PRINTED: 06/28/2022
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F 684	Continued From page 138 (2) Tylenol - is used to treat mild to moderate pain Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html Complaint Deficiency.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, facility document review and in the course of a complaint investigation it was determined that the facility staff failed to provide care and services to promote healing of a pressure ulcer for one of 59 residents in the survey sample, Resident #87. The findings include: The facility staff failed to evidence a treatment to the Stage 4 pressure ulcer between	F 686	F686 Criteria 1 R87 in the facility was noted to have improvement in pressure injury per wound physician documentation. Criteria 2 All residents who have pressure injuries have the potential to be affected by the alleged deficiency. Criteria 3 Nursing staff will be re-educated on following physician's orders and documentation of treatments and interventions. Criteria 4 DON/designee or designee will complete five (5) random audits of documentation for residents who have pressure injury treatment orders. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. The results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 686	Continued From page 139 1/7/2022-1/9/2022 and 1/11/2022-1/17/2022 for Resident #87 (R87). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/12/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was not cognitively impaired for making daily decisions. Section M documented R87 having 1 Stage 4 pressure ulcer and 1 Stage 3 pressure ulcer. On 6/14/2022 at 8:25 a.m., an interview was conducted with R87 in their room. R87 stated that the nurses had been in earlier that morning to change their wound dressing and had gotten better about doing the wound care as ordered. R87 stated that they had problems in the past with getting the wound dressing changed and their family had complained to the nurses about it. A request was made to ASM (administrative staff member) #2, the director of nursing, to observe wound care for R87 on 6/14/2022 at approximately 8:00 a.m. On 6/14/2022 at approximately 9:30 a.m., ASM #2 stated that R87's wound care had been completed for the day and they would arrange the observation for 6/15/2022. On 6/15/2022 at approximately 10:15 a.m., LPN (licensed practical nurse) #2, the wound nurse was observed performing wound care on another resident. LPN #2 stated that the assigned nurse for R87 had already completed the wound care that morning and it could not be observed. The physician orders reviewed from 1/1/2022 through 1/31/2022 documented in part;	F 686		

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F 686	Continued From page 140 - "Wound care: Sacral wound- clean with NS (normal saline)- apply flagyl and pack with 1/4 Dakins moistened gauze QD (every day) and PRN (as needed) - apply dry dressing every evening shift for wound related to pressure ulcer of sacral region unspecified stage. Order date: 12/14/2021. Start Date: 12/14/2021. End Date: 01/07/2022." - "Wound care: Sacral wound- clean with 1/4 Dakins solution- pack with Silver Calcium Alginate QD (every day) and PRN (as needed)- cover with dry dressing. Order Date: 01/07/2022, End Date: 01/17/2022..." The order failed to evidence a start date. - "Wound care: Sacral wound- clean with 1/4 Dakins solution- pack with Silver Calcium alginate QD and PRN- cover with Dry dressing in the morning for wound care. Order Date: 01/17/2022. Start Date: 01/18/2022. End Date: 01/18/2022." The eTAR (electronic treatment administration record) for R87 dated 1/1/2022-1/31/2022 failed to evidence documentation of a treatment provided to the sacral wound 1/7/2022 through 1/17/2022. The progress notes documented in part, - "1/10/2022 22:38 (10:38 p.m.) Note Text: Sacral wound care provided during shift. Yellow/reddish discharge noted. Foul odor noted. No c/o pain/discomfort while providing wound care. Pain meds offered, declined per resident." The progress notes failed to evidence documentation of treatment to the sacral wound 1/7/2022-1/9/2022 and 1/11/2022-1/17/2022. The wound evaluation & management summary	F 686		

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F 686	Continued From page 141 dated 1/7/2022 documented in part, "Stage 4 pressure wound sacrum full thickness...Wound progress: deteriorated, Additional wound detail: larger, d/c dakins packing, start Silver Alginate, dressing treatment plan, primary dressing(s), Sodium hypochlorite solution (dakins) apply once daily for 30 days: clean with 1/4 dakins solution; Alginate calcium w/silver apply once daily for 30 days. secondary dressing(s), gauze island (w/bdr) (with border) apply once daily for 30 days..." The wound evaluation & management summary dated 1/14/2022 documented in part, "Stage 4 pressure wound sacrum full thickness...Wound progress: improved, Additional wound detail: smaller, dressing treatment plan, primary dressing(s), Sodium hypochlorite solution (dakins) apply once daily for 23 days: clean with 1/4 dakins solution; Alginate calcium w/silver apply once daily for 23 days. secondary dressing(s), gauze island (w/bdr) apply once daily for 23 days..." The wound evaluation & management summary dated 1/28/2022 documented in part, "Stage 4 pressure wound sacrum full thickness...Wound progress: improved, Additional wound detail: shorter, no longer with exposed bone, dressing treatment plan, primary dressing(s), Sodium hypochlorite solution (dakins) apply once daily for 9 days: clean with 1/4 dakins solution; Alginate calcium w/silver apply once daily for 9 days. secondary dressing(s), gauze island (w/bdr) apply once daily for 9 days..." The comprehensive care plan for R87 documented in part, "Skin #2: [R87] has pressure ulcers to sacrum and right thigh. Stage 4, Being followed by wound doctor. Date Initiated:	F 686		

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F 686	Continued From page 142 07/17/2019. Revision on: 06/14/2022..." On 6/15/2022 at 9:56 a.m., a telephone interview was conducted with ASM (administrative staff member) #7, the wound physician. ASM #7 stated that R87 had a sacral wound they had been following for 956 days. ASM #7 stated that R87's wound was slow to heal due to medical comorbidities and noncompliance with offloading and turning and positioning. ASM #7 stated that there was a zinc barrier cream ordered for the skin around the wound but was not the primary treatment for the pressure ulcer. ASM #7 stated that there should be a continuous treatment in place for the Stage 4 pressure wound treatment. On 6/15/2022 at 10:54 a.m., an interview was conducted with LPN (licensed practical nurse) #3, unit manager. LPN #3 stated that treatments were evidenced as completed by documenting them on the eTAR. LPN #3 stated that if there was no documentation there was no evidence to support that anything was done. LPN #3 they were always taught that if it was not documented it was not done. LPN #3 reviewed the eTAR for R87 dated 1/1/2022-1/31/2022 and stated that they did not see any evidence that there was a treatment in place for the sacral pressure ulcer between 1/7/2022-1/17/2022. On 6/15/2022 at 1:29 p.m., an interview was conducted with LPN #2, the wound nurse. LPN #2 stated that they were new to the wound nurse position. LPN #2 stated that R87's pressure ulcer was slow to heal due to non-compliance with offloading and turning and positioning off of the wound. LPN #2 stated that they round with the wound doctor and make any changes to treatment orders as needed when the physician	F 686		

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F 686	Continued From page 143 rounds. LPN #2 reviewed the physician orders and the eTAR for R87 dated 1/1/2022-1/31/2022 and stated that they did not see any evidence of a treatment in place for the pressure ulcer from 1/7/2022-1/17/2022. LPN #2 stated that R87 had the pressure ulcer during that time and there should have been a treatment in place. The facility policy, "Skin Management" dated 5/1/2010 documented in part, "...Guests/residents with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing..." On 6/15/2022 at approximately 4:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator and ASM #4, the regional director of operations were notified of the findings. No further information was provided prior to exit. Complaint deficiency.	F 686		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690	F690 Criteria 1 R40 in the facility suffered no adverse effects related to frequency of condom catheter changes. Upon notification of this information, resident #40's condom catheter orders were changed to meet the standards of practice. Criteria 2 There are no additional residents in the facility using condom catheters. Any guest with orders for condom catheters could be affected by this alleged deficient practice.	

