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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated, and revisit to the standard survey conducted 5/17/2022 through 5/20/2022 and 5/23/2022, was conducted 7/5/2022 through 7/7/2022. Three complaints were investigated during the survey, VA00055255-substantiated, VA00055593-unsubstantiated, VA00055482-substantiated. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care - Requirements. The census in this 194 bed facility was 169 at the time of the survey. The survey sample consisted of 16 current resident reviews and 4 closed record reviews.	{F 000}		
F 540 SS=F	Definitions CFR(s): 483.5 §483.5 Definitions. As used in this subpart, the following definitions apply: Abuse. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of	F 540	1. Corrective Action Concern forms were generated and resolved on Residents #105,#109,#118, #119 related to the key pads being disarmed. The facility disarmed the key pad on the unit 6 elevator and unit 2 unit doors on 7-6-22. 2. Like Residents/Areas The administrator reviewed the facility floorplan to validate that facility units were accessible to residents in the center based on their careplan. 3. Systemic Change The Regional Director of Operations re-educated the administrator on F540 to include making sure residents can move about the facility without restriction. The Administrator re-educated the IDT team on F540 to include making sure residents can move about the facility without restriction. 4. Monitoring The Administrator/designee will review facility floorplan weekly times 4 weeks and the facility grievance log weekly times 4 weeks to validate no concerns were received related to keypads restricting access of the residents.	8-10-22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joe Catrambone	Administrator	7/20/2022

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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technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

Adverse event. An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.

Common area. Common areas are areas in the facility where residents may gather together with other residents, visitors, and staff or engage in individual pursuits, apart from their residential rooms. This includes but is not limited to living rooms, dining rooms, activity rooms, outdoor areas, and meeting rooms where residents are located on a regular basis.

Composite distinct part.
(1) Definition. A composite distinct part is a distinct part consisting of two or more non-contiguous components that are not located within the same campus, as defined in §413.65(a)(2) of this chapter.
(2) Requirements. In addition to meeting the requirements of specified in the definition of "distinct part" of this section, a composite distinct part must meet all of the following requirements:
(i) A SNF or NF that is a composite of more than one location will be treated as a single distinct part of the institution of which it is a distinct part. As such, the composite distinct part will have only one provider agreement and only one provider number.
(ii) If two or more institutions (each with a distinct part SNF or NF) undergo a change of ownership, CMS must approve the existing SNFs or NFs as meeting the requirements before they are

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considered a composite distinct part of a single institution. In making such a determination, CMS considers whether its approval or disapproval of a composite distinct part promotes the effective and efficient use of public monies without sacrificing the quality of care. If there is a change of ownership of a composite distinct part SNF or NF, the assignment of the provider agreement to the new owner will apply to all of the approved locations that comprise the composite distinct part SNF or NF.
(iii) To ensure quality of care and quality of life for all residents, the various components of a composite distinct part must meet all of the requirements for participation independently in each location.
(iv) To ensure quality of care and quality of life for all residents, the various components of a composite distinct part must meet all of the requirements for participation independently in each location.
(v) Use of composite distinct parts to segregate residents by payment source or on a basis other than care needs is prohibited.

Distinct part
(1) Definition. A distinct part SNF or NF is physically distinguishable from the larger institution or institutional complex that houses it, meets the requirements of this paragraph and of paragraph (2) of this definition, and meets the applicable statutory requirements for SNFs or NFs in sections 1819 or 1919 of the Act, respectively. A distinct part SNF or NF may be comprised of one or more buildings or designated parts of buildings (that is, wings, wards, or floors) that are: In the same physical area immediately adjacent to the institution's main buildings; other

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areas and structures that are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and any other areas that CMS determines on an individual basis, to be part of the institution's campus. A distinct part must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant. The term "distinct part" also includes a composite distinct part that meets the additional requirements specified in the definition of "composite distinct part" of this section.
(2) Requirements. In addition to meeting the participation requirements for long-term care facilities set forth elsewhere in this subpart, a distinct part SNF or NF must meet all of the following requirements:
(i) The SNF or NF must be operated under common ownership and control (that is, common governance) by the institution of which it is a distinct part, as evidenced by the following:
(A) The SNF or NF is wholly owned by the institution of which it is a distinct part.
(B) The SNF or NF is subject to the by-laws and operating decisions of common governing body.
(C)The institution of which the SNF or NF is a distinct part has final responsibility for the distinct part's administrative decisions and personnel policies, and final approval for the distinct part's personnel actions.
(D) The SNF or NF functions as an integral and subordinate part of the institution of which it is a distinct part, with significant common resource usage of buildings, equipment, personnel, and services.
(ii)The administrator of the SNF or NF reports to and is directly accountable to the management of

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the institution of which the SNF or NF is a distinct part.
(iii) The SNF or NF must have a designated medical director who is responsible for implementing care policies and coordinating medical care, and who is directly accountable to the management of the institution of which it is a distinct part.
(iv) The SNF or NF is financially integrated with the institution of which it is a distinct part, as evidenced by the sharing of income and expenses with that institution, and the reporting of its costs on that institution's cost report.
(v) A single institution can have a maximum of only one distinct part SNF and one distinct part NF.
(vi) (A) An institution cannot designate a distinct part SNF or NF, but instead must submit a written request with documentation that demonstrates it meets the criteria set forth above to CMS to determine if it may be considered a distinct part.
(B) The effective date of approval of a distinct part is the date that CMS determines all requirements (including enrollment with the fiscal intermediary (FI)) are met for approval, and cannot be made retroactive.
(C)The institution must request approval from CMS for all proposed changes in the number of beds in the approved distinct part.

Exploitation. Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.

Facility defined. For purposes of this subpart, facility means a skilled nursing facility (SNF) that meets the requirements of section s1819(a), (b), (c), and (d) of the Act, or a nursing facility (NF)

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that meets the requirements of sections 1919(a), (b), (c), and (d) of the Act. "Facility" may include a distinct part of an institution (as defined in paragraph (b) of this section and specified in §440.40 and §440.155 of this chapter), but does not include an institution for individuals with intellectual disabilities or persons with related conditions described in §440.150 of this chapter. For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity that participates in the program, whether that entity is comprised of all of, or a distinct part of, a larger institution. For Medicare, an SNF (see section 1819(a)(1) of the Act), and for Medicaid, and NF (see section 1919(a)(1) of the Act) may not be an institution for mental diseases as defined in §435.1010 of this chapter.

Fully sprinklered. A fully sprinklered long term care facility is one that has all areas sprinklered in accordance with National Fire Protection Association 13 "Standard for the Installation of Sprinkler Systems" without the use of waivers or the Fire Safety Evaluation System.

Licensed health professional. A licensed health professional is a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker; or registered respiratory therapist or certified respiratory therapy technician.

Major modification means the modification of more than 50 percent, or more than 4,500 square feet, of the smoke compartment.

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Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

Mistreatment means inappropriate treatment or exploitation of a resident.

Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

Nurse aide. A nurse aide is any individual providing nursing or nursing-related services to residents in a facility. This term may also include an individual who provides these services through an agency or under a contract with the facility, but is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.

Person-centered care. For purposes of this subpart, person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

Resident representative. For purposes of this subpart, the term resident representative means any of the following:
(1) An individual chosen by the resident to act on

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behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
(2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or
(3) Legal representative, as used in section 712 of the Older Americans Act; or
(4) The court-appointed guardian or conservator of a resident.
(5) Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

Sexual abuse is non-consensual sexual contact of any type with a resident.

Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility documentation review, clinical record reviews, and in the course of a complaint investigation, the facility staff failed to ensure the facility met the requirements/definitions of a

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Skilled Nursing Facility (SNF) or a Nursing Facility (NF). This determination has the potential to affect the entire certification of 194 facility beds.

There were 83 of the 169 residents in the facility that were in locked units. These units either had locked doors (which required a code to open) on both ends or were located on the second floor (600 rooms) and the elevator and doors leading to the second floor required a code. Surveyor was provided code to unlock doors or elevator when asked for the code. A review of the 50 resident records of residents located on the second floor unit (600 rooms) revealed the following: 24 of 50 had no behavioral/elopement assessments and only 1 of 50 was assessed as exit seeking. A review of the Resident Council minutes dated 4/19/22 revealed the following, "New business-administration: Administrator invited by president to inform residents of new locks and doors." Residents #109, #118, #119 and #105 were included in the survey sample of 20 residents.

Review of the Code of Federal Regulations at 42 CFR 483.5 revealed "Definitions. Facility defined. facility means a nursing facility (NF) that meets the requirements of sections 1919 (a), (b), (c), and (d) of the Act...and for Medicaid, an NF may not be an institution for mental diseases as defined in 435.1010 of this chapter."

The Social Security Act Sec. 1919. [42 U.S.C. 1396r] (a) Nursing Facility Defined.-In this title, the term "nursing facility" means an institution (or a distinct part of an institution) which-
(1) Is primarily engaged in providing to residents-
(A) Skilled nursing care and related services for residents who require medical or nursing care,

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(B) Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or
(C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases;

The findings included:

1) Resident #109 was observed waiting for the elevator on 7/5/22 at 3:55 PM. Resident #109 stated, "We are in Alcatraz. This is our home not a prison."

Resident #109 was admitted to the facility on 1/1/21 with diagnosis that included but were not limited to: quadriplegia, chronic kidney disease (CKD) and atherosclerotic cardiovascular disease (ASCVD).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/2/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring total dependence for bed mobility, transfer, dressing, hygiene and bathing; extensive assistance for dressing and supervision for eating. Locomotion is coded as independent.

A review of the comprehensive care plan dated 11/16/19 and revised 6/6/22, revealed, "GOAL: Resident will choose and engage in independent

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leisure pursuits of interest on a daily basis. INTERVENTIONS: Respect choices in regard to activity participation."

A review of the behavioral assessment for Resident #109 dated 3/25/19 revealed the following: "Identified Behavior symptoms: verbal aggression, agitation, irritability or hyperactivity checked. Seriousness of Behavioral Symptom: Patient is threat to himself or others-no, disruptive-no, distressing to self and/or others-no."

An interview was conducted on 7/6/22 at 11:05 AM with LPN (licensed practical nurse) #2. When asked the purpose of the coded elevator, LPN #2 stated the purpose is to keep the residents safe. When asked if all the residents had been assessed for safety, LPN #2 stated, "I am not sure."

An interview was conducted on 7/6/22 at 10:55 AM with Resident #109. When asked if he was able to move throughout the facility freely, Resident #109 stated, no, this is like Alcatraz, I do not have any control of getting off of this floor without the staff coming to enter the code. They will not give us the code.

An interview was conducted on 7/6/22 at 1:00 PM with ASM (administrative staff member) #2, the director of nursing. When asked the purpose of the locked units, ASM #2 stated, "We have had an unusual number of elopements reported to the state, any patient that could leave the facility without a LOA (leave of absence) order and it is unsafe to do so. There is a door that takes you out in the parking lot." When asked what assessments are completed to determine if a

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resident requires placement on a locked unit, ASM #2 stated, "What we do have is a behavior assessment, if they have had behaviors they would have a behavior assessment. The security is designed so that all they need to do is to ask staff to get out. There are sign out books on each unit." When asked if a resident has not been assessed as a risk, why would the resident not be allowed that independence, ASM #2 stated, "It is because the residents would share the codes. We do not give the code to the resident. I believe it would lengthen your time to get off the unit since they have to ask the staff for the code." When asked if a resident says they want to come and go are they offered another room placement, ASM #2 stated, no, they are not. When asked how many residents on the 600 hall were assessed as exit seeking, ASM #2 stated, "I am not sure how many on the 600 hall are exit seeking. I will have to check on that." When asked how this impacts the residents ability for choice and rights, ASM #2 stated, "Other than the reasons I have already stated, I do not have anything else to offer."

An interview was conducted on 7/6/22 at 1:59 PM with ASM #2, the director of nursing. When asked who was responsible to the locked units, ASM #2 stated, that was not nursing, that was a plant operations. When asked who the plant operations contact is, ASM #2 stated, the administrator. When asked what discussions nursing has with plant operations regarding resident rights and independence, ASM #2 stated, "I state my case or speak for resident's rights, generally I would think the administrator would take it up to corporate. We discussed it thoroughly with the Ombudsman, another gentleman from another building. We need to do

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it for residents who are at risk. I personally did not want the locks, but I do not know that I specifically said that. I do not know that that I came down that hard. There are four residents on the 600 hall that are exit seeking." When asked their names, ASM #2 stated the resident names, Resident #120 and three other residents. When ASM #2 was informed that only Resident #120 had a behavior assessment that listed exit seeking as a behavior, ASM #2 stated, "These are the names I was given."