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F 690	Continued From page 144 comprehensive assessment, the facility must ensure that- (I) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (II) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (III) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview clinical record review and in the course of a complaint investigation, the facility staff failed to provide condom catheter care and services per professional standards for one of 59 residents in the survey sample, Resident #40. The facility staff failed to change Resident #40's (R40) condom catheter every other day. The findings include: "URINARY INCONTINENCE DEVICES: The	F 690	Criteria 3 Licensed nurses will be re-educated on the use and care of condom catheters to meet nursing standards of practice. Criteria 4 DON and/or designee will audits of condom catheters. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month.. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 690	Continued From page 145	F 690		

systems for men most often consist of a pouch or condom-like device. This device is securely placed around the penis. This is often called a condom catheter. A drainage tube is attached at the tip of the device to remove urine. This tube empties into a storage bag, which can be emptied directly into the toilet. Condom catheters are most effective when applied to a clean, dry penis. You may need to trim the hair around the pubic area for better grip of the device. You must change the device at least every other day to protect the skin and prevent urinary tract infections." This information was obtained from the website: https://medlineplus.gov/ency/article/003974.htm

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/6/22, 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 6/13/22 at 3:12 p.m., an interview was conducted with R40. R40 stated the condom catheter is supposed to be changed "right much" but nurses are currently changing it about every 10 days. R40 stated the nurses say they forgot to change it or don't know how to change it so the resident has "to wait until a good nurse comes in."

A review of R40's clinical record failed to reveal a physician's order to routinely change R40's condom catheter. A physician's order dated 6/29/21 documented to change the resident's condom catheter as needed and another physician's order dated 3/31/22 documented to change the resident's condom catheter as

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F 690	Continued From page 146 needed. R40's comprehensive care plan last reviewed on 4/15/22 documented, "(R40) is at risk for urinary tract infection and catheter-related trauma: has Condom Catheter r/t (related to) paraplegia. Change catheter and tubing per facility policy..." A review of TARs (treatment administration records) for August 2021 through Jun 2022 revealed R40's condom catheter was changed on the following dates: 8/5/21, 8/26/21, 9/16/21, 1/24/22, 2/6/22, 2/13/22, 3/29/22, 4/7/22, 4/18/22, 4/29/22, 5/9/22, 5/15/22, 5/25/22, 6/4/22, 6/12/22 and 6/14/22. There was no documentation to evidence the catheter was changed on any other dates. On 6/15/22 at 12:11 p.m., an interview was conducted with ASM (administrative staff member) #6 (the nurse practitioner). ASM #6 stated it is a professional standard and best practice to change a condom catheter every day. ASM #6 stated she was not aware R40's condom catheter change was only ordered as needed. On 6/15/22 at 3:10 p.m. a telephone interview was conducted with ASM #5 (Resident #40's physician). ASM #5 stated a condom catheter should be changed every 24 to 48 hours to check the skin for irritation/pressure ulcers and to prevent UTIs (urinary tract infections). ASM #5 stated she could not explain why R40 only had an as needed order for the condom catheter change. ASM #5 stated maybe this was per R40's request or the routine order got lost. R40 stated she tries to go through residents' orders when completing recertifications but she cannot review every resident's orders every day.	F 690		

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F 690	Continued From page 147 Further review of R40's clinical record revealed antibiotic medication treatment was initiated for UTIs on 9/16/21 and 6/15/22. On 6/15/22 at 3:35 a.m., ASM #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional clinical coordinator) and ASM #4 (the regional director of operations) were made aware of the above concern. On 6/15/22 at 6:20 p.m., ASM #1 and ASM #2 stated the facility did not have a policy or standard of practice for condom catheters. No further information was presented prior to exit. Complaint Deficiency.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(l) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to provide respiratory care and services for 3 of 59 residents in the survey sample, Residents #289, #94 and #61.	F 695	F695 Criteria 1 Resident #289,#94, #61. Resident #289 O2 was bagged after identification. Resident#94 O2 rate was adjusted to to 3L as per MD order. Resident#61 O2 was adjusted to the rate of 2L/min per MD order. Criteria 2 All residents who receive O2 have the potential to be affected by the alleged deficiency. Criteria 3 Nursing staff will be reeducated on O2 orders and checking the O2 for correct flow rate. Criteria 4 DON/designee or designee will complete five (5) random audits of residents with O2 ordered by MD for flow rate. These audits will be completed 5 days a week for four weeks; Then one day a week for four weeks; then twice in the last month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 695	Continued From page 148 The findings include: 1. The facility staff failed to store Resident # 289's (R289) nasal cannula (1) in a sanitary manner. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/05/2022, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded (R289) for "Oxygen Therapy" while a resident. On 06/13/22 at approximately 1:09 p.m., an observation of (R289's) nasal cannula was observed hanging over the partially open drawer of the bedside dresser uncovered. On 06/14/22 at approximately 3:10 p.m., an observation of (R289's) nasal cannula was observed hanging over the partially open drawer of the bedside dresser uncovered. The physician's order for (R289) documented in part, "Oxygen 2l/min (two liters per minute) via (by) nasal cannula as needed for SOB (shortness of breath). Order Date: 5/31/2022. Start Date: 06/03/2022." On 06/15/22 at approximately 8:06 a.m., an interview was conducted with LPN (licensed practical nurse) #7. When asked to describe the procedure for storing a resident's nasal cannula when it was not in use LPN #7 stated it should be wrapped up and placed inside a bag for infection control purposes. When informed of the	F 695		

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F 695	Continued From page 149 observations described above LPN #7 stated that the nasal cannula should not have been stored that way. The facility's policy "Use of Oxygen" documented in part, "III. The O2 cannula or mask, when not in use, should be stored in a clean bag. Bag should be changed weekly." On 06/15/2022 at approximately 11:35 a.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional clinical coordinator, ASM #4, regional director of operations. No further information was presented prior to exit. References: (1) Tubing used to deliver oxygen at levels from 1 to 6 L/min. The nasal prongs of the cannula extend approx. 1 cm into each naris and are connected to a common tube, which is then connected to the oxygen source. This information was obtained from the website: http://medical-dictionary.thefreedictionary.com/nasal+cannula. 2. For Resident #94 the facility staff failed to administer oxygen at the physician ordered rate. Resident #94 was admitted to the facility on 3/30/20. On the most recent MDS (Minimum Data Set) an annual assessment with an ARD (Assessment Reference Date) of 5/10/22, Resident #94 scored an 11 out of a possible 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for all	F 695		

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F 695	Continued From page 150 areas of activities of daily living, except for eating which only required supervision. A review of the clinical record revealed a physician's order dated 1/25/22 for oxygen at 3 liters per minute continuously. On 6/13/22 at 1:13 PM and 6/14/22 at 9:04 AM, Resident #94 was observed in bed with oxygen on. The flow meter reflected an oxygen rate of 1.5 liters per minute as evidenced by the line for the 1.5 liter mark crossing through the middle of the flow meter ball. On 6/14/22 at 3:00 PM, an interview was conducted with LPN #4 (Licensed Practical Nurse). She stated that the resident's oxygen rate should be 3 liters per minute. When asked if the rate was set at 1.5 liters, was the oxygen being administered as ordered, she stated that it was not. A review of the comprehensive care plan revealed one dated 10/10/20 for "[Resident #94] has a potential for difficulty breathing and risk for respiratory complications..." This care plan included the intervention, dated 3/15/21 for "Administer medication and treatments per physician orders....oxygen per order..." The facility policy, "Use of Oxygen" was reviewed. This policy did not document anything about verifying physician's orders for the use of and rate of oxygen. On 6/15/22 at approximately 4:00 PM, ASM #1 (Administrative Staff Member), the Administrator, ASM #2, the Director of Nursing, and ASM #4, the Regional Director of Operations were made	F 695		

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F 695	Continued From page 151 aware of the findings. No further information was provided by the end of the survey. 3. The facility staff failed to provide respiratory therapy as ordered for Resident #61. Resident #61 was observed with oxygen via nasal cannula at 3 liters per minute on 6/13/22 at 1:09 PM, 6/14/22 at 9:00 AM and 6/14/22 at 2:50 PM. Resident #61 was admitted to the facility on 4/23/21 with diagnoses that include but are not limited to: COPD (chronic obstructive pulmonary disease). Resident #61's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/22/22, coded the resident as scoring 7 out of 15 on the BIMS (brief interview for mental status score), indicating the resident was severely cognitively impaired. Resident #61's care plan dated 4/24/21 with no revision date, revealed the following, "Need: Resident has a potential for difficulty breathing and risk for respiratory complications related to: COPD. Interventions: Elevate head of bed, encourage cough & deep breathing, Oxygen as ordered via nasal cannula every shift for SOB (shortness of breath), COPD oxygen per order." A review of the physician's orders dated 4/4/22, revealed the following, "Oxygen 2l/min via nasal cannula for SOB. every shift for SOB." Resident #61 was observed with oxygen via nasal cannula at 3 liters per minute on 6/13/22 at 1:09 PM, 6/14/22 at 9:00 AM and 6/14/22 at 2:50 PM. The oxygen concentrator is the Invacare Perfecto2.	F 695		

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F 695	Continued From page 152 Resident #61 wa unable to be interviewed due to cognitive impairment. On 6/14/22 at 2:55 PM, LPN (licensed practical nurse) #3 was asked to observe the oxygen setting on Resident #61. An interview was conducted on 6/14/22 at 3:00 PM with LPN #3. When asked the oxygen setting observed, LPN #3 stated, it is set on 3 liters nasal cannula. I need to check the order. When asked how she read the level at 3 liters, LPN #3 stated, you read the number where the center of the ball is located. LPN #3 checked the order in the medical record and stated, the order is for 2 liters nasal cannula. I will go change it now. When asked if the oxygen being set at 3 liters nasal cannula, indicated that the oxygen was being monitored for correct therapy, LPN #3 stated, "No, it is not." On 6/14/22 at 4:20 PM, ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator were informed of the above concern. According to the instruction manual for the Invacare Perfecto2 oxygen concentrator, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow know until the ball rises to the line. Now center the ball on the liters per minute line prescribed." According to the facility's "Physician orders" policy dated 6/24/21, which revealed the following, "Treatment rendered to a guest/resident must be in accordance with the specific standing, written, verbal, or telephone	F 695		

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F 695	Continued From page 153 order of a physician or other licensed health professional ordering within their scope of practice and clinical privileges." No further information was provided prior to exit.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. 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 implement a complete pain management program for one of 59 residents in the survey sample, Resident #58 (R58). The findings include: Facility staff failed to conduct complete pain assessments and attempt non-pharmacological interventions prior to the administration of a PRN (as needed) pain medication, tramadol (1). (R58) was admitted to the facility with a diagnosis that included by not limited to: rheumatoid arthritis. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 04/17/2022, the resident scored 15 out of 15 on the BIMS (brief interview	F 697	F697 Criteria 1: R#58 was provided as needed pain medication without documented non-pharmacologic interventions. Resident #58 is now receiving non-pharmacological interventions prior to administration of pain medication. Criteria 2 All residents who have as needed medications for pain have the potential to be affected by the alleged deficiency. Criteria 3 Nursing staff will be re-educated on documentation of NPI (non-pharmacological interventions) prior to administering any as needed (PRN) medication. Criteria 4 DON/designee or designee will complete five (5) random audits of resident documentation who are prescribed As Needed/PRN medications by the MD/NP. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. The results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 697	Continued From page 154	F 697		

for mental status), indicating the resident is cognitively intact for making daily decisions. Section J0300 "Pain Presence" coded (R58) as having frequent pain in the past 5 (five) days. Section J0600 "Pain Intensity" coded (R58) as having a pain level of five out of ten with ten being the worse pain.

The physician's order for (R58) documented in part, "Tramadol HCl (hydrochloride) Tablet 50 MG (milligram). Give 1 tablet by mouth every 6 (six) hours as needed for pain. Complete NPI (non-pharmacological interventions) with use. Order date: 4/18/2022."

The eMAR (electronic medication administration record) for (R58) dated June 2022 documented the physician's order as stated above and "Pain-Non-Pharmacological Interventions: Document Non Pharmacological interventions used: 1)Massage. 2) Meditation/Relaxation. 3)Positioning. 4) Ice/cold pack. 5)Diversional Activity. 6) Guided Imagery. 7) Rest. 8)Social Interaction. as needed Document NonPharmacological interventions using the corresponding number. Start Date 04/12/2022."

Review of the eMAR failed to evidence documentation of non-pharmacological interventions as stated above from 06/01/2022 through 06/12/2022. The eMAR revealed that (R58) received 50 mgs of tramadol on the following dates and times, with no evidence of the location of pain, type of pain and non-pharmacological interventions being attempted on: 06/01/2022 at 7:06 a.m., 06/02/2022 at 10:48 a.m. and at 6:29 p.m., 06/04/2022 at 12:21 p.m., 06/06/2022 at 8:24 a.m., 06/07/2022 at 10:19 a.m. and at 9:59 p.m.,

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F 697	Continued From page 155 06/08/2022 at 5:20 p.m., 06/09/2022 at 8:25 p.m., 06/10/2022 at 5:50 a.m., 06/11/2022 at 9:38 p.m. and on 06/12/2022 at 4:32 a.m. and at 9:33 p.m. Further review of the eMAR failed to evidence non-pharmacological interventions being attempted on: 06/03/2022 at 11:07 a.m., 06/08/2022 at 9:43 p.m. and on 06/09/2022 at 8:46 a.m. The comprehensive care plan for (R58) documented in part, "Focus. (R58) is at risk for pain and/or has acute/chronic pain r/t (related to) DX (diagnoses: RA (rheumatoid arthritis), DJD (degenerative joint disease), GERD (gastroesophageal reflux disease). Date initiated: 04/13/2022." Under "Interventions" it documented in part, "Evaluate the effectiveness of pain interventions as given. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition as needed. Date initiated: 04/13/2022." Review of the facility's nurse's notes for (R58) dated 06/01/2022 through 06/12/2022 failed to evidence the location of pain, type of pain and non-pharmacological interventions being attempted on the dates and times listed above and failed to evidence non-pharmacological interventions being attempted on the dates and times listed above. On 06/13/22 at approximately 12:52 p.m., an interview was conducted with (R58). When asked if they receive as needed pain medication (R58) stated yes. When asked of the nurse attempts to alleviate their pain by other means before administering their pain medication (R58) stated that nurse just gives them their medication.	F 697		