An interview was conducted on 7/6/22 at 2:43 PM with ASM #1, the administrator. When asked to tell us about the locked units, ASM #1 stated, they are not units for elopement risks, like the arcadia unit. We punch in a code for any resident that wants to come off the unit. Residents do not all have same cognition. They do not abide by the LOA policy and procedure. I have had to report quite a few elopements. If you want to go shopping, go with the activities department. Residents are free to come and go as you please. When asked do you consider the resident as independent if they have to have someone enter a code for them to leave the unit. ASM #1 stated, "Yes." When asked would you consider this as independent in your home, ASM #1 stated, "Yes, I have to enter a code to go into one of my rooms in my home." When asked what discussion does plant operations have with nursing regarding resident rights and independence, ASM #1 stated, "Yes, I am the one who talked with corporate. We are committed to making the elevator accessible to all residents at all time as long as they are appropriate to go down on the elevator and sign out in the book on each unit. Generally the residents just talk with the nurse and let them know where they are going. Anyone

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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can have an acute episodic event, and we want to make sure that the resident is secure. We have seen residents elope from the facility and are doing our best to make sure the residents stay safe." When asked if behavior /exit seeking assessments were done on all residents on those locked units, ASM #1 stated, "No, we would not do elopement assessments on everyone because of an acute episodic events, those are completely unexpected and unpredictable. You cannot tell that something is not going to happen tomorrow that will not put the resident in harm's way."

On 7/6/22 at approximately 4:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate quality assurance coordinator were made aware of the findings.

According to the facility's policy "Interdisciplinary Care Planning/Resident Rights/Person Centered Care/Quality of Life" dated 3/2018, which reveals, "Comprehensive Care Planning Requirements: The care plan must describe the following: the services that are to be furnished to maintain the patient's highest practicable physical, mental and psychosocial well-being."

No further information was provided prior to exit.

2. The facility staff failed to the facility staff failed to ensure facility meets the requirements/definitions of a Skilled Nursing Facility (SNF) or a Nursing Facility (NF) for Resident #118.

Resident #118 was admitted to the facility on 7/18/18 with diagnosis that included but were not limited to: Parkinson's disease, lymphedema and

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hypertension.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/16/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as independent for bed mobility, transfer, walking, locomotion, eating, hygiene and bathing; limited assistance for dressing.

A review of the comprehensive care plan dated 11/16/19, which revealed, "GOAL: Resident will participated in independent leisure activities of choice daily. INTERVENTIONS: Assist in planning/encourage to plan own leisure-time activities."

A review of the Resident #118's medical record found there was no behavioral assessment completed.

An interview was conducted on 7/6/22 at 11:05 AM with LPN (licensed practical nurse) #2. When asked the purpose of the coded elevator, LPN #2 stated, the purpose is to keep the residents safe. When asked if all the residents had been assessed for safety, LPN #2 stated, I am not sure.

An interview was conducted on 7/6/22 at 10:50 AM with Resident #118. When asked if he was able to move throughout the facility freely, Resident #118 stated, no, I have to wait for a staff person to enter the code. I can push the down button, but the door won't open until the staff

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comes to enter the code. We are not allowed to have the code. I don't understand why.

An interview was conducted on 7/6/22 at 1:00 PM with ASM (administrative staff member) #2, the director of nursing. When asked the purpose of the locked units, ASM #2 stated, "We have had an unusual number of elopements reported to the state, any patient that could leave the facility without a LOA (leave of absence) order and it is unsafe to do so. There is a door that takes you out in the parking lot." When asked what assessments are completed to determine if a resident requires placement on a locked unit, ASM #2 stated, "What we do have is a behavior assessment, if they have had behaviors they would have a behavior assessment. The security is designed so that all they need to do is to ask staff to get out. There are sign out books on each unit." When asked if a resident has not been assessed as a risk, why would the resident not be allowed that independence, ASM #2 stated, "It is because the residents would share the codes. We do not give the code to the resident. I believe it would lengthen your time to get off the unit since they have to ask the staff for the code." When asked if a resident says they want to come and go are they offered another room placement, ASM #2 stated, no, they are not. When asked how many residents on the 600 hall were assessed as exit seeking, ASM #2 stated, "I am not sure how many on the 600 hall are exit seeking. I will have to check on that." When asked how this impacts the residents ability for choice and rights, ASM #2 stated, "Other than the reasons I have already stated, I do not have anything else to offer."

An interview was conducted on 7/6/22 at 1:59 PM

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with ASM #2, the director of nursing. When asked who was responsible to the locked units, ASM #2 stated, that was not nursing, that was a plant operations. When asked who the plant operations contact is, ASM #2 stated, the administrator. When asked what discussions nursing has with plant operations regarding resident rights and independence, ASM #2 stated, "I state my case or speak for resident's rights, generally I would think the administrator would take it up to corporate. We discussed it thoroughly with the Ombudsman, another gentleman from another building. We need to do it for residents who are at risk. I personally did not want the locks, but I do not know that I specifically said that. I do not know that that I came down that hard. There are four residents on the 600 hall that are exit seeking." When asked their names, ASM #2 stated the resident names, Resident #120 and three other residents. When ASM #2 was informed that only Resident #120 had a behavior assessment that listed exit seeking as a behavior, ASM #2 stated, "These are the names I was given."

An interview was conducted on 7/6/22 at 2:43 PM with ASM #1, the administrator. When asked to tell us about the locked units, ASM #1 stated, they are not units for elopement risks, like the arcadia unit. We punch in a code for any resident that wants to come off the unit. Residents do not all have same cognition. They do not abide by the LOA policy and procedure. I have had to report quite a few elopements. If you want to go shopping, go with the activities department. Residents are free to come and go as you please. When asked do you consider the resident as independent if they have to have someone enter a code for them to leave the unit. ASM #1 stated,

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"Yes." When asked would you consider this as independent in your home, ASM #1 stated, "Yes, I have to enter a code to go into one of my rooms in my home." When asked what discussion does plant operations have with nursing regarding resident rights and independence, ASM #1 stated, "Yes, I am the one who talked with corporate. We are committed to making the elevator accessible to all residents at all time as long as they are appropriate to go down on the elevator and sign out in the book on each unit. Generally the residents just talk with the nurse and let them know where they are going. Anyone can have an acute episodic event, and we want to make sure that the resident is secure. We have seen residents elope from the facility and are doing our best to make sure the residents stay safe." When asked if behavior /exit seeking assessments were done on all residents on those locked units, ASM #1 stated, "No, we would not do elopement assessments on everyone because of an acute episodic events, those are completely unexpected and unpredictable. You cannot tell that something is not going to happen tomorrow that will not put the resident in harm's way."

On 7/6/22 at approximately 4:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate quality assurance coordinator were made aware of the findings.

According to the facility's policy "Interdisciplinary Care Planning/Resident Rights/Person Centered Care/Quality of Life" dated 3/2018, which reveals, "Comprehensive Care Planning Requirements: The care plan must describe the following: the services that are to be furnished to maintain the patient's highest practicable physical, mental and psychosocial well-being."

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No further information was provided prior to exit.

3. The facility staff failed to the facility staff failed to ensure facility meets the requirements/definitions of a Skilled Nursing Facility (SNF) or a Nursing Facility (NF) for Resident #119.

Resident #119 was admitted to the facility on 2/26/21 with diagnosis that included but were not limited to: right above the knee amputation, diabetes mellitus and chronic obstructive pulmonary disease.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/22/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; supervision for eating and independent in locomotion.

A review of the comprehensive care plan dated 2/27/21, which revealed, "GOAL: Resident will improve functional mobility. Resident will actively participate in group events of interest daily. INTERVENTIONS: Assist in planning/encourage to plan own leisure-time activities."

A review of the Resident #119's medical record found there was no behavioral assessment completed.

An interview was conducted on 7/6/22 at 11:05

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AM with LPN (licensed practical nurse) #2. When asked the purpose of the coded elevator, LPN #2 stated, the purpose is to keep the residents safe. When asked if all the residents had been assessed for safety, LPN #2 stated, I am not sure.

An interview was conducted on 7/6/22 at 10:50 AM with Resident #118. When asked if he was able to move throughout the facility freely, Resident #118 stated, no, I have to wait for a staff person to enter the code. I can push the down button, but the door won't open until the staff comes to enter the code. We are not allowed to have the code. I don't understand why.

An interview was conducted on 7/6/22 at 1:00 PM with ASM (administrative staff member) #2, the director of nursing. When asked the purpose of the locked units, ASM #2 stated, "We have had an unusual number of elopements reported to the state, any patient that could leave the facility without a LOA (leave of absence) order and it is unsafe to do so. There is a door that takes you out in the parking lot." When asked what assessments are completed to determine if a resident requires placement on a locked unit, ASM #2 stated, "What we do have is a behavior assessment, if they have had behaviors they would have a behavior assessment. The security is designed so that all they need to do is to ask staff to get out. There are sign out books on each unit." When asked if a resident has not been assessed as a risk, why would the resident not be allowed that independence, ASM #2 stated, "It is because the residents would share the codes. We do not give the code to the resident. I believe it would lengthen your time to get off the unit since they have to ask the staff for the code."

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When asked if a resident says they want to come and go are they offered another room placement, ASM #2 stated, no, they are not. When asked how many residents on the 600 hall were assessed as exit seeking, ASM #2 stated, "I am not sure how many on the 600 hall are exit seeking. I will have to check on that." When asked how this impacts the residents ability for choice and rights, ASM #2 stated, "Other than the reasons I have already stated, I do not have anything else to offer."

An interview was conducted on 7/6/22 at 1:59 PM with ASM #2, the director of nursing. When asked who was responsible to the locked units, ASM #2 stated, that was not nursing, that was a plant operations. When asked who the plant operations contact is, ASM #2 stated, the administrator. When asked what discussions nursing has with plant operations regarding resident rights and independence, ASM #2 stated, "I state my case or speak for resident's rights, generally I would think the administrator would take it up to corporate. We discussed it thoroughly with the Ombudsman, another gentleman from another building. We need to do it for residents who are at risk. I personally did not want the locks, but I do not know that I specifically said that. I do not know that that I came down that hard. There are four residents on the 600 hall that are exit seeking." When asked their names, ASM #2 stated the resident names, Resident #120 and three other residents. When ASM #2 was informed that only Resident #120 had a behavior assessment that listed exit seeking as a behavior, ASM #2 stated, "These are the names I was given."

An interview was conducted on 7/6/22 at 2:43 PM

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with ASM #1, the administrator. When asked to tell us about the locked units, ASM #1 stated, they are not units for elopement risks, like the arcadia unit. We punch in a code for any resident that wants to come off the unit. Residents do not all have same cognition. They do not abide by the LOA policy and procedure. I have had to report quite a few elopements. If you want to go shopping, go with the activities department. Residents are free to come and go as you please. When asked do you consider the resident as independent if they have to have someone enter a code for them to leave the unit. ASM #1 stated, "Yes." When asked would you consider this as independent in your home, ASM #1 stated, "Yes, I have to enter a code to go into one of my rooms in my home." When asked what discussion does plant operations have with nursing regarding resident rights and independence, ASM #1 stated, "Yes, I am the one who talked with corporate. We are committed to making the elevator accessible to all residents at all time as long as they are appropriate to go down on the elevator and sign out in the book on each unit. Generally the residents just talk with the nurse and let them know where they are going. Anyone can have an acute episodic event, and we want to make sure that the resident is secure. We have seen residents elope from the facility and are doing our best to make sure the residents stay safe." When asked if behavior /exit seeking assessments were done on all residents on those locked units, ASM #1 stated, "No, we would not do elopement assessments on everyone because of an acute episodic events, those are completely unexpected and unpredictable. You cannot tell that something is not going to happen tomorrow that will not put the resident in harm's way."

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On 7/6/22 at approximately 4:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate quality assurance coordinator were made aware of the findings.

According to the facility's policy "Interdisciplinary Care Planning/Resident Rights/Person Centered Care/Quality of Life" dated 3/2018, which reveals, "Comprehensive Care Planning Requirements: The care plan must describe the following: the services that are to be furnished to maintain the patient's highest practicable physical, mental and psychosocial well-being."

No further information was provided prior to exit.

4. For Resident #105, on the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/29/2022, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. Resident #105 (R105) was coded as making themselves understood and understanding others. In Section E - Behaviors, the resident was not coded as having had any behaviors during the look back period. In Section G - Functional Status, the resident was coded as requiring supervision with set up help only for walking in the room, walking in the hallway, locomotion on the unit and locomotion off the unit.

The Recreational Services note dated, 11/22/2021, documented in part, "Resident admitted to the facility...he enjoys movies, cards, religious programs and TV."
The Recreational Services note dated, 2/17/2022 documented in part, "He pursues independent

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activities in room and is out to dialysis 3 days/week. He voices no need for additional activity supplies."
The Recreational Services note dated, 5/2/2022, documented in part, "No changes in activity interests. Current goal to be continued over next 90 days."

The Behavioral Symptoms Assessment, dated, 6/2/2022, documented in part: a check mark was documented next to, "Agitation, irritability, or hyperactivity." Exit seeking or wandering without intent or purpose was not checked.

The comprehensive care plan dated, 1/10/2022, documented in part, "Focus: (R105) enjoys country music, spades, news, outdoors, church, TV, computer and talking...Needs opportunities to pursue his interests." The "Interventions" documented. "Assist in planning and/or encourage to plan own leisure time activities. Encourage participation in group activities of interest. Provide supplies/materials for leisure activities as needed/requested."