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F 697	Continued From page 156 On 06/15/22 at 8:00 a.m., an interview was conducted with LPN (licensed practical nurse) # 7. When asked to describe the procedure when administering as needed pain medication LPN # 7 stated that the nurse assesses the resident's pain by obtaining the severity of the resident's pain on a scale of zero to ten, with ten being the worse pain, the location of the pain and the type of pain such as throbbing or stabbing. LPN # 7 stated that the nurse would then start with non-pharmacological interventions such as repositioning, ice pack, or heat, and if that does not alleviate the resident's pain, they would administer the prescribe medication. When asked how often non-pharmacological interventions LPN # 7 stated that it should be attempted each time before the as needed pain medication is administered. When asked where it would be documented that the location of pain, type of pain and non-pharmacological interventions were attempted LPN # 7 stated that it would be documented in the nurse's notes or the eMAR. When asked why it is important to attempt non-pharmacological interventions prior to the administration of as needed pain medication LPN # 7 stated that it could decrease use of pain medication. After review of the eMAR for non-pharmacological interventions LPN # 7 was asked about the missing documentation. LPN # 7 stated that they could not say non-pharmacological interventions were attempted because it was not documented. After reviewing the facility's nurse's notes for (R58) dated 06/01/2022 through 06/12/2022 and the eMAR for the administration of Tramadol LPN # 7 was asked if the location of pain, type of pain and non-pharmacological interventions were documented for the dates listed above. LPN # 7	F 697		

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F 697	Continued From page 157 stated, "No." The facility's policy "Pain Management" documented in part, "6. Ask the guest/resident and observe to determine the intensity of pain: Mild pain - if a guest/resident indicates his or her pain is "mild". Moderate pain - if a guest/resident indicates his or her pain is "moderate". Severe Pain- if a guest/resident indicates his or her pain is "severe". Very severe or Horrible - if a guest/resident indicates his or her pain is "very severe or horrible". 7. Ask the guest/resident and observe to determine the location of pain ...14. The staff will implement the care plan, monitor the guest/resident, and administer therapeutic interventions for pain, if ordered." On 06/15/2022 at approximately 11:35 a.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 3, regional clinical coordinator, ASM# 4, regional director of operations. No further information was presented prior to exit. References: (1) Tramadol is used to relieve moderate to moderately severe pain. Tramadol extended-release tablets and capsules are only used by people who are expected to need medication to relieve pain around-the-clock. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html.	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		

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F 698	Continued From page 158 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review, and facility document review, it was determined the facility staff failed to provide dialysis care and services for two of 59 residents in the survey sample, Resident #76 and Resident #116. The findings include: 1. For Resident #76, the facility failed to provide communication to the dialysis facility for 10 of 14 visits in March 2022, 11 of 13 visits in April 2022, 13 of 13 visits in May 2022 and 4 of 5 visits in June 2022 and failed to monitor the catheter site for signs of infection and bleeding. Resident #76 was admitted to the facility on 7/19/21. Resident #76's diagnoses included but were not limited to: ESRD (end stage renal disease) and dementia. Resident #76's most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 3/19/22, coded the resident as scoring 9 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of Resident #76's comprehensive care plan revised 9/9/21, revealed the following, "NEED: Resident is at risk for complications related to needs for dialysis due to: End Stage	F 698	F698 Criteria 1 Resident #76 suffered no adverse outcomes related to the alleged failure of the facility to monitor the resident's catheter site for signs of infection and bleeding or provide communication to the dialysis facility where the resident receives treatment. Resident #116 suffered no adverse outcomes related to the alleged failure of the facility to provide dialysis communication forms for resident #116's dialysis appointments. Upon notification of the allegations, unit staff and ward clerk were re-educated on providing dialysis communication forms for residents #76 and #116 and the staff responsible for resident #76 were re-educated on monitoring the catheter site for signs and symptoms of infection. Criteria 2 All residents receiving dialysis have the potential of being affected by the alleged deficient practice. Audit completed on dialysis residents and those with dialysis catheters to ensure compliance. Criteria 3 Nursing staff and ward clerk will be re-educated on ensuring dialysis communication forms are used and that catheter sites are monitored for signs and symptoms of infection. Criteria 4 Don and/or designee will complete audits to ensure dialysis communication forms are utilized and the dialysis catheter sites are monitored for signs and symptoms of infection. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 698	Continued From page 159 Renal Disease. dialysis cath replaced 1/6/21. Hemodialysis Tuesday, Thursday, Saturday. INTERVENTIONS: Observe for signs/symptoms of infection to access site: Redness, Swelling, warmth or drainage/bleeding and other signs of infection: fever, generalized malaise, complaints of abdominal pain, chills. Document and report abnormal findings to the physician. For Hemodialysis: Facility will utilize the Dialysis Communication form to communicate with the dialysis center. Send the dialysis communication book to the dialysis center with each appointment. Upon return from the dialysis center review the communication book including any progress notes. Provide an update to the physician and any staff member/disciplines as needed. A review of the physician's orders dated 8/9/21 renewed 5/2/22, revealed the following, "Hemodialysis Tuesday, Thursday, Saturday. Monitor dialysis catheter Right Chest for signs/symptoms of infection. May reinforce dressing if needed. Monitor every shift." A review of the dialysis binder for Resident #76 on 6/14/22, revealed the following, the facility's "Hemodialysis Communication Form" was completed on the following dates, 6/14/22, 4/22/22, 4/7/22, 3/29/22, 3/26/22 and 3/24/22. The facility failed to provide communication to the dialysis facility for 10 of 14 visits in March 2022, the missing dates in March 2022 were: 3/1, 3/3, 3/8, 3/10, 3/12 3/15, 3/17, 3/19, 3/22 and 3/31. The facility failed to provide communication to the dialysis facility for 11 of 13 visits in April 2022, the missing dates in April 2022 were: 4/2, 4/5, 4/9,	F 698		