An interview was conducted with R105 on 7/6/2022 at 11:05 a.m. When asked how he gets off the unit, R105 stated they have to get a staff member to put in the code and open the door. When asked if the staff would give them the code to open the door, R105 stated, "No, it's like we are in a prison."

An interview was conducted with ASM #2, the director of nursing, on 7/6/2022 at 1:00 p.m. When asked why are the doors locked. ASM #2 stated the facility has had an unusual number of elopements reported to the state. It's an added security for patients, it's for any patient that

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leaves the facility. Residents that leave the facility without an LOA order, would be considered an elopement. When asked how the facility assesses the resident that need to be in an environment that is more secured, ASM #2 stated they assess through a behavioral assessment. When asked about residents on Station 2, ASM #2 stated if the resident has indicated behaviors, they would have an assessment. When asked if resident that reside on that unit (Station 2) and don't have behaviors, is that impacting them, that it's locked, ASM #2 stated the security is designed to let us be aware of where the residents are. When asked if a resident asked for the code, could they get it, ASM #2 stated, generally speaking, codes are shared. A resident is not allowed to be given the code. When asked if that infringes upon a resident's ability to attain their highest level of well-being, it would lessen the resident's time to get off the unit, ASM #2 stated, "This is not a secured unit, it's for the resident's safety. The residents can still go off the unit, they just need to ask". When asked if all of the residents on Station 2 considered an elopement risk, ASM #2 stated, "No, Ma'am." When asked but you have them on a locked unit ASM #2 stated, "Yes." When asked why the residents can't go independently about the facility, ASM #2 stated, "I have nothing else to offer other that what I have already stated."

An interview was conducted on 7/6/22 at 2:43 p.m. with ASM (administrative staff member) #1, the administrator. When asked to tell us about the locked units, ASM #1 stated, "They are not units for elopement risks, like the arcadia unit (secured dementia care unit). We punch in a code for any resident that wants to come off the unit. Residents do not all have same cognition.

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They do not abide by the LOA (leave of absence) policy and procedure. I have had to report quite a few elopements. If you want to go shopping, go with the activities department. Residents are free to come and go as they please." When asked do you consider the resident as independent if they have to have someone enter a code for them to leave the unit. ASM #1 stated, yes. When asked would you consider this as independent in your home, ASM #1 stated, "Yes, I have to enter a code to go into one of my rooms in my home." When asked what discussion does plant operations have with nursing regarding resident rights and independence, ASM #1 stated, yes, he is the one who talked with corporate. ASM #1 stated, "We are committed to making the elevator accessible to all residents, at all time, as long as they are appropriate to go down on the elevator and sign out in the book on each unit. Generally the residents just talk with the nurse and let them know where they are going. Anyone can have an acute episodic event, and we want to make sure that the resident is secure. We have seen residents elope from the facility and are doing our best to make sure the residents stay safe." When asked if behavior /exit seeking assessments were done on all residents on those locked units, ASM #1 stated, "No, we would not do elopement assessments on everyone because of an acute episodic event, those are completely unexpected and unpredictable. You cannot tell that something is going to happen tomorrow that will not put the resident in harm's way."

ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/6/2022 at 4:29 p.m.

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F 540	Continued From page 26 No further information was provided prior to exit.	F 540		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that 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	F 550	1. Corrective Action Concern forms were generated and resolved on Residents #105,#109,#118, #119 related to the key pads being disarmed. The facility disarmed the key pad on the unit 6 elevator and unit 2 unit doors on 7-6-22. 2. Like Residents/Areas The administrator reviewed the facility floorplan to validate that facility units were accessible to residents in the center based on their careplan. 3. Systemic Change The Regional Director of Operations re-educated the administrator on F550 to include making sure residents can move about the facility without restriction. The Administrator re-educated the IDT team on F550 to include making sure residents can move about the facility without restriction. 4. Monitoring The Administrator/designee will review facility floorplan weekly times 4 weeks and the facility grievance log weekly times 4 weeks to validate no concerns were received related to keypads restricting access of the residents.	8-10-22

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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 review of facility's documentation and staff interview, it was determined that the facility failed to promote and enhance each resident's right to a dignified existence by restricting the ability to move freely about the facility for 4 of 20 residents in the survey sample, Residents #109, #118, #119 and #105.

There were 83 of the 169 resident in the facility that were in locked units. These units either had locked doors (which required a code to open) on both ends or were located on the second floor (600 rooms) and the elevator and doors leading to the second floor required a code. Surveyor was provided code to unlock doors or elevator when asked for the code. A review of the 50 resident records of residents located on the second floor unit (600 rooms) revealed the following: 24/50 had no behavioral/elopement assessment and only 1/50 being assessed as exit seeking. A review of the Resident Council minutes dated 4/19/22 revealed the following, "New business-administration: Administrator invited by president to inform residents of new locks and doors."

The findings included:

1. The facility staff failed to allow Resident #109 to exercise their right to freely move about the facility. Resident #109 was observed waiting for the elevator on 7/5/22 at 3:55 PM. Resident #109

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stated, "We are in Alcatraz. This is our home not a prison."

Resident #109 was admitted to the facility on 1/1/21 with diagnosis that included but were not limited to: quadriplegia, chronic kidney disease (CKD) and atherosclerotic cardiovascular disease (ASCVD).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/2/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring total dependence for bed mobility, transfer, dressing, hygiene and bathing; extensive assistance for dressing and supervision for eating. Locomotion is coded as independent.

A review of the comprehensive care plan dated 11/16/19 and revised 6/6/22, which revealed, "GOAL: Resident will choose and engage in independent leisure pursuits of interest on a daily basis. INTERVENTIONS: Respect choices in regard to activity participation."

A review of the behavioral assessment for Resident #109 dated 3/25/19 revealed the following "Identified Behavior symptoms: verbal aggression, agitation, irritability or hyperactivity checked. Seriousness of Behavioral Symptom: Patient is threat to himself or others-no, disruptive-no, distressing to self and/or others-no."

An interview was conducted on 7/6/22 at 11:05

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AM with LPN (licensed practical nurse) #2. When asked the purpose of the coded elevator, LPN #2 stated, the purpose is to keep the residents safe. When asked if all the residents had been assessed for safety, LPN #2 stated, I am not sure.

An interview was conducted on 7/6/22 at 10:55 AM with Resident #109. When asked if he was able to move throughout the facility freely, Resident #109 stated, no, this is like Alcatraz, I do not have any control of getting off of this floor without the staff coming to enter the code. They will not give us the code.

An interview was conducted on 7/6/22 at 1:00 PM with ASM (administrative staff member) #2, the director of nursing. When asked the purpose of the locked units, ASM #2 stated, "We have had an unusual number of elopements reported to the state, any patient that could leave the facility without a LOA (leave of absence) order and it is unsafe to do so. There is a door that takes you out in the parking lot." When asked what assessments are completed to determine if a resident requires placement on a locked unit, ASM #2 stated, "What we do have is a behavior assessment, if they have had behaviors they would have a behavior assessment. The security is designed so that all they need to do is to ask staff to get out. There are sign out books on each unit." When asked if a resident has not been assessed as a risk, why would the resident not be allowed that independence, ASM #2 stated, "It is because the residents would share the codes. We do not give the code to the resident. I believe it would lengthen your time to get off the unit since they have to ask the staff for the code." When asked if a resident says they want to come

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and go are they offered another room placement, ASM #2 stated, "No, they are not." When asked how many residents on the 600 hall were assessed as exit seeking, ASM #2 stated, "I am not sure how many on the 600 hall are exit seeking. I will have to check on that." When asks how this impacts the residents ability for choice and rights, ASM #2 stated, "Other than the reasons I have already stated, I do not have anything else to offer."

An interview was conducted on 7/6/22 at 1:59 PM with ASM #2, the director of nursing. When asked who was responsible to the locked units, ASM #2 stated, that was not nursing, that was a plant operations. When asked who the plant operations contact is, ASM #2 stated, the administrator. When asked what discussions nursing has with plant operations regarding resident rights and independence, ASM #2 stated, "I state my case or speak for resident's rights, generally I would think the administrator would take it up to corporate. We discussed it thoroughly with the Ombudsman, another gentleman from another building. We need to do it for residents who are at risk. I personally did not want the locks, but I do not know that I specifically said that. I do not know that that I came down that hard. There are four residents on the 600 hall that are exit seeking." When asked their names, ASM #2 stated, "These are the resident names, (Resident #120 and three other residents)." When ASM #2 was informed that only Resident #120 had a behavior assessment that listed exit seeking as a behavior, ASM #2 stated, "These are the names I was given."

An interview was conducted on 7/6/22 at 2:43 PM

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with ASM #1, the administrator. When asked to tell us about the locked units, ASM #1 stated, they are not units for elopement risks, like the arcadia unit. We punch in a code for any resident that wants to come off the unit. Residents do not all have same cognition. They do not abide by the LOA policy and procedure. I have had to report quite a few elopements. If you want to go shopping, go with the activities department. Residents are free to come and go as you please. When asked do you consider the resident as independent if they have to have someone enter a code for them to leave the unit. ASM #1 stated, yes. When asked would you consider this as independent in your home, ASM #1 stated, yes, I have to enter a code to go into one of my rooms in my home. When asked what discussion does plant operations have with nursing regarding resident rights and independence, ASM #1 stated, yes, I am the one who talked with corporate. We are committed to making the elevator accessible to all residents at all time as long as they are appropriate to go down on the elevator and sign out in the book on each unit. Generally the residents just talk with the nurse and let them know where they are going. Anyone can have an acute episodic event, and we want to make sure that the resident is secure. We have seen residents elope from the facility and are doing our best to make sure the residents stay safe. When asked if behavior /exit seeking assessments were done on all residents on those locked units, ASM #1 stated, no, we would not do elopement assessments on everyone because of an acute episodic events, those are completely unexpected and unpredictable. You cannot tell that something is not going to happen tomorrow that will not put the resident in harm's way.

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On 7/6/22 at approximately 4:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate quality assurance coordinator were made aware of the findings.

According to the facility's policy "Interdisciplinary Care Planning/Resident Rights/Person Centered Care/Quality of Life" dated 3/2018, which reveals, "Comprehensive Care Planning Requirements: The care plan must describe the following: the services that are to be furnished to maintain the patient's highest practicable physical, mental and psychosocial well-being."

No further information was provided prior to exit.

2. The facility staff failed to allow Resident #118 to exercise their right to freely move about the facility.

Resident #118 was admitted to the facility on 7/18/18 with diagnosis that included but were not limited to: Parkinson's disease, lymphedema and hypertension

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/16/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as independent for bed mobility, transfer, walking, locomotion, eating, hygiene and bathing; limited assistance for dressing.

A review of the comprehensive care plan dated 11/16/19, which revealed, "GOAL: Resident will

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participated in independent leisure activities of choice daily. INTERVENTIONS: Assist in planning/encourage to plan own leisure-time activities."

A review of the Resident #118's medical record found there was no behavioral assessment completed.

An interview was conducted on 7/6/22 at 11:05 AM with LPN (licensed practical nurse) #2. When asked the purpose of the coded elevator, LPN #2 stated, the purpose is to keep the residents safe. When asked if all the residents had been assessed for safety, LPN #2 stated, "I am not sure."

An interview was conducted on 7/6/22 at 10:50 AM with Resident #118. When asked if he was able to move throughout the facility freely, Resident #118 stated, "No, I have to wait for a staff person to enter the code. I can push the down button, but the door won't open until the staff comes to enter the code. We are not allowed to have the code. I don't understand why."

An interview was conducted on 7/6/22 at 1:00 PM with ASM (administrative staff member) #2, the director of nursing. When asked the purpose of the locked units, ASM #2 stated, "We have had an unusual number of elopements reported to the state, any patient that could leave the facility without a LOA (leave of absence) order and it is unsafe to do so. There is a door that takes you out in the parking lot." When asked what assessments are completed to determine if a resident requires placement on a locked unit, ASM #2 stated, "What we do have is a behavior

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assessment, if they have had behaviors they would have a behavior assessment. The security is designed so that all they need to do is to ask staff to get out. There are sign out books on each unit." When asked if a resident has not been assessed as a risk, why would the resident not be allowed that independence, ASM #2 stated, "It is because the residents would share the codes. We do not give the code to the resident. I believe it would lengthen your time to get off the unit since they have to ask the staff for the code." When asked if a resident says they want to come and go are they offered another room placement, ASM #2 stated, "No, they are not." When asked how many residents on the 600 hall were assessed as exit seeking, ASM #2 stated, "I am not sure how many on the 600 hall are exit seeking. I will have to check on that." When asks how this impacts the residents ability for choice and rights, ASM #2 stated, "Other than the reasons I have already stated, I do not have anything else to offer."

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specifically said that. I do not know that that I came down that hard. There are four residents on the 600 hall that are exit seeking." When asked their names, ASM #2 stated, "These are the resident names, (Resident #120 and three other residents). When ASM #2 was informed that only Resident #120 had a behavior assessment (completed 6/21/22) that listed exit seeking as a behavior, ASM #2 stated, "These are the names I was given."

An interview was conducted on 7/6/22 at 2:43 PM with ASM #1, the administrator. When asked to tell us about the locked units, ASM #1 stated, "They are not units for elopement risks, like the arcadia unit. We punch in a code for any resident that wants to come off the unit. Residents do not all have same cognition. They do not abide by the LOA policy and procedure. I have had to report quite a few elopements. If you want to go shopping, go with the activities department. Residents are free to come and go as you please." When asked do you consider the resident as independent if they have to have someone enter a code for them to leave the unit. ASM #1 stated, "Yes." When asked would you consider this as independent in your home, ASM #1 stated, "Yes, I have to enter a code to go into one of my rooms in my home." When asked what discussion does plant operations have with nursing regarding resident rights and independence, ASM #1 stated, "Yes, I am the one who talked with corporate. We are committed to making the elevator accessible to all residents at all time as long as they are appropriate to go down on the elevator and sign out in the book on each unit. Generally the residents just talk with the nurse and let them know where they are going. Anyone can have an acute episodic event,

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and we want to make sure that the resident is secure. We have seen residents elope from the facility and are doing our best to make sure the residents stay safe." When asked if behavior /exit seeking assessments were done on all residents on those locked units, ASM #1 stated, "No, we would not do elopement assessments on everyone because of an acute episodic events, those are completely unexpected and unpredictable. You cannot tell that something is not going to happen tomorrow that will not put the resident in harm's way."

On 7/6/22 at approximately 4:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate quality assurance coordinator were made aware of the findings.

According to the facility's policy "Interdisciplinary Care Planning/Resident Rights/Person Centered Care/Quality of Life" dated 3/2018, which reveals, "Comprehensive Care Planning Requirements: The care plan must describe the following: the services that are to be furnished to maintain the patient's highest practicable physical, mental and psychosocial well-being."

No further information was provided prior to exit.

3. The facility staff failed to allow Resident #119 to exercise his right to freely move about the facility.

Resident #119 was admitted to the facility on 2/26/21 with diagnosis that included but were not limited to: right above the knee amputation, diabetes mellitus and chronic obstructive pulmonary disease.

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The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/22/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; supervision for eating and independent in locomotion.

A review of the comprehensive care plan dated 2/27/21, which revealed, "GOAL: Resident will improve functional mobility. Resident will actively participate in group events of interest daily. INTERVENTIONS: Assist in planning/encourage to plan own leisure-time activities."

A review of the Resident #119's medical record found there was no behavioral assessment completed.

An interview was conducted on 7/6/22 at 10:50 AM with Resident #118. When asked if he was able to move throughout the facility freely, Resident #118 stated, no, I have to wait for a staff person to enter the code. I can push the down button, but the door won't open until the staff comes to enter the code. We are not allowed to have the code. I don't understand why.

An interview was conducted on 7/6/22 at 11:05 AM with LPN (licensed practical nurse) #2. When asked the purpose of the coded elevator, LPN #2 stated, the purpose is to keep the residents safe. When asked if all the residents had been assessed for safety, LPN #2 stated, "I am not sure."

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An interview was conducted on 7/6/22 at 1:00 PM with ASM (administrative staff member) #2, the director of nursing. When asked the purpose of the locked units, ASM #2 stated, "We have had an unusual number of elopements reported to the state, any patient that could leave the facility without a LOA (leave of absence) order and it is unsafe to do so. There is a door that takes you out in the parking lot." When asked what assessments are completed to determine if a resident requires placement on a locked unit, ASM #2 stated, "What we do have is a behavior assessment, if they have had behaviors they would have a behavior assessment. The security is designed so that all they need to do is to ask staff to get out. There are sign out books on each unit." When asked if a resident has not been assessed as a risk, why would the resident not be allowed that independence, ASM #2 stated, "It is because the residents would share the codes. We do not give the code to the resident. I believe it would lengthen your time to get off the unit since they have to ask the staff for the code." When asked if a resident says they want to come and go are they offered another room placement, ASM #2 stated, "No, they are not." When asked how many residents on the 600 hall were assessed as exit seeking, ASM #2 stated, "I am not sure how many on the 600 hall are exit seeking. I will have to check on that." When asks how this impacts the residents ability for choice and rights, ASM #2 stated, "Other than the reasons I have already stated, I do not have anything else to offer."

An interview was conducted on 7/6/22 at 1:59 PM with ASM #2, the director of nursing. When asked who was responsible to the locked units,

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ASM #2 stated, that was not nursing, that was a plant operations. When asked who the plant operations contact is, ASM #2 stated, the administrator. When asked what discussions nursing has with plant operations regarding resident rights and independence, ASM #2 stated, "I state my case or speak for resident's rights, generally I would think the administrator would take it up to corporate. We discussed it thoroughly with the Ombudsman, another gentleman from another building. We need to do it for residents who are at risk. I personally did not want the locks, but I do not know that I specifically said that. I do not know that that I came down that hard. There are four residents on the 600 hall that are exit seeking." When asked their names, ASM #2 stated, "These are the resident names, (Resident #120 and three other residents). When ASM #2 was informed that only Resident #120 had a behavior assessment (completed 6/21/22) that listed exit seeking as a behavior, ASM #2 stated, "These are the names I was given."

An interview was conducted on 7/6/22 at 2:43 PM with ASM #1, the administrator. When asked to tell us about the locked units, ASM #1 stated, "They are not units for elopement risks, like the arcadia unit. We punch in a code for any resident that wants to come off the unit. Residents do not all have same cognition. They do not abide by the LOA policy and procedure. I have had to report quite a few elopements. If you want to go shopping, go with the activities department. Residents are free to come and go as you please." When asked do you consider the resident as independent if they have to have someone enter a code for them to leave the unit. ASM #1 stated, "Yes." When asked would you

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consider this as independent in your home, ASM #1 stated, "Yes, I have to enter a code to go into one of my rooms in my home." When asked what discussion does plant operations have with nursing regarding resident rights and independence, ASM #1 stated, "Yes, I am the one who talked with corporate. We are committed to making the elevator accessible to all residents at all time as long as they are appropriate to go down on the elevator and sign out in the book on each unit. Generally the residents just talk with the nurse and let them know where they are going. Anyone can have an acute episodic event, and we want to make sure that the resident is secure. We have seen residents elope from the facility and are doing our best to make sure the residents stay safe." When asked if behavior /exit seeking assessments were done on all residents on those locked units, ASM #1 stated, "No, we would not do elopement assessments on everyone because of an acute episodic events, those are completely unexpected and unpredictable. You cannot tell that something is not going to happen tomorrow that will not put the resident in harm's way."

On 7/6/22 at approximately 4:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate quality assurance coordinator were made aware of the findings.

According to the facility's policy "Interdisciplinary Care Planning/Resident Rights/Person Centered Care/Quality of Life" dated 3/2018, which reveals, "Comprehensive Care Planning Requirements: The care plan must describe the following: the services that are to be furnished to maintain the patient's highest practicable physical, mental and psychosocial well-being."

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No further information was provided prior to exit.
4. The facility staff failed to allow Resident #105 (R105) to exercise his right to freely move about the facility.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/29/2022, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. Resident #105 (R105) was coded as making themselves understood and understanding others. In Section E - Behaviors, the resident was not coded as having had any behaviors during the look back period. In Section G - Functional Status, the resident was coded as requiring supervision with set up help only for walking in the room, walking in the hallway, locomotion on the unit and locomotion off the unit.

An interview was conducted with R105 on 7/6/2022 at 11:05 a.m. When asked how he gets off the unit, R105 stated they have to get a staff member to put in the code and open the door. When asked if the staff would give them the code to open the door, R105 stated, "No, it's like we are in a prison."

The Recreational Services note dated, 11/22/2021, documented in part, "Resident admitted to the facility...he enjoys movies, cards, religious programs and TV."
The Recreational Services note dated, 2/17/2022 documented in part, "He pursues independent activities in room and is out to dialysis 3 days/week. He voices no need for additional activity supplies."

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The Recreational Services note dated, 5/2/2022, documented in part, "No changes in activity interests. Current goal to be continued over next 90 days."

The Behavioral Symptoms Assessment, dated, 6/2/2022, documented in part: a check mark was documented next to, "Agitation, irritability, or hyperactivity." Exit seeking or wandering without intent or purpose was not checked.

The comprehensive care plan dated, 1/10/2022, documented in part, "Focus: (R105) enjoys country music, spades, news, outdoors, church, TV, computer and talking...Needs opportunities to pursue his interests." The "Interventions" documented. "Assist in planning and/or encourage to plan own leisure time activities. Encourage participation in group activities of interest. Provide supplies/materials for leisure activities as needed/requested."

An interview was conducted with ASM #2, the director of nursing, on 7/6/2022 at 1:00 p.m. When asked why are the doors locked. ASM #2 stated the facility has had an unusual number of elopements reported to the state. It's an added security for patients, it's for any patient that leaves the facility. Residents that leave the facility without an LOA order, would be considered an elopement. When asked how the facility assesses the resident that need to be in an environment that is more secured, ASM #2 stated they assess through a behavioral assessment. When asked about residents on Station 2, ASM #2 stated if the resident has indicated behaviors, they would have an assessment. When asked if resident that reside on that unit (Station 2) and don't have behaviors, is that impacting them, that

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it's locked, ASM #2 stated the security is designed to let us be aware of where the residents are. When asked if a resident asked for the code, could they get it, ASM #2 stated, generally speaking, codes are shared. A resident is not allowed to be given the code. When asked if that infringes upon a resident's ability to attain their highest level of well-being, it would lessen the resident's time to get off the unit, ASM #2 stated, "This is not a secured unit, it's for the resident's safety. The residents can still go off the unit, they just need to ask". When asked if all of the residents on Station 2 considered an elopement risk, ASM #2 stated, "No, Ma'am." When asked but you have them on a locked unit ASM #2 stated, "Yes." When asked why the residents can't go independently about the facility, ASM #2 stated, "I have nothing else to offer other that what I have already stated."

An interview was conducted on 7/6/22 at 2:43 p.m. with ASM (administrative staff member) #1, the administrator. When asked to tell us about the locked units, ASM #1 stated, "They are not units for elopement risks, like the arcadia unit (secured dementia care unit). We punch in a code for any resident that wants to come off the unit. Residents do not all have same cognition. They do not abide by the LOA (leave of absence) policy and procedure. I have had to report quite a few elopements. If you want to go shopping, go with the activities department. Residents are free to come and go as they please." When asked do you consider the resident as independent if they have to have someone enter a code for them to leave the unit. ASM #1 stated, yes. When asked would you consider this as independent in your home, ASM #1 stated, "Yes, I have to enter a code to go into one of my rooms in my home."

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F 550	Continued From page 44 When asked what discussion does plant operations have with nursing regarding resident rights and independence, ASM #1 stated, yes, he is the one who talked with corporate. ASM #1 stated, "We are committed to making the elevator accessible to all residents, at all time, as long as they are appropriate to go down on the elevator and sign out in the book on each unit. Generally the residents just talk with the nurse and let them know where they are going. Anyone can have an acute episodic event, and we want to make sure that the resident is secure. We have seen residents elope from the facility and are doing our best to make sure the residents stay safe." When asked if behavior /exit seeking assessments were done on all residents on those locked units, ASM #1 stated, "No, we would not do elopement assessments on everyone because of an acute episodic event, those are completely unexpected and unpredictable. You cannot tell that something is going to happen tomorrow that will not put the resident in harm's way." ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/6/2022 at 4:29 p.m. No further information was provided prior to exit.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:	F 554	1. Corrective Action RN#1 removed the loition from Resident #117 beside on 7-6-22. 2.Like Residents/Area The Director of Nursing/Designee will inspect resident rooms in the center to validate no medications are left at the bedside 3. Systemic Change The Director of Nursing/Designee will re-educate licensed nurses on the medication administration process to include not leaving medications/loitions at the bedside.	

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F 554	Continued From page 45 Based on observation, resident interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to assess a resident for self-administration of medication prior to leaving the medication at the resident's bedside, for one of 20 residents in the survey sample, Resident #117 (R117). On 7/6/22, the facility staff left a prescription cream at R117's bedside. The findings include: R117 was admitted to the facility on 6/24/22. R117 had not been in the facility long enough for an MDS (minimum data set) to be completed. A review of R117's admission assessment dated 6/24/22 revealed R117 was alert and oriented to person, place, and time. On 7/6/22 at 9:03 a.m., R117 was observed sitting up in bed. A tube of Clindamycin Phosphate (antibiotic) 1% Topical Lotion was observed on R117's overbed table. When asked if R117 used the lotion, R117 stated they applied the lotion whenever needed to treat symptoms from overactive sweat glands. R117 stated they never used the lotion more than once a day. A review of R117's clinical record revealed the following order dated 7/1/22: "Clindamycin Phosphate Lotion 1%. Apply to armpit topically one time a day for anti-bacterial." A review of R117's baseline care plan dated 6/27/22 revealed, in part: "Infection of wound/skin lower breast fungal...administer medication per	F 554	4. Monitoring The Director of Nursing/Designee will randomly audit 5 resident rooms weekly times 4 weeks to validate that no medications are left at the bedside.	8-10-22

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physician orders."