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F 698	Continued From page 160 4/12, 4/14, 4/16, 4/19, 4/23, 4/26, 4/28 and 4/30. The facility failed to provide communication to the dialysis facility for 13 of 13 visits in May 2022, the missing dates in May 2022 were: 5/3, 5/5, 5/7, 5/10, 5/12, 5/14, 5/17, 5/19, 5/21, 5/24, 5/26, 5/28 and 5/31. The facility failed to provide communication to the dialysis facility for 5 of 5 visits in June 2022, the missing dates in June 2022 were: 6/2, 6/4, 6/7, 6/9 and 6/11. A review of the TAR (treatment administration record) for March 2022, revealed the following, "Monitor dialysis catheter Right Chest for signs/symptoms of infection. May reinforce dressing if needed. Monitor every shift" evidenced that 24 out of 93 shifts were missing documentation. Missing dates were day shift: 3/1, 3/2, ¾, 3/5, 3/6, 3/7, 3/12, and 3/15; evening shift 3/3, 3/6, 3/8, 3/9, 3/24 and 3/26 and night shift 3/1, ¾, 3/6, 3/7, 3/9, 3/10 3/11, 3/14, 3/15, 3/22 and 3/29. A review of the TAR for April 2022, revealed the following, "Monitor dialysis catheter Right Chest for signs/symptoms of infection. May reinforce dressing if needed. Monitor every shift" evidenced that 6 out of 61 shifts were missing documentation. Missing dates were day shift: 4/1, 4/9; 4/10 and 4/21; evening shift 4/8 and night shift 4/4. A review of the TAR for May 2022, revealed the following, "Monitor dialysis catheter Right Chest for signs/symptoms of infection. May reinforce dressing if needed. Monitor every shift" evidenced that 8 out of 90 shifts were missing	F 698		

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PRINTED: 06/28/2022
FORM APPROVED
OMB NO. 0938-0391

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F 698	Continued From page 161 documentation. Missing dates were day shift: 5/8, 5/17 and 6/23; evening shift: 5/23, 5/25, 5/26 and 5/28 and night shift 5/11. A review of the TAR for June 2022, revealed the following, "Monitor dialysis catheter Right Chest for signs/symptoms of infection. May reinforce dressing if needed. Monitor every shift" evidenced that 6 of 42 shifts were missing documentation. Missing dates were day shift: 6/5, 6/8, 6/10 and 6/11; evening shift: 6/10 and night shift 6/8. On 6/13/222 at 3:25 PM, an interview was conducted with Resident #76. When asked if she had a dialysis binder, Resident #76 stated, "I have one. I believe I left it at the dialysis center." When asked if they (nursing staff) check the dialysis catheter site every shift, Resident #76 stated, "I do not think so." An interview was conducted on 6/13/22 at 3:30 PM with LPN (licensed practical nurse) #1. When asked for the dialysis binder for Resident #76, LPN #1 stated, "It is not up here, it may be in the resident's room." When asked the purpose of the dialysis communication form, LPN #1 stated, "It is to provide information to the dialysis center about the resident's vital signs, weight and any additional important information. The dialysis center sends us information back about weight changes or orders." When asked the frequency of sending the communication form to the dialysis center, LPN #1 stated, it is sent with every visit. When asked what specific care is provided to a resident with hemodialysis, LPN #1 stated, "We check the dialysis catheter or fistula site for bleeding or infection. If there is a fistula, we check for a bruit or thrill." When asked the	F 698		

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F 698	Continued From page 162 frequency of these checks, LPN #1 stated, it is every shift. When asked where this is documented, LPN #1 stated, it is documented on the TAR. When asked if there are blanks in the TAR, what does that indicate, LPN #1 stated, it means that it was not done. A request was made on 6/14/22 at 12:15 PM for the dialysis communication forms from 3/1/22 through 6/14/22 for Resident #76. The dialysis binder was provided on 6/14/22 at 2:09 PM. On 6/14/22 at 4:20 PM, ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator were informed of the above concern. A review of the facility's "Hemodialysis" policy dated 10/19, which reveals, "The facility completes the appropriate section of the hemodialysis communication form prior to the guest/resident receiving each dialysis session and again when the resident returns. Evaluate the resident daily for dialysis access site and possible complications, including, but not limited to: bleeding, stenosis, infection, steel syndrome or aneurysms. No further information was provided prior to exit. 2. The facility staff failed to provide dialysis communication forms for (R116's) to the dialysis center on 05/20/2022, 05/23/2022, 05/26/2022, 05/27/2022, 05/30/2022, 06/01/2022, 06/10/2022 and 06/13/2022 and failed to complete dialysis communication forms on 05/13/2022, 05/16/2022, 05/18/2022, 06/03/2022, 06/06/2022 and 06/08/2022.	F 698		

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F 698	Continued From page 163 (R116) was admitted to the facility with diagnoses included but were not limited to: acute kidney failure. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 05/15/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded (R116) for "Dialysis" while a resident. The physician's order for (R116) documented in part, "Hemodialysis Monday, Wednesday, Friday. "[Name of Dialysis Center and Phone Number] chairtime (chair time) 1200p (12:00 p.m.). Order Date: 05/12/2022." "Check vital signs prior to dialysis (T,P,R,BP) (temperature, pulse, respiration, blood pressure) post (after) dialysis Monday, Wednesday, Friday. Every day shift Mon, Wed, Fri. (Monday, Wednesday, Friday). Order Date: 05/12/2022." The comprehensive care plan for (R116) dated 05/12/2022 documented in part, "(R116) is at risk for complications R/T (related to) needs dialysis due to: ESRD (end stage renal disease). Date Initiated: 05/12/2022." Under "Interventions" it documented in part, "Resident receives dialysis Monday, Wednesday, Friday. Date Initiated: 05/12/2022." The facility's "Hemodialysis Communication Forms" for (R116) documented in part, "COMPLETED BY THE FACILITY BEFORE	F 698		

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F 698	Continued From page 164 DEPARTURE. VS (vital signs): BP: T: P: R:, Mental Status:, Medication Dialysis:, Medication Changes:, Pertinent Labs: Condition of Shunt:, Special Instructions to Dialysis Unit:, Nurse Signature:." Under "COMPLETED BY THE FACILITY UPON RETURN" it documented, "VS: BP: T: P: R:, Mental Status:, Condition of Access Site:, Nurse Signature:." Review of (R116's) dialysis communication book failed to evidence the facility's "Hemodialysis Communication Forms" for 05/20/2022, 05/23/2022, 05/25/2022, 05/27/2022, 05/30/2022, 06/01/2022, 06/10/2022 and 06/13/2022. Further review of (R116's) dialysis communication book revealed blanks under VS: BP: T: P: R:, Mental Status:, Medication Dialysis:, Medication Changes:, Pertinent Labs: Condition of Shunt: and Nurse Signature: on 06/03/2022 under the heading "COMPLETED BY THE FACILITY BEFORE DEPARTURE." Under "COMPLETED BY THE FACILITY UPON RETURN" there were blanks under "VS: BP: T: P: R:, Mental Status:, Condition of Access Site:, Nurse Signature:" on 05/13/2022, 05/16/2022, 05/18/2022, 06/03/2022, 06/06/2022 and on 06/08/2022." On 06/14/2022 at approximately 10:10 a.m., an interview was conducted with LPN (licensed practical nurse) #7. When asked why it was important to complete the dialysis communication forms prior the resident going to the dialysis center LPN # 7 stated that it provided a baseline and the nurse could compare the resident's medical status before and after dialysis and with dialysis. When asked why it was important to complete the dialysis communication forms when the resident comes back to the facility from the dialysis center LPN # 7 stated that it directed the	F 698		