A review of R117's TARs (treatment administration records) for June and July 2022 revealed the resident received the lotion as ordered.

On 7/6/22 at 9:06 a.m., CNA (certified nursing assistant) #2 was interviewed. She stated R117 should not have had any prescription medications at the bedside. CNA #2 stated she needed to go and tell R117's nurse.

On 7/6/22 at 9:15 a.m., RN (registered nurse) #1 was interviewed. She stated CNA #2 had informed her about the prescription lotion on R117's bedside table. She stated she had removed the lotion from the resident's room and placed it in the medication cart. She stated no resident should have medication at the bedside unless the resident has been determined to be able to self-administer the medication. She stated this was a safety concern. RN #2 stated she was not aware that R117 had been assessed to self-administer medication.

On 7/6/22 at 1:00 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked what process is to be followed for a resident to be allowed to have prescription medication at the resident's bedside, she stated medications should not be left at a resident's bedside. She stated it could be a safety concern if the resident takes too little or too much medication. She stated she could not quote the process for assessing a resident for self-administering medication, but she would check.

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On 7/6/22 at 2:00 p.m., ASM #2 stated a resident must be assessed to determine their ability to self-administer medication. She stated R117 had not been assessed.

On 7/6/22 at 3:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality assurance coordinator, were informed of these concerns.

A review of the facility policy, "Medication Administration: Self-Administration of Medications," revealed, in part: "When determining if self-administration is clinically appropriate for a patient, the IDT (interdisciplinary team) should consider the following criteria...the safety and appropriateness of the medication(s) for self-administration...the patient's physical capacity to swallow without difficulty and to open medication bottles...the patient's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for...the patient's capacity to follow directions and tell time to know when medications need to be taken...the patient's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff...the patient's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs...the patient's ability to ensure that medication is stored safely and securely...The decision to allow a patient to self-administer medication(s) is subject to periodic assessment by the IDT based on changes in the patient's medical and decision-making status...Medications, if stored at the patient's bedside, are to be secured in a

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F 554	Continued From page 48 locked storage unit until use. Medications may also be retained in the medication cart and accessed by the nurse upon patient request for scheduled medications...The patient can only begin self-administer of medications after the evaluation has been completed and it is determined that the patient is granted approval to fully self-administer medications. The patient signs and dates along with the individual who explained the evaluation process to the patient." No further information was provided prior to exit. Complaint deficiency.	F 554		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the	F 561	1. Corrective Action Concern forms were generated and resolved on Residents #105,#109,#118, #119 related to the key pads being disarmed. The facility disarmed the key pad on the unit 6 elevator and unit 2 unit doors on 7-6-22. 2. Like Residents/Areas The administrator reviewed the facility floorplan to validate that facility units were accessible to residents in the center based on their careplan. 3. Systemic Change The Regional Director of Operations re-educated the administrator on F561 to include making sure residents can move about the facility without restriction. The Administrator re-educated the IDT team on F 561 to include making sure residents can move about the facility without restriction. 4. Monitoring The Administrator/designee will review facility floorplan weekly times 4 weeks and the facility grievance log weekly times 4 weeks to validate no concerns were received related to keypads restricting access of the residents.	8-10-22

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facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on review of staff interview and facility documentation review, it was determined that the facility failed to promote and facilitate the resident's right to self-determination by restricting resident's choice in freely moving about the facility for 4 of 20 residents in the survey sample, Resident #109, #118, #119 and #105.

There were 83 of the 169 resident in the facility that were in locked units. These units either had locked doors (which required a code to open) on both ends or were located on the second floor (600 rooms) and the elevator and doors leading to the second floor required a code. Surveyor was provided code to unlock doors or elevator when asked for the code. A review of the 50 resident records of residents located on the second floor unit (600 rooms) revealed the following: 24/50 had no behavioral/elopement assessment and only 1/50 being assessed as exit seeking. A review of the Resident Council minutes dated 4/19/22 revealed the following, "New business-administration: Administrator invited by president to inform residents of new locks and doors."

The findings included:

1. The facility staff failed to allow Resident #109 their independence to move about freely

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throughout the facility.

Resident #109 was observed waiting for the elevator on 7/5/22 at 3:55 PM. Resident #109 stated, "We are in Alcatraz. This is our home not a prison."

Resident #109 was admitted to the facility on 1/1/21 with diagnosis that included but were not limited to: quadriplegia, chronic kidney disease (CKD) and atherosclerotic cardiovascular disease (ASCVD).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/2/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring total dependence for bed mobility, transfer, dressing, hygiene and bathing; extensive assistance for dressing and supervision for eating. Locomotion is coded as independent.

A review of the comprehensive care plan dated 11/16/19 and revised 6/6/22, which revealed, "GOAL: Resident will choose and engage in independent leisure pursuits of interest on a daily basis. INTERVENTIONS: Respect choices in regard to activity participation."

A review of the behavioral assessment for Resident #109 dated 3/25/19 revealed the following "Identified Behavior symptoms: verbal aggression, agitation, irritability or hyperactivity checked. Seriousness of Behavioral Symptom: Patient is threat to himself or others-no,

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disruptive-no, distressing to self and/or others-no."

An interview was conducted on 7/6/22 at 11:05 AM with LPN (licensed practical nurse) #2. When asked the purpose of the coded elevator, LPN #2 stated, the purpose is to keep the residents safe. When asked if all the residents had been assessed for safety, LPN #2 stated, I am not sure.

An interview was conducted on 7/6/22 at 10:55 AM with Resident #109. When asked if he was able to move throughout the facility freely, Resident #109 stated, "No, this is like Alcatraz, I do not have any control of getting off of this floor without the staff coming to enter the code. They will not give us the code."

An interview was conducted on 7/6/22 at 1:00 PM with ASM (administrative staff member) #2, the director of nursing. When asked the purpose of the locked units, ASM #2 stated, "We have had an unusual number of elopements reported to the state, any patient that could leave the facility without a LOA (leave of absence) order and it is unsafe to do so. There is a door that takes you out in the parking lot." When asked what assessments are completed to determine if a resident requires placement on a locked unit, ASM #2 stated, "What we do have is a behavior assessment, if they have had behaviors they would have a behavior assessment. The security is designed so that all they need to do is to ask staff to get out. There are sign out books on each unit." When asked if a resident has not been assessed as a risk, why would the resident not be allowed that independence, ASM #2 stated, "It is because the residents would share the codes.

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We do not give the code to the resident. I believe it would lengthen your time to get off the unit since they have to ask the staff for the code." When asked if a resident says they want to come and go are they offered another room placement, ASM #2 stated, "No, they are not." When asked how many residents on the 600 hall were assessed as exit seeking, ASM #2 stated, "I am not sure how many on the 600 hall are exit seeking. I will have to check on that." When asks how this impacts the residents ability for choice and rights, ASM #2 stated, "Other than the reasons I have already stated, I do not have anything else to offer."

An interview was conducted on 7/6/22 at 1:59 PM with ASM #2, the director of nursing. When asked who was responsible to the locked units, ASM #2 stated, that was not nursing, that was a plant operations. When asked who the plant operations contact is, ASM #2 stated, the administrator. When asked what discussions nursing has with plant operations regarding resident rights and independence, ASM #2 stated, "I state my case or speak for resident's rights, generally I would think the administrator would take it up to corporate. We discussed it thoroughly with the Ombudsman, another gentleman from another building. We need to do it for residents who are at risk. I personally did not want the locks, but I do not know that I specifically said that. I do not know that that I came down that hard. There are four residents on the 600 hall that are exit seeking." When asked their names, ASM #2 stated, "These are the resident names, (Resident #120 and three other residents)." When ASM #2 was informed that only Resident #120 had a behavior assessment that listed exit seeking as a behavior,

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ASM #2 stated, "These are the names I was given."

An interview was conducted on 7/6/22 at 2:43 PM with ASM #1, the administrator. When asked to tell us about the locked units, ASM #1 stated, "They are not units for elopement risks, like the arcadia unit. We punch in a code for any resident that wants to come off the unit. Residents do not all have same cognition. They do not abide by the LOA policy and procedure. I have had to report quite a few elopements. If you want to go shopping, go with the activities department. Residents are free to come and go as you please." When asked do you consider the resident as independent if they have to have someone enter a code for them to leave the unit. ASM #1 stated, "Yes." When asked would you consider this as independent in your home, ASM #1 stated, "Yes, I have to enter a code to go into one of my rooms in my home." When asked what discussion does plant operations have with nursing regarding resident rights and independence, ASM #1 stated, "Yes, I am the one who talked with corporate. We are committed to making the elevator accessible to all residents at all time as long as they are appropriate to go down on the elevator and sign out in the book on each unit. Generally the residents just talk with the nurse and let them know where they are going. Anyone can have an acute episodic event, and we want to make sure that the resident is secure. We have seen residents elope from the facility and are doing our best to make sure the residents stay safe." When asked if behavior /exit seeking assessments were done on all residents on those locked units, ASM #1 stated, "No, we would not do elopement assessments on everyone because of an acute episodic events,

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those are completely unexpected and unpredictable. You cannot tell that something is not going to happen tomorrow that will not put the resident in harm's way."

On 7/6/22 at approximately 4:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate quality assurance coordinator were made aware of the findings.

According to the facility's policy "Interdisciplinary Care Planning/Resident Rights/Person Centered Care/Quality of Life" dated 3/2018, which reveals, "Comprehensive Care Planning Requirements: The care plan must describe the following: the services that are to be furnished to maintain the patient's highest practicable physical, mental and psychosocial well-being."

No further information was provided prior to exit.

2. The facility staff failed to allow Resident #118 their independence to move about freely throughout the facility.

Resident #118 was admitted to the facility on 7/18/18 with diagnosis that included but were not limited to: Parkinson's disease, lymphedema and hypertension.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/16/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as independent for bed mobility, transfer, walking, locomotion, eating,

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hygiene and bathing; limited assistance for dressing.

A review of the comprehensive care plan dated 11/16/19, which revealed, "GOAL: Resident will participated in independent leisure activities of choice daily. INTERVENTIONS: Assist in planning/encourage to plan own leisure-time activities."

A review of the Resident #118's medical record found there was no behavioral assessment completed.

An interview was conducted on 7/6/22 at 11:05 AM with LPN (licensed practical nurse) #2. When asked the purpose of the coded elevator, LPN #2 stated, the purpose is to keep the residents safe. When asked if all the residents had been assessed for safety, LPN #2 stated, I am not sure.

An interview was conducted on 7/6/22 at 10:50 AM with Resident #118. When asked if he was able to move throughout the facility freely, Resident #118 stated, no, I have to wait for a staff person to enter the code. I can push the down button, but the door won't open until the staff comes to enter the code. We are not allowed to have the code. I don't understand why.

An interview was conducted on 7/6/22 at 1:00 PM with ASM (administrative staff member) #2, the director of nursing. When asked the purpose of the locked units, ASM #2 stated, "We have had an unusual number of elopements reported to the state, any patient that could leave the facility without a LOA (leave of absence) order and it is unsafe to do so. There is a door that takes you

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out in the parking lot." When asked what assessments are completed to determine if a resident requires placement on a locked unit, ASM #2 stated, "What we do have is a behavior assessment, if they have had behaviors they would have a behavior assessment. The security is designed so that all they need to do is to ask staff to get out. There are sign out books on each unit." When asked if a resident has not been assessed as a risk, why would the resident not be allowed that independence, ASM #2 stated, "It is because the residents would share the codes. We do not give the code to the resident. I believe it would lengthen your time to get off the unit since they have to ask the staff for the code." When asked if a resident says they want to come and go are they offered another room placement, ASM #2 stated, "No, they are not." When asked how many residents on the 600 hall were assessed as exit seeking, ASM #2 stated, "I am not sure how many on the 600 hall are exit seeking. I will have to check on that." When asks how this impacts the residents ability for choice and rights, ASM #2 stated, "Other than the reasons I have already stated, I do not have anything else to offer."

An interview was conducted on 7/6/22 at 1:59 PM with ASM #2, the director of nursing. When asked who was responsible to the locked units, ASM #2 stated, that was not nursing, that was a plant operations. When asked who the plant operations contact is, ASM #2 stated, the administrator. When asked what discussions nursing has with plant operations regarding resident rights and independence, ASM #2 stated, "I state my case or speak for resident's rights, generally I would think the administrator would take it up to corporate. We discussed it

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thoroughly with the Ombudsman, another gentleman from another building. We need to do it for residents who are at risk. I personally did not want the locks, but I do not know that I specifically said that. I do not know that that I came down that hard. There are four residents on the 600 hall that are exit seeking." When asked their names, ASM #2 stated, "These are the resident names, (Resident #120 and three other residents)." When ASM #2 was informed that only Resident #120 had a behavior assessment that listed exit seeking as a behavior, ASM #2 stated, "These are the names I was given."

An interview was conducted on 7/6/22 at 2:43 PM with ASM #1, the administrator. When asked to tell us about the locked units, ASM #1 stated, "They are not units for elopement risks, like the arcadia unit. We punch in a code for any resident that wants to come off the unit. Residents do not all have same cognition. They do not abide by the LOA policy and procedure. I have had to report quite a few elopements. If you want to go shopping, go with the activities department. Residents are free to come and go as you please." When asked do you consider the resident as independent if they have to have someone enter a code for them to leave the unit. ASM #1 stated, "Yes." When asked would you consider this as independent in your home, ASM #1 stated, "Yes, I have to enter a code to go into one of my rooms in my home." When asked what discussion does plant operations have with nursing regarding resident rights and independence, ASM #1 stated, "Yes, I am the one who talked with corporate. We are committed to making the elevator accessible to all residents at all time as long as they are appropriate to go

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down on the elevator and sign out in the book on each unit. Generally the residents just talk with the nurse and let them know where they are going. Anyone can have an acute episodic event, and we want to make sure that the resident is secure. We have seen residents elope from the facility and are doing our best to make sure the residents stay safe." When asked if behavior /exit seeking assessments were done on all residents on those locked units, ASM #1 stated, "No, we would not do elopement assessments on everyone because of an acute episodic events, those are completely unexpected and unpredictable. You cannot tell that something is not going to happen tomorrow that will not put the resident in harm's way."

On 7/6/22 at approximately 4:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate quality assurance coordinator were made aware of the findings.

According to the facility's policy "Interdisciplinary Care Planning/Resident Rights/Person Centered Care/Quality of Life" dated 3/2018, which reveals, "Comprehensive Care Planning Requirements: The care plan must describe the following: the services that are to be furnished to maintain the patient's highest practicable physical, mental and psychosocial well-being."

No further information was provided prior to exit.

3. The facility staff failed to allow Resident #119 their independence to move about freely throughout the facility.

Resident #119 was admitted to the facility on 2/26/21 with diagnosis that included but were not

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limited to: right above the knee amputation, diabetes mellitus and chronic obstructive pulmonary disease.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/22/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; supervision for eating and independent in locomotion.

A review of the comprehensive care plan dated 2/27/21, which revealed, "GOAL: Resident will improve functional mobility. Resident will actively participate in group events of interest daily. INTERVENTIONS: Assist in planning/encourage to plan own leisure-time activities."

A review of the Resident #119's medical record found there was no behavioral assessment completed.

An interview was conducted on 7/6/22 at 11:05 AM with LPN (licensed practical nurse) #2. When asked the purpose of the coded elevator, LPN #2 stated, the purpose is to keep the residents safe. When asked if all the residents had been assessed for safety, LPN #2 stated, I am not sure.

An interview was conducted on 7/6/22 at 10:50 AM with Resident #118. When asked if he was able to move throughout the facility freely, Resident #118 stated, no, I have to wait for a staff

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person to enter the code. I can push the down button, but the door won't open until the staff comes to enter the code. We are not allowed to have the code. I don't understand why.

An interview was conducted on 7/6/22 at 1:00 PM with ASM (administrative staff member) #2, the director of nursing. When asked the purpose of the locked units, ASM #2 stated, "We have had an unusual number of elopements reported to the state, any patient that could leave the facility without a LOA (leave of absence) order and it is unsafe to do so. There is a door that takes you out in the parking lot." When asked what assessments are completed to determine if a resident requires placement on a locked unit, ASM #2 stated, "What we do have is a behavior assessment, if they have had behaviors they would have a behavior assessment. The security is designed so that all they need to do is to ask staff to get out. There are sign out books on each unit." When asked if a resident has not been assessed as a risk, why would the resident not be allowed that independence, ASM #2 stated, "It is because the residents would share the codes. We do not give the code to the resident. I believe it would lengthen your time to get off the unit since they have to ask the staff for the code." When asked if a resident says they want to come and go are they offered another room placement, ASM #2 stated, "No, they are not." When asked how many residents on the 600 hall were assessed as exit seeking, ASM #2 stated, "I am not sure how many on the 600 hall are exit seeking. I will have to check on that." When asks how this impacts the residents ability for choice and rights, ASM #2 stated, "Other than the reasons I have already stated, I do not have anything else to offer."

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An interview was conducted on 7/6/22 at 1:59 PM with ASM #2, the director of nursing. When asked who was responsible to the locked units, ASM #2 stated, that was not nursing, that was a plant operations. When asked who the plant operations contact is, ASM #2 stated, the administrator. When asked what discussions nursing has with plant operations regarding resident rights and independence, ASM #2 stated, "I state my case or speak for resident's rights, generally I would think the administrator would take it up to corporate. We discussed it thoroughly with the Ombudsman, another gentleman from another building. We need to do it for residents who are at risk. I personally did not want the locks, but I do not know that I specifically said that. I do not know that that I came down that hard. There are four residents on the 600 hall that are exit seeking." When asked their names, ASM #2 stated, "These are the resident names, (Resident #120 and three other residents)." When ASM #2 was informed that only Resident #120 had a behavior assessment that listed exit seeking as a behavior, ASM #2 stated, "These are the names I was given."

An interview was conducted on 7/6/22 at 2:43 PM with ASM #1, the administrator. When asked to tell us about the locked units, ASM #1 stated, "They are not units for elopement risks, like the arcadia unit. We punch in a code for any resident that wants to come off the unit. Residents do not all have same cognition. They do not abide by the LOA policy and procedure. I have had to report quite a few elopements. If you want to go shopping, go with the activities department. Residents are free to come and go as you

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please." When asked do you consider the resident as independent if they have to have someone enter a code for them to leave the unit. ASM #1 stated, "Yes." When asked would you consider this as independent in your home, ASM #1 stated, "Yes, I have to enter a code to go into one of my rooms in my home." When asked what discussion does plant operations have with nursing regarding resident rights and independence, ASM #1 stated, "Yes, I am the one who talked with corporate. We are committed to making the elevator accessible to all residents at all time as long as they are appropriate to go down on the elevator and sign out in the book on each unit. Generally the residents just talk with the nurse and let them know where they are going. Anyone can have an acute episodic event, and we want to make sure that the resident is secure. We have seen residents elope from the facility and are doing our best to make sure the residents stay safe." When asked if behavior /exit seeking assessments were done on all residents on those locked units, ASM #1 stated, "No, we would not do elopement assessments on everyone because of an acute episodic events, those are completely unexpected and unpredictable. You cannot tell that something is not going to happen tomorrow that will not put the resident in harm's way."

On 7/6/22 at approximately 4:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate quality assurance coordinator were made aware of the findings.

According to the facility's policy "Interdisciplinary Care Planning/Resident Rights/Person Centered Care/Quality of Life" dated 3/2018, which reveals, "Comprehensive Care Planning Requirements:

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The care plan must describe the following: the services that are to be furnished to maintain the patient's highest practicable physical, mental and psychosocial well-being."

No further information was provided prior to exit.
4. The facility staff failed to allow Resident #105 (R105) their independence to move about freely throughout the facility.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/29/2022, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. Resident #105 (R105) was coded as making themselves understood and understanding others. In Section E - Behaviors, the resident was not coded as having had any behaviors during the look back period. In Section G - Functional Status, the resident was coded as requiring supervision with set up help only for walking in the room, walking in the hallway, locomotion on the unit and locomotion off the unit.

An interview was conducted with R105 on 7/6/2022 at 11:05 a.m. When asked how he gets off the unit, R105 stated they have to get a staff member to put in the code and open the door. When asked if the staff would give them the code to open the door, R105 stated, "No, it's like we are in a prison."

The Recreational Services note dated, 11/22/2021, documented in part, "Resident admitted to the facility...he enjoys movies, cards, religious programs and TV."
The Recreational Services note dated, 2/17/2022

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documented in part, "He pursues independent activities in room and is out to dialysis 3 days/week. He voices no need for additional activity supplies."
The Recreational Services note dated, 5/2/2022, documented in part, "No changes in activity interests. Current goal to be continued over next 90 days."

The Behavioral Symptoms Assessment, dated, 6/2/2022, documented in part: a check mark was documented next to, "Agitation, irritability, or hyperactivity." Exit seeking or wandering without intent or purpose was not checked.

The comprehensive care plan dated, 1/10/2022, documented in part, "Focus: (R105) enjoys country music, spades, news, outdoors, church, TV, computer and talking...Needs opportunities to pursue his interests." The "Interventions" documented. "Assist in planning and/or encourage to plan own leisure time activities. Encourage participation in group activities of interest. Provide supplies/materials for leisure activities as needed/requested."

An interview was conducted with ASM #2, the director of nursing, on 7/6/2022 at 1:00 p.m. When asked why are the doors locked. ASM #2 stated the facility has had an unusual number of elopements reported to the state. It's an added security for patients, it's for any patient that leaves the facility. Residents that leave the facility without an LOA order, would be considered an elopement. When asked how the facility assesses the resident that need to be in an environment that is more secured, ASM #2 stated they assess through a behavioral assessment. When asked about residents on Station 2, ASM

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#2 stated if the resident has indicated behaviors, they would have an assessment. When asked if resident that reside on that unit (Station 2) and don't have behaviors, is that impacting them, that it's locked, ASM #2 stated the security is designed to let us be aware of where the residents are. When asked if a resident asked for the code, could they get it, ASM #2 stated, generally speaking, codes are shared. A resident is not allowed to be given the code. When asked if that infringes upon a resident's ability to attain their highest level of well-being, it would lessen the resident's time to get off the unit, ASM #2 stated "This is not a secured unit, it's for the resident's safety. The residents can still go off the unit, they just need to ask." When asked if all of the residents on Station 2 considered an elopement risk, ASM #2 stated, "No, Ma'am." When asked but you have them on a locked unit ASM #2 stated, "Yes.". When asked why the residents can't go independently about the facility, ASM #2 stated, "I have nothing else to offer other that what I have already stated."

An interview was conducted on 7/6/22 at 2:43 p.m. with ASM (administrative staff member) #1, the administrator. When asked to tell us about the locked units, ASM #1 stated, "They are not units for elopement risks, like the arcadia unit (secured dementia care unit). We punch in a code for any resident that wants to come off the unit. Residents do not all have same cognition. They do not abide by the LOA (leave of absence) policy and procedure. I have had to report quite a few elopements. If you want to go shopping, go with the activities department. Residents are free to come and go as they please." When asked do you consider the resident as independent if they have to have someone enter a code for them to

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F 561	Continued From page 66 leave the unit. ASM #1 stated, yes. When asked would you consider this as independent in your home, ASM #1 stated, "Yes, I have to enter a code to go into one of my rooms in my home." When asked what discussion does plant operations have with nursing regarding resident rights and independence, ASM #1 stated, yes, he is the one who talked with corporate. ASM #1 stated, "We are committed to making the elevator accessible to all residents, at all time, as long as they are appropriate to go down on the elevator and sign out in the book on each unit. Generally the residents just talk with the nurse and let them know where they are going. Anyone can have an acute episodic event, and we want to make sure that the resident is secure. We have seen residents elope from the facility and are doing our best to make sure the residents stay safe." When asked if behavior /exit seeking assessments were done on all residents on those locked units, ASM #1 stated, "No, we would not do elopement assessments on everyone because of an acute episodic event, those are completely unexpected and unpredictable. You cannot tell that something is going to happen tomorrow that will not put the resident in harm's way." ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/6/2022 at 4:29 p.m. No further information was provided prior to exit.	F 561		
{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	{F 656}	1.Corrective Action Resident #105,#109,#118,and #119 careplan was reviewed by the IDT team to validate accuracy related to moving about the facility. Resident #102 had an incident report completed related to the administration of Coreg outside of the parameters and food preferences.	

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{F 656}	Continued From page 67 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the 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.	{F 656}	2. Like Residents/Areas The Director of Nursing/designee has reviewed resident careplans related to freedom movement, medication parameters, and food preferences to validate accuracy. Type text here 3. Systemic Change The Director of Nursing/designee has re-educated licensed nurses on F656 specific to the implementation of resident careplans related to freedom of movement, medication parameters, and food preferences. 4.Monitoring The Director of Nurisng/designee will aduit 5 random resdient careplans weekly times 4 weeks to validate implementation of freedome of movement,medication parameters, and food preferences .	8-10-22

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This REQUIREMENT is not met as evidenced by:
5. The facility staff failed to implement the comprehensive care plan for independence in freedom of movement in the facility for Resident #109.

Resident #109 was observed waiting for the elevator on 7/5/22 at 3:55 PM. Resident #109 stated, "We are in Alcatraz. This is our home not a prison."

Resident #109 was admitted to the facility on 1/1/21 with diagnosis that included but were not limited to: quadriplegia, chronic kidney disease (CKD) and atherosclerotic cardiovascular disease (ASCVD).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/2/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring total dependence for bed mobility, transfer, dressing, hygiene and bathing; extensive assistance for dressing and supervision for eating. Locomotion is coded as independent.

A review of the comprehensive care plan dated 11/16/19 and revised 6/6/22, which revealed, "GOAL: Resident will choose and engage in independent leisure pursuits of interest on a daily basis. INTERVENTIONS: Respect choices in regard to activity participation."

An interview was conducted on 7/6/22 at 8:00 AM

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with LPN (licensed practical nurse) #2. When asked the purpose of the care plan, LPN #2 stated, the purpose is to look at the care of the resident and know what to do for the resident. When asked if being unable to exit the floor via elevator without having the code was independence, LPN #2 stated, "No, we have to enter the code for them."

On 7/6/22 at approximately 4:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate quality assurance coordinator were made aware of the findings.

According to the facility's policy "Interdisciplinary Care Planning" dated 3/2018, which reveals, "Care Planning: The care plan should focus on preventing an avoidable decline in function. Care Planning Process: Evaluation-evaluating the effectiveness of the care plan interventions will help the interdisciplinary team to modify the care plan as needed to help the resident reach their highest practicable level of well-being.

No further information was provided prior to exit.

6. The facility staff failed to implement the comprehensive care plan for independence in freedom of movement in the facility for Resident #118.

Resident #118 was admitted to the facility on 7/18/18 with diagnosis that included but were not limited to: Parkinson's disease, lymphedema and hypertension.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an

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ARD (assessment reference date) of 6/16/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as independent for bed mobility, transfer, walking, locomotion, eating, hygiene and bathing; limited assistance for dressing.

A review of the comprehensive care plan dated 11/16/19, which revealed, "GOAL: Resident will participated in independent leisure activities of choice daily. INTERVENTIONS: Assist in planning/encourage to plan own leisure-time activities."

An interview was conducted on 7/6/22 at 8:00 AM with LPN (licensed practical nurse) #2. When asked the purpose of the care plan, LPN #2 stated, the purpose is to look at the care of the resident and know what to do for the resident. When asked if being unable to exit the floor via elevator without having the code was independence, LPN #2 stated, "No, we have to enter the code for them."

An interview was conducted on 7/6/22 at 10:50 AM with Resident #118. When asked if he was able to exit his second floor via elevator independently, Resident #118 stated, "No, I have to wait for a staff person to enter the code. I can push the down button, but the door won't open until the staff comes to enter the code. We are not allowed to have the code. I don't understand why."

On 7/6/22 at approximately 4:30 PM, ASM (administrative staff member) #1, the

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administrator, ASM #2, the director of nursing and ASM #3, the corporate quality assurance coordinator were made aware of the findings.

According to the facility's policy "Interdisciplinary Care Planning" dated 3/2018, which reveals, "Care Planning: The care plan should focus on preventing an avoidable decline in function. Care Planning Process: Evaluation-evaluating the effectiveness of the care plan interventions will help the interdisciplinary team to modify the care plan as needed to help the resident reach their highest practicable level of well-being.

No further information was provided prior to exit.

7. The facility staff failed to implement the comprehensive care plan for independence in freedom of movement in the facility for Resident #119.

Resident #119 was admitted to the facility on 2/26/21 with diagnosis that included but were not limited to: right above the knee amputation, diabetes mellitus and chronic obstructive pulmonary disease.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/22/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; supervision for eating and independent in locomotion.

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A review of the comprehensive care plan dated 2/27/21, which revealed, "GOAL: Resident will improve functional mobility. Resident will actively participate in group events of interest daily. INTERVENTIONS: Assist in planning/encourage to plan own leisure-time activities."

An interview was conducted on 7/6/22 at 8:00 AM with LPN (licensed practical nurse) #2. When asked the purpose of the care plan, LPN #2 stated, the purpose is to look at the care of the resident and know what to do for the resident. When asked if being unable to exit the floor via elevator without having the code was independence, LPN #2 stated, "No, we have to enter the code for them."

An interview was conducted on 7/6/22 at 11:00 AM with Resident #119. Resident #119 was found in the activity room on the first floor. When asked if he was able to exit his second floor via elevator independently, Resident #119 stated, "No, it is like a jail. We cannot come down on the elevator without staff entering the code for us. I do not understand why they do that. We should be able to have the code."

On 7/6/22 at approximately 4:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate quality assurance coordinator were made aware of the findings.

According to the facility's policy "Interdisciplinary Care Planning" dated 3/2018, which reveals, "Care Planning: The care plan should focus on preventing an avoidable decline in function. Care Planning Process: Evaluation-evaluating the effectiveness of the care plan interventions will

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help the interdisciplinary team to modify the care plan as needed to help the resident reach their highest practicable level of well-being.

No further information was presented prior to exit.
8. A. The facility staff failed to implement the comprehensive care plan to give blood pressure medications per the physician's orders for Resident #102 (R102).

On the most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/6/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired to make daily decisions.

The comprehensive care plan dated, 8/18/2021, documented in part, "Focus: Cardiac disease related to HTN, heart failure." The "Interventions" documented in part, "Administer medication per physician orders."

The physician order dated, 3/3/2022, documented, "Carvedilol Tablet - Coreg (used to treat high blood pressure and heart disease) (1) 3.125 MG (milligrams) - give 1 tablet by mouth every 12 hours every Tue (Tuesday), Thu (Thursday), Sat (Saturday), Sun (Sunday) for HTN (hypertension - high blood pressure) Hold for SBP (systolic blood pressure) < (less than) 120."

The May 2022 MAR (medication administration record) documented the above order. On the following days and times, the medication was administered with the documented blood pressure:

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{F 656}	Continued From page 74 5/1/2022 at 8:00 p.m. - 117/70 5/5/2022 at 8:00 a.m. - 117/71 5/7/2022 at 8:00 a.m. - 104/66 5/7/2022 at 8:00 p.m. - 107/67 5/8/2022 at 8:00 a.m. - 114/68 5/12/2022 at 8:00 a.m. - 112/78 5/14/2022 at 8:00 p.m. - 118/74 5/15/2022 at 8:00 p.m. - 112/73 5/17/2022 at 8:00 a.m. - 110/68 5/22/2022 at 8:00 p.m. - 108/72 5/28/2022 at 8:00 p.m. - 116/72 5/31/2022 at 8:00 p.m. - 80/55 Review of the May 2022 nurse's notes failed to evidence documentation regarding the holding of the medication for the above blood pressures. The June 2022 MAR documented the above order. On the following days and times, the medication was administered with the documented blood pressure: 6/5/2022 at 8:00 a.m. - 102/68 6/16/2022 at 8:00 a.m. - 95/56 6/23/2022 at 8:00 a.m. - 107/62 Review of the June 2022 nurse's notes failed to evidence documentation regarding the holding of the medication for the above blood pressures. The July 2022 MAR documented the above order. On the following day and time, the medication was administered with the documented blood pressure: 7/5/2022 at 8:00 p.m. - 118/77. Review of the July 2022 nurse's notes failed to evidence documentation regarding the holding of the medication for the above blood pressures.	{F 656}		

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An interview was conducted with LPN (licensed practical nurse) #3 on 7/6/2022 at 10:37 a.m. When asked the purpose of the care plan, LPN #3 stated it is there for us to follow what we are supposed to do for that resident. When asked if the care plan documents to give medications per the physician order and they are not given according to the physician order, is that following the care plan, LPN #3 stated, "No."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/6/2022 at 4:29 p.m.

No further information was provided prior to exit.
(1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697042.html.

8. B The facility staff failed to honor Resident #102's food preferences per the plan of care.

On the most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/6/2022, Resident #102 (R102) scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired to make daily decisions.

The comprehensive care plan dated, 5/28/2021, documented in part, "Focus: (R102) has the potential for nutrition/hydration imbalance r/t (related to) multiple medical dx (diagnoses)." The "Interventions" documented in part, "Honor food preferences."

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An interview was conducted with R102 on 7/5/2022 at 2:55 p.m. When asked about the food, the resident stated his breakfasts are not good. They get served white bread, not toasted. Eggs and if available a small bowl of cereal. R102 stated they would like the eggs, either hard boiled or fried. They would like toast in the morning, not white untoasted bread. R102 stated the jelly falls off the bread making it very hard to eat. R102 stated they are a dialysis patient and a diabetic and needs to eat something substantial before going to dialysis three times a week. R102 stated they only gets two turkey sandwiches for dinner most nights. They stated they do not eat beef or pork.

A request was made on 7/5/2022 at 5:00 p.m. to ASM (administrative staff member) #1, the administrator, for a copy of the resident's food preferences and their meal ticket from their dietary food system.

Observation was made on 7/6/2022 at 8:00 a.m. of R102 sitting up in the wheelchair, no breakfast was present. The resident had to leave the facility at 8:45 a.m. for dialysis. Breakfast arrived at 8:08 a.m. The breakfast consisted of two pieces of white bread, untoasted, two hard boiled eggs, a container of milk, a container of cranberry juice, and a small bowl of bran cereal. R102 stated he couldn't eat the bran cereal if he was going to be sitting on a dialysis machine for three hours. When the CNA (certified nursing assistant) opened the hard boiled eggs, they were not fully cooked and runny. When asked what they got for dinner last night, R102 stated they got two turkey sandwiches. They stated what happened to tuna salad or chicken salad. R102 stated they get two

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peanut butter and jelly sandwiches to go with them on dialysis days, but wondered if there was something other than turkey and peanut butter and jelly. R102 stated they missed getting vegetables. They like vegetables. When asked if they got anything else with the turkey sandwiches, R102 stated, no.

The menu was reviewed on 7/6/2022 at approximately 9:00 a.m. On 7/5/2022 for dinner, pork was to be served. The alternate was fish.

The "Patient Summary" documented the following:
Diet - regular
Fluid restriction - none
Beverages - Grape or Apple Juice
Extra Items - oatmeal, tuna or chicken salad sandwich, toast, yogurt, eggs scram (scrambled)
Additional Directions - early breakfast tray
Dislikes: sausage, gravy, red meat, Pork, bacon, beef ground, grilled cheese sandwich, corned beef, meatballs, meatloaf, and sloppy joe.
Special Instructions: Turkey sandwich or salad as alternate to main meal.

An interview was conducted with LPN (licensed practical nurse) #3 on 7/6/2022 at 10:37 a.m. When asked the purpose of the care plan, LPN #3 stated it is there for us to follow what we are supposed to do for that resident. When asked if the care plan documents an intervention and the intervention is not followed, is that following the care plan, LPN #3 stated, no.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on

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7/6/2022 at 4:29 p.m.

No further information was provided prior to exit.

9. The facility staff failed to implement the comprehensive care plan for activities for Resident #105's.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/29/2022, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. Resident #105 (R105) was coded as making themselves understood and understanding others. In Section E - Behaviors, the resident was not coded as having had any behaviors during the look back period. In Section G - Functional Status, the resident was coded as requiring supervision with set up help only for walking in the room, walking in the hallway, locomotion on the unit and locomotion off the unit.

Resident #105 resided on a locked unit.

The comprehensive care plan dated, 1/10/2022, documented in part, "Focus: (R105) enjoys country music, spades, news, outdoors, church, TV, computer and talking...Needs opportunities to pursue his interests." The "Interventions" documented. "Assist in planning and/or encourage to plan own leisure time activities. Encourage participation in group activities of interest. Provide supplies/materials for leisure activities as needed/requested."

The Recreational Services note dated, 11/22/2021, documented in part, "Resident

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admitted to the facility...he enjoys movies, cards, religious programs and TV."
The Recreational Services note dated, 2/17/2022 documented in part, "He pursues independent activities in room and is out to dialysis 3 days/week. He voices no need for additional activity supplies."
The Recreational Services note dated, 5/2/2022, documented in part, "No changes in activity interests. Current goal to be continued over next 90 days."

The Behavioral Symptoms Assessment, dated, 6/2/2022, documented in part: a check mark was documented next to, "Agitation, irritability, or hyperactivity." Exit seeking or wandering without intent or purpose was not checked.

An interview was conducted with LPN (licensed practical nurse) #3 on 7/6/2022 at 10:37 a.m. When asked the purpose of the care plan, LPN #3 stated it is there for us to follow what we are supposed to do for that resident. When asked if the care plan documents an intervention and the intervention is not followed, is that following the care plan, LPN #3 stated, "No."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 7/6/2022 at 1:00 p.m. When asked who is responsible for implementing the care plan, ASM #2 stated, nursing. When asked if the care plan says the resident is independent in his activities and the resident resides on a locked unit, is that following the care plan, ASM #2 stated, "It's not as I see it, but they can't go independently."