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F 698	Continued From page 165 nurse to "put eyes on the resident", gauges how well the resident was doing, see any recommendations from the dialysis center and check the resident's dialysis access site. After reviewing the dialysis communications sheets dated 05/13/2022, 05/16/2022, 05/18/2022, 06/03/2022, 06/06/2022 and on 06/08/2022 for (R116) LPN # 7 stated that if it wasn't documented then it wasn't done. When asked about (R116's) missing dialysis communication sheets for 05/20/2022, 05/23/2022, 05/25/2022, 05/27/2022, 05/30/2022, 06/01/2022, 06/10/2022 and 06/13/2022, LPN # 7 stated that they did not have them. The facility's policy "Hemodialysis" documented in part, "4. The facility completes the appropriate section of the hemodialysis communication form prior to guest/resident receiving each dialysis session and again when the guest/resident returns from hemodialysis." On 06/14/2022 at approximately 4:13 a.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional clinical coordinator, ASM #4, regional director of operations. No further information was presented prior to exit. References: (1) Dialysis treats end-stage kidney failure. It removes waste from your blood when your kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000707.htm.	F 698		

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F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and employee record review, it was determined the facility staff failed to complete annual performance/competency reviews for two of five CNA (certified nursing assistant), CNA #7 and CNA #8. The findings include: Five CNA employee records were reviewed for their annual performance/competency reviews. On 6/13/2022 at approximately 5:00 p.m. a request was made for the annual performance/competency reviews completed on CNA #7 and CNA #8. CNA #7 was hired on 9/2/2020 and CNA #8 was hired on 3/17/2021. A second request for the annual performance/competency reviews was made on 6/15/2022 at approximately 10:30 a.m. At the end of the day meeting on 6/15/2022 at 2:34 p.m. A third request was made for the performance/competency reviews for CNA #7 and CNA #8. At that time ASM (administrative staff member) #1, the administrator, stated the facility did not have the annual performance/competency reviews for CNA #7 and CNA #8.	F 730	F730 Criteria 1 Facility residents suffered no adverse outcomes related to CNA #7 and CNA #8 allegedly not receiving their performance/competency reviews. Nursing leadership re-educated on completing performance reviews and ensuring CNAs complete their annual competencies. Criteria 2 All active residents receiving assistance from facility CNAs have the potential to be affected by the alleged deficiency. Audit completed of all current CNAs and performance reviews were completed to ensure compliance with the alleged deficiency. Criteria 3 Nursing leadership will be re-educated on completing CNA performance reviews and CNA's will be re-educated on completing their annual competencies. Criteria 4 Director of Nursing and/or designee will complete audits of CNAs annual competencies and performance reviews to ensure they have met the regulation. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. The results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 730	Continued From page 167 An interview was conducted on 6/15/2022 at 2:45 p.m. with ASM #4, the regional director of operations. When asked the process for CNAs to get their annual performance/competency reviews, ASM #4 stated the payroll employee tracks who is due and gives the list to the department manager. ASM #4 stated the DON (director of nursing) has only been in the position for two months as well as the payroll employee. A policy on annual performance/competency reviews was requested on 6/15/2022 at approximately 4:00 p.m. ASM #1, ASM #2, the director of nursing, ASM #3, the regional clinical coordinator, and ASM #4, the regional director of operations, were made aware of the above concern on 6/15/2022 at 4:18 p.m. On 6/15/2022 at 6:20 p.m. ASM #1 and ASM #2, the director of nursing, informed the surveyors the facility did not have a policy on annual performance/competency reviews. No further information was provided prior to exit.	F 730		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. 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, resident interview, staff	F 759	F759 Criteria 1 The medication Errors for residents # 14 and 96 did not result in any ill affects. MD was notified on both residents and order to monitor was received. Criteria 2 All residents who have medications administered at the facility have the potential to be affected by the alleged deficiency.	

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F 759	Continued From page 168 Interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure a medication error rate of less than 6%. The facility medication error rate was 10.71%, having made 3 identified medication errors out of 28 opportunities. The errors were for 2 of 3 residents in the Medication Administration task; Residents #14 and #96. The findings include: 1. For Resident #14, the facility staff failed to ensure the resident was free of medication errors. Resident #14 was admitted to the facility on 3/12/21. On the annual MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 3/11/22, Resident #14 scored a 15 out of a possible 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact in ability to make daily life decisions. A review of the facility policy, "Medication Administration" was conducted. This policy documented, "Medications are administered in accordance with written orders of the attending physician." On 6/14/22 at 8:17 AM, LPN #5 (Licensed Practical Nurse) was observed to prepare and administer the following medications for Resident #14: Methimazole (1) 5 mg (milligrams), 1 tab. Buspar (2) 10 mg, 1 tab Aspirin (3) 81 mg, 1 tab Magnesium Oxide (4) 400 mg, 1 tab	F 759	Criteria 1 Licensed nurses will be re educated on the Medication Administration policy. Licensed nurses will have a medication pass audit completed Criteria 4 DON/designee or designee will complete five (5) random audits of residents with medications ordered for assurance medications are signed and given. Medication pass audits will be reviewed by DON/Designee to assure competency. These audits will be completed 5 days a week for four weeks; Then one day a week for four weeks; then twice in the last month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 759	Continued From page 169 On 6/14/22 at 11:16 AM, reconciliation of the medications was conducted compared with the physician's orders. An order dated 9/8/21 for a lidocaine 4% patch (5) to the left knee every morning was noted. It was noted that LPN #5 signed out for a lidocaine patch to left knee as being administered when it had not been administered. On 6/14/22 at 12:40 PM an interview was conducted with Resident #14. When asked if they received their pain patch on their knee this morning, they stated that they did not. On 6/14/22 at 12:40 PM an interview was attempted with LPN #5 regarding the missed medication. He refused to answer any questions, denied doing anything wrong and walked away from the surveyor. On 6/14/22 at 12:45 PM the above concern was reported to ASM #1 (Administrative Staff Member) the Administrator and ASM #4, the Regional Director of Operations. On 6/14/22 at 3:00 PM, an interview was conducted with LPN #4 (Licensed Practical Nurse) in regard to medication administration. LPN #4 stated that staff should not sign out for medications that were not given. A review of the comprehensive care plan revealed one dated 3/23/21 for "[Resident #14] is at risk for constipation R/T (related to): decreased mobility, medications side effects." This care plan included the intervention, dated 3/23/21 for "Administer medications as ordered and observe for ineffectiveness/side effects. Report abnormal findings to the physician."	F 759		

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F 759	Continued From page 170 On 6/15/22 at approximately 4:00 PM, ASM #1 (Administrative Staff Member), the Administrator, ASM #2, the Director of Nursing, and ASM #4, the Regional Director of Operations were made aware of the findings. No further information was provided by the end of the survey. References: (1) Methimazole - is used to treat hyperthyroidism Information obtained from https://medlineplus.gov/druginfo/meds/a682464.html (2) Buspar - is used to treat anxiety Information obtained from https://medlineplus.gov/druginfo/meds/a688005.html (3) Aspirin - is used to treat pain, fever, prevent heart attacks and strokes Information obtained from https://medlineplus.gov/druginfo/meds/a682878.html (4) Magnesium Oxide - is used to treat indigestion Information obtained from https://medlineplus.gov/druginfo/meds/a601074.html (5) Lidocaine - is used to treat pain Information obtained from https://medlineplus.gov/druginfo/meds/a603026.html 2. For Resident #96, the facility staff failed to ensure the resident was free of medication errors.	F 759		

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F 759	Continued From page 171 Resident #96 was admitted to the facility on 2/15/20. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/11/22, Resident #96 scored a 13 out of a possible 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact in ability to make daily life decisions. The resident was coded as supervision for eating and extensive to total care for other areas of activities of daily living. A review of the facility policy, "Medication Administration" was conducted. This policy documented, "Medications are administered in accordance with written orders of the attending physician." On 6/14/22 at 8:28 AM, LPN #5 (Licensed Practical Nurse) was observed to prepare and administer the following medications for Resident #96: Dulera (1) 100 mcg (micrograms) / 5 mcg inhaler Aspirin (2) 325 mg (milligrams), 1 tab Vitamin D3 (3) 25 mcg, 1 tab Colace (4) 100 mg, 1 tab Glipizide (5) 5 mg, 1 tab Genvoya (6) 150 mg/150 mg/200 mg/10 mg, 1 tab Risperdone (7) 0.5 mg, 1 tab Prednisone (8) 10 mg, 1 tab Senna (9) 8.6 mg, 1 tab Acetaminophen (10) 325 mg, 1 tab Spiriva (11) 18 mcg On 6/14/22 at 11:15 AM, reconciliation of the medications was conducted compared with the physician's orders. An order dated 6/30/21 for Alaway (12) eye drops and an order dated	F 759		

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F 759	Continued From page 172 1/18/21 for Pepcid (13) were noted. It was noted that LPN #5 signed out these medications as being administered when they had not been administered. On 6/14/22 at 12:40 PM an interview was attempted with LPN #5 regarding the missed medication. He refused to answer any questions and denied doing anything wrong and walked away from the surveyor. On 6/14/22 at 12:45 PM the above concern was reported to ASM #1 (Administrative Staff Member) the Administrator and ASM #4, the Regional Director of Operations. On 6/14/22 at 3:00 PM, an interview was conducted with LPN #4 (Licensed Practical Nurse) regarding medication administration. She stated that staff should not sign out for medications that were not given. A review of the comprehensive care plan revealed one dated 5/12/21 for "[Resident #96] is at risk for abnormal bleeding/bruising R/T (related to): medication use..." This care plan included an intervention dated 5/12/21 for "Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician." Another care plan, dated 7/22/21 was for "[Resident #96] is at risk for constipation R/T: decreased mobility, diminished appetite, Hx (history) of constipation, medications side effects." This care plan included the intervention, dated 7/22/21 for "Administer medications as ordered and observe for ineffectiveness/side effects. Report abnormal findings to the physician."	F 759		

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F 759	Continued From page 173 On 6/15/22 at approximately 4:00 PM, ASM #1 (Administrative Staff Member), the Administrator, ASM #2, the Director of Nursing, and ASM #4, the Regional Director of Operations were made aware of the findings. No further information was provided by the end of the survey. References: (1) Dulera is used to treat asthma and COPD Information obtained from https://medlineplus.gov/druginfo/meds/a602023.html and from https://medlineplus.gov/druginfo/meds/a606035.html (2) Aspirin - is used to treat pain, fever, prevent heart attacks and strokes Information obtained from https://medlineplus.gov/druginfo/meds/a682878.html (3) Vitamin D3 is used to treat Vitamin D deficiency and to improve absorption of calcium Information obtained from https://medlineplus.gov/druginfo/meds/a620058.html (4) Colace is used for the treatment of constipation Information obtained from https://medlineplus.gov/druginfo/meds/a601113.html (5) Glipizide is used for the treatment of diabetes Information obtained from https://medlineplus.gov/druginfo/meds/a684060.h	F 759		

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PRINTED: 06/28/2022
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F 759	Continued From page 174 tml (6) Genvoya is used for the treatment of HIV Information obtained from https://medlineplus.gov/druginfo/meds/a612035.html (7) Risperdone is used to treat symptoms of schizophrenia, bipolar, and behavior. Information obtained from https://medlineplus.gov/druginfo/meds/a694015.html (8) Prednisone is used to reduce swelling and redness Information obtained from https://medlineplus.gov/druginfo/meds/a601102.html (9) Senna is used for the treatment of constipation Information obtained from https://medlineplus.gov/druginfo/natural/652.html (10) Acetaminophen is used to treat mild to moderate pain Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html (11) Spiriva is used for the treatment of COPD Information obtained from https://medlineplus.gov/druginfo/meds/a604018.html (12) Alaway is used for the treatment of allergy symptoms of the eyes Information obtained from https://medlineplus.gov/druginfo/meds/a604033.h	F 759		

PRINTED: 08/28/2022
FORM APPROVED
OMB NO. 0938-0391

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F 759	Continued From page 175 tml (13) Pepcid is used for the treatment of reflux and ulcers Information obtained from https://medlineplus.gov/druginfo/meds/a687011.html	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to. abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility	F761 F 761	Criteria 1 Resident # 96 did receive all his medications. Medication Cart was locked and no medications were left on top after nurse was relieved of duty Criteria 2 All residents who have medications administered at the facility have the potential to be affected by the alleged deficiency. Criteria 3 Licensed nurses will be re- educated on the Medication Administration policy. Licensed nurses will have a medication pass audit completed Criteria 4 DON/designee or designee will complete five (5) random audits of Medication carts to ensure all medications are locked up appropriately per policy and cart is locked. These audits will be completed 5 days a week for four weeks; Then one day a week for four weeks; then twice in the last month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits or actions. Criteria 5 Date of compliance is 7/26/22.	

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F 761	Continued From page 176 document review, it was determined that the facility staff failed to ensure medication was stored in a safe and secure manner on one of 3 facility nursing units; the Jefferson unit. The findings include: During medication administration on the Jefferson unit, LPN #5 left a bottle of Folic Acid on top of the medication cart while in Resident #96's room, with the cart out of line of sight. Resident #96 was admitted to the facility on 2/15/20. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/11/22, Resident #96 scored a 13 out of a possible 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact in ability to make daily life decisions. On 6/14/22 at 8:28 AM, LPN #5 (Licensed Practical Nurse) was observed preparing medications on the Jefferson unit. A CNA (Certified Nursing Assistant) came and reported to LPN #5 that Resident #96 was asking for their inhaler. LPN #5 then began to prepare medications for Resident #96, by first pulling the resident's Dulera (1) and taking it to the resident. It was noted that while LPN #5 was in the room of Resident #96, a bottle of Folic Acid (2) was left on top of the medication cart, with the cart out of the line of sight of LPN #5 while he was in Resident #96's room. A staff member was observed to pass by the cart with the unsupervised medication on top. On 6/14/22 at 12:40 PM an interview was attempted with LPN #5 regarding the storage of	F 761		

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F 761	Continued From page 177	F 761		

medication. He refused to answer any questions, denied doing anything wrong and walked away from the surveyor.

On 6/14/22 at 12:45 PM the above concern was reported to ASM #1 (Administrative Staff Member) the Administrator and ASM #4, the Regional Director of Operations.

On 6/14/22 at 3:00 PM, an interview was conducted with LPN #4 (Licensed Practical Nurse). She stated that staff should not leave a medication cart unlocked and medications on top of it when the cart is unsupervised.