ASM #1, the administrator, ASM #2, the director

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{F 656}	Continued From page 80 of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/6/2022 at 4:29 p.m. No further information was provided prior to exit.	{F 656}		
F 675 SS=E	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on review of facility's documentation and staff interview, it was determined that the facility failed to promote and enhance each resident's quality of life by allowing residents to maintain the highest degree of practicability of well-being for 4 of 20 residents in the survey sample, Resident #109, #118, #119 and #105. There were 83 of the 169 resident in the facility that were in locked units. These units either had locked doors (which required a code to open) on both ends or were located on the second floor (600 rooms) and the elevator and doors leading to the second floor required a code. Surveyor was provided code to unlock doors or elevator when asked for the code. A review of the 50 resident records of residents located on the second floor unit (600 rooms) revealed the	F 675	1. Corrective Action Concern forms were generated and resolved on Residents #105,#109,#118, #119 related to the key pads being disarmed. The facility disarmed the key pad on the unit 6 elevator and unit 2 unit doors on 7-6-22. 2. Like Residents/Areas The administrator reviewed the facility floorplan to validate that facility units were accessible to residents in the center based on their careplan. 3. Systemic Change The Regional Director of Operations re-educated the administrator on F675 to include making sure residents can move about the facility without restriction. The Administrator re-educated the IDT team on F675 to include making sure residents can move about the facility without restriction. 4. Monitoring The Administrator/designee will review facility floorplan weekly times 4 weeks and the facility grievance log weekly times 4 weeks to validate no concerns were received related to keypads restricting access of the residents.	8-10-22

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following: 24/50 had no behavioral/elopement assessment and only 1/50 being assessed as exit seeking. A review of the Resident Council minutes dated 4/19/22 revealed the following, "New business-administration: Administrator invited by president to inform residents of new locks and doors."

The findings included:

1. The facility staff failed to allow Resident #109 to attain their highest level of well-being.

Resident #109 was observed waiting for the elevator on 7/5/22 at 3:55 PM. Resident #109 stated, "We are in Alcatraz. This is our home not a prison."

Resident #109 was admitted to the facility on 1/1/21 with diagnosis that included but were not limited to: quadriplegia, chronic kidney disease (CKD) and atherosclerotic cardiovascular disease (ASCVD).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/2/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring total dependence for bed mobility, transfer, dressing, hygiene and bathing; extensive assistance for dressing and supervision for eating. Locomotion is coded as independent.

A review of the comprehensive care plan dated 11/16/19 and revised 6/6/22, which revealed,

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"GOAL: Resident will choose and engage in independent leisure pursuits of interest on a daily basis. INTERVENTIONS: Respect choices in regard to activity participation."

A review of the behavioral assessment for Resident #109 dated 3/25/19 revealed the following "Identified Behavior symptoms: verbal aggression, agitation, irritability or hyperactivity checked. Seriousness of Behavioral Symptom: Patient is threat to himself or others-no, disruptive-no, distressing to self and/or others-no."

An interview was conducted on 7/6/22 at 11:05 AM with LPN (licensed practical nurse) #2. When asked the purpose of the coded elevator, LPN #2 stated, the purpose is to keep the residents safe. When asked if all the residents had been assessed for safety, LPN #2 stated, I am not sure.

An interview was conducted on 7/6/22 at 10:55 AM with Resident #109. When asked if he was able to move throughout the facility freely, Resident #109 stated, no, this is like Alcatraz, I do not have any control of getting off of this floor without the staff coming to enter the code. They will not give us the code.

An interview was conducted on 7/6/22 at 1:00 PM with ASM (administrative staff member) #2, the director of nursing. When asked the purpose of the locked units, ASM #2 stated, "We have had an unusual number of elopements reported to the state, any patient that could leave the facility without a LOA (leave of absence) order and it is unsafe to do so. There is a door that takes you out in the parking lot." When asked what

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assessments are completed to determine if a resident requires placement on a locked unit, ASM #2 stated, "What we do have is a behavior assessment, if they have had behaviors they would have a behavior assessment. The security is designed so that all they need to do is to ask staff to get out. There are sign out books on each unit." When asked if a resident has not been assessed as a risk, why would the resident not be allowed that independence, ASM #2 stated, "It is because the residents would share the codes. We do not give the code to the resident. I believe it would lengthen your time to get off the unit since they have to ask the staff for the code." When asked if a resident says they want to come and go are they offered another room placement, ASM #2 stated, no, they are not. When asked how many residents on the 600 hall were assessed as exit seeking, ASM #2 stated, "I am not sure how many on the 600 hall are exit seeking. I will have to check on that." When asked how this impacts the residents ability for choice and rights, ASM #2 stated, "Other than the reasons I have already stated, I do not have anything else to offer."

An interview was conducted on 7/6/22 at 1:59 PM with ASM #2, the director of nursing. When asked who was responsible to the locked units, ASM #2 stated, that was not nursing, that was a plant operations. When asked who the plant operations contact is, ASM #2 stated, the administrator. When asked what discussions nursing has with plant operations regarding resident rights and independence, ASM #2 stated, "I state my case or speak for resident's rights, generally I would think the administrator would take it up to corporate. We discussed it thoroughly with the Ombudsman, another

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gentleman from another building. We need to do it for residents who are at risk. I personally did not want the locks, but I do not know that I specifically said that. I do not know that that I came down that hard. There are four residents on the 600 hall that are exit seeking." When asked their names, ASM #2 stated the resident names, Resident #120 and three other residents. When ASM #2 was informed that only Resident #120 had a behavior assessment that listed exit seeking as a behavior, ASM #2 stated, "These are the names I was given."

An interview was conducted on 7/6/22 at 2:43 PM with ASM #1, the administrator. When asked to tell us about the locked units, ASM #1 stated, they are not units for elopement risks, like the arcadia unit. We punch in a code for any resident that wants to come off the unit. Residents do not all have same cognition. They do not abide by the LOA policy and procedure. I have had to report quite a few elopements. If you want to go shopping, go with the activities department. Residents are free to come and go as you please. When asked do you consider the resident as independent if they have to have someone enter a code for them to leave the unit. ASM #1 stated, "Yes." When asked would you consider this as independent in your home, ASM #1 stated, "Yes, I have to enter a code to go into one of my rooms in my home." When asked what discussion does plant operations have with nursing regarding resident rights and independence, ASM #1 stated, "Yes, I am the one who talked with corporate. We are committed to making the elevator accessible to all residents at all time as long as they are appropriate to go down on the elevator and sign out in the book on each unit. Generally the residents just talk with the nurse

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and let them know where they are going. Anyone can have an acute episodic event, and we want to make sure that the resident is secure. We have seen residents elope from the facility and are doing our best to make sure the residents stay safe." When asked if behavior /exit seeking assessments were done on all residents on those locked units, ASM #1 stated, "No, we would not do elopement assessments on everyone because of an acute episodic events, those are completely unexpected and unpredictable. You cannot tell that something is not going to happen tomorrow that will not put the resident in harm's way."

On 7/6/22 at approximately 4:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate quality assurance coordinator were made aware of the findings.

According to the facility's policy "Interdisciplinary Care Planning/Resident Rights/Person Centered Care/Quality of Life" dated 3/2018, which reveals, "Comprehensive Care Planning Requirements: The care plan must describe the following: the services that are to be furnished to maintain the patient's highest practicable physical, mental and psychosocial well-being."

No further information was provided prior to exit.

2. The facility staff failed to allow Resident #118 to attain their highest level of well-being.

Resident #118 was admitted to the facility on 7/18/18 with diagnosis that included but were not limited to: Parkinson's disease, lymphedema and hypertension

The most recent MDS (minimum data set)

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assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/16/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as independent for bed mobility, transfer, walking, locomotion, eating, hygiene and bathing; limited assistance for dressing.

A review of the comprehensive care plan dated 11/16/19, which revealed, "GOAL: Resident will participated in independent leisure activities of choice daily. INTERVENTIONS: Assist in planning/encourage to plan own leisure-time activities."

A review of the Resident #118's medical record found there was no behavioral assessment completed.

An interview was conducted on 7/6/22 at 11:05 AM with LPN (licensed practical nurse) #2. When asked the purpose of the coded elevator, LPN #2 stated, the purpose is to keep the residents safe. When asked if all the residents had been assessed for safety, LPN #2 stated, I am not sure.

An interview was conducted on 7/6/22 at 10:50 AM with Resident #118. When asked if he was able to move throughout the facility freely, Resident #118 stated, No, I have to wait for a staff person to enter the code. I can push the down button, but the door won't open until the staff comes to enter the code. We are not allowed to have the code. I don't understand why."

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An interview was conducted on 7/6/22 at 1:00 PM with ASM (administrative staff member) #2, the director of nursing. When asked the purpose of the locked units, ASM #2 stated, "We have had an unusual number of elopements reported to the state, any patient that could leave the facility without a LOA (leave of absence) order and it is unsafe to do so. There is a door that takes you out in the parking lot." When asked what assessments are completed to determine if a resident requires placement on a locked unit, ASM #2 stated, "What we do have is a behavior assessment, if they have had behaviors they would have a behavior assessment. The security is designed so that all they need to do is to ask staff to get out. There are sign out books on each unit." When asked if a resident has not been assessed as a risk, why would the resident not be allowed that independence, ASM #2 stated, "It is because the residents would share the codes. We do not give the code to the resident. I believe it would lengthen your time to get off the unit since they have to ask the staff for the code." When asked if a resident says they want to come and go are they offered another room placement, ASM #2 stated, no, they are not. When asked how many residents on the 600 hall were assessed as exit seeking, ASM #2 stated, "I am not sure how many on the 600 hall are exit seeking. I will have to check on that." When asked how this impacts the residents ability for choice and rights, ASM #2 stated, "Other than the reasons I have already stated, I do not have anything else to offer."

An interview was conducted on 7/6/22 at 1:59 PM with ASM #2, the director of nursing. When asked who was responsible to the locked units,

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ASM #2 stated, that was not nursing, that was a plant operations. When asked who the plant operations contact is, ASM #2 stated, the administrator. When asked what discussions nursing has with plant operations regarding resident rights and independence, ASM #2 stated, "I state my case or speak for resident's rights, generally I would think the administrator would take it up to corporate. We discussed it thoroughly with the Ombudsman, another gentleman from another building. We need to do it for residents who are at risk. I personally did not want the locks, but I do not know that I specifically said that. I do not know that that I came down that hard. There are four residents on the 600 hall that are exit seeking." When asked their names, ASM #2 stated the resident names, Resident #120 and three other residents. When ASM #2 was informed that only Resident #120 had a behavior assessment that listed exit seeking as a behavior, ASM #2 stated, "These are the names I was given."

An interview was conducted on 7/6/22 at 2:43 PM with ASM #1, the administrator. When asked to tell us about the locked units, ASM #1 stated, they are not units for elopement risks, like the arcadia unit. We punch in a code for any resident that wants to come off the unit. Residents do not all have same cognition. They do not abide by the LOA policy and procedure. I have had to report quite a few elopements. If you want to go shopping, go with the activities department. Residents are free to come and go as you please. When asked do you consider the resident as independent if they have to have someone enter a code for them to leave the unit. ASM #1 stated, "Yes." When asked would you consider this as independent in your home, ASM #1 stated, "Yes, I

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have to enter a code to go into one of my rooms in my home." When asked what discussion does plant operations have with nursing regarding resident rights and independence, ASM #1 stated, "Yes, I am the one who talked with corporate. We are committed to making the elevator accessible to all residents at all time as long as they are appropriate to go down on the elevator and sign out in the book on each unit. Generally the residents just talk with the nurse and let them know where they are going. Anyone can have an acute episodic event, and we want to make sure that the resident is secure. We have seen residents elope from the facility and are doing our best to make sure the residents stay safe." When asked if behavior /exit seeking assessments were done on all residents on those locked units, ASM #1 stated, "No, we would not do elopement assessments on everyone because of an acute episodic events, those are completely unexpected and unpredictable. You cannot tell that something is not going to happen tomorrow that will not put the resident in harm's way."

On 7/6/22 at approximately 4:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate quality assurance coordinator were made aware of the findings.

According to the facility's policy "Interdisciplinary Care Planning/Resident Rights/Person Centered Care/Quality of Life" dated 3/2018, which reveals, "Comprehensive Care Planning Requirements: The care plan must describe the following: the services that are to be furnished to maintain the patient's highest practicable physical, mental and psychosocial well-being."

No further information was provided prior to exit.

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3. The facility staff failed to allow Resident #119 to attain their highest level of well-being.

Resident #119 was admitted to the facility on 2/26/21 with diagnosis that included but were not limited to: right above the knee amputation, diabetes mellitus and chronic obstructive pulmonary disease.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/22/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; supervision for eating and independent in locomotion.

A review of the comprehensive care plan dated 2/27/21, which revealed, "GOAL: Resident will improve functional mobility. Resident will actively participate in group events of interest daily. INTERVENTIONS: Assist in planning/encourage to plan own leisure-time activities."

A review of the Resident #119's medical record found there was no behavioral assessment completed.

An interview was conducted on 7/6/22 at 11:05 AM with LPN (licensed practical nurse) #2. When asked the purpose of the coded elevator, LPN #2 stated, the purpose