The facility policy, "Medication Administration" was reviewed. This policy documented, "Make sure that the medication cart is locked at all times when it is not in use or not within your constant vision. Store the locked medication cart in the appropriate storage area between med passes." The policy did not address not leaving medications out on top of the cart, unsupervised.

On 6/15/22 at approximately 4:00 PM, ASM #1 (Administrative Staff Member), the Administrator, ASM #2, the Director of Nursing, and ASM #4, the Regional Director of Operations were made aware of the findings. No further information was provided by the end of the survey.

References:

(1) Dulera is used to treat asthma and COPD
Information obtained from
https://medlineplus.gov/druginfo/meds/a602023.html
and from
https://medlineplus.gov/druginfo/meds/a608035.h

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F 761	Continued From page 178 tml (2) Folic Acid is used to help the body make healthy new cells. Information obtained from https://medlineplus.gov/folicacid.html	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(l) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(l)(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 facility staff failed to store food in one of one kitchens in accordance with professional standards for food service safety. The findings include:	F 812	F812 Criteria 1 Upon notification from surveyor regarding the facility failing to properly store plastic scoops in the dry good area, the facility immediately stored the scoops correctly. When they surveyor identified improper storage of frozen food, the facility immediately corrected the issue, and when the expired milk was identified by the surveyor, it was immediately discarded. Criteria 2 All residents who are served meals at the facility have the potential to be affected by the alleged deficiency. Audit completed to ensure compliance with the alleged deficiency. Criteria 3 Dietary staff will be re-educated on proper storage of plastic scoops in dry goods areas, proper storage of frozen foods, and ensuring milk is thrown away when expired. Criteria 4 Dietary Manager or designee will complete audits of the kitchen to ensure plastic scoops are stored properly in dry goods areas, frozen food is stored properly and the expiration dates on milk. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. The results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 812	Continued From page 179 The facility failed to properly store plastic scoops in the dry good area, properly store opened, available for use frozen foods in the walk in freezer, and discard milk past it's expiration date in the walk in refrigerator. On 6/13/2022 at 10:44 a.m., an observation was made of the facility kitchen with OSM (other staff member) #11, the dietary aide. Observation of the dry goods area revealed three 18 quart plastic bins. One of the plastic bins was labeled "Salt" and was approximately 1/2 full. A blue plastic scoop was located inside the bin resting on top of the salt. Another plastic bin labeled "Powdered milk" was observed to be approximately 3/4 full. A plastic gallon sized zipper closure bag was observed laying on top of the lid to the bin with a plastic scoop sitting on top of the bag exposed to air. OSM #11 stated that the plastic scoops were supposed to be stored in the plastic bags when not in use and should not be stored on top of the bag exposed to air or in the bin touching the food product. OSM #11 stated that the plastic scoops were stored in the bags to keep them clean. OSM #11 stated that the plastic scoops were not stored on the food to prevent potential contamination. Observation of the walk in refrigerator revealed a gallon of whole milk approximately 1/4 full with a date on the outside of the container of "Jun 08." OSM #11 stated that the date meant that it expired on 6/8/2022 and should have been discarded. OSM #11 agreed that it was available for use in the refrigerator. Observation of the walk in freezer revealed a box labeled as french petit rolls-unbaked. The inner plastic bag in the box was observed to be	F 812		

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F 812	Continued From page 180 approximately 3/4 full and open with rolls exposed to air. One 3.5 lb bag of hashbrown patties was observed to be opened with hashbrowns exposed to air. One 3 ounce bag in a 10 pound box of battered pollock wedges was observed to be approximately 1/4 full with pollock wedges exposed to air. OSM #11 stated that products in the freezer should be dated and closed in plastic wrap after opening to keep them fresh. OSM #11 stated that it appeared someone had dated the products but had not closed the bags like they were supposed to. The facility policy "Food purchasing and storage" dated 8/1/2011 documented in part, "...Dry Storage: ...Containers with tight fitting covers or sealed plastic bags will be use for storing foods that have been removed form their original container. Scoops will be provided for items stored in bulk, kept covered near the containers and sanitized at least daily...Perishable Food Storage:...All frozen food will be dated, labeled and wrapped or sealed. Moisture-proof, tight-fitting materials will be used to prevent freezer burn..." On 6/14/2022 at 4:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator, and ASM #4, the regional director of operations were made aware of the findings. No further information was provided prior to exit.	F 812		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse	F 947		

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F 947	Continued From page 181 aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less then 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and employee record review, it was determined the facility staff failed to ensure two of five CNAs had their annual training in dementia and abuse, CNA #7 and CNA #8. The findings include: Five CNA employee records were reviewed for documentation of their annual training in abuse and dementia. On 6/13/2022 at approximately 5:00 p.m. a request was made for the annual training in abuse and dementia for CNA #7 and CNA #8. CNA #7 was hired on 9/2/2020 and CNA #8 was hired on 3/17/2021. A second request for documentation for the annual training in abuse and dementia for CNA #7 and CNA #8 was made on 6/15/2022 at	F 947	F947 Criteria 1 Residents in the facility suffered no adverse outcomes related to CNA #7 and #8 allegedly failing to complete their annual abuse and dementia training. CNA's have completed their annual abuse and dementia training. Criteria 2 All residents who are cared for by CNAs have the potential to be affected by the alleged deficiency. An audit was completed to ensure compliance with the alleged deficient practice. Criteria 3 CNA's will be re-educated on completing their annual abuse and dementia training. Criteria 4 HR and/or designee will complete audits of CNAs annual abuse and dementia training. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	

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F 947	Continued From page 182 approximately 10:30 a.m. At the end of the day meeting on 6/15/2022 at 2:34 p.m. A third request was made for the documentation of annual abuse and dementia training for CNA #7 and CNA #8. At this time ASM (administrative staff member) #1, the administrator, stated the facility did not have evidence of annual training in abuse and dementia for CNA #7 and CNA #8. An interview was conducted with LPN (licensed practical nurse) #8, the assistant director of nursing, on 6/15/2022 at 3:20 p.m. When asked the process for ensuring the staff receive their annual required educations, LPN #8 stated she had just started two days ago. Her understanding is that the facility goes through in-services. Every staff member just have abuse and dementia training. LPN #8 stated she is developing a calendar for educations. LPN #8 stated the facility also has an on-line education program where the staff are assigned educations that are due monthly. LPN #8 stated the abuse and dementia training is included in the on-line education program. When asked to provide documentation for CNA #7 and CNA #8's education for abuse and dementia, LPN #8 returned at 3:27 p.m. and stated they had looked at the on-line training for both of the CNAs and didn't find the documentation trainings. ASM #1, ASM #2, the director of nursing, ASM #3, the regional clinical coordinator, and ASM #4, the regional director of operations, were made aware of the above concern on 6/15/2022 at 4:16 p.m. A request was made for a policy regarding mandatory annual training at this time.	F 947		

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

PRINTED: 06/28/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	496109	A. BUILDING _____ B. WING _____	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(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 947	Continued From page 183 On 6/15/2022 at 6:20 p.m. ASM #1 and ASM #2, the director of nursing, informed the surveyors the facility did not have a policy on annual mandatory trainings. No further information was provided prior to exit.	F 947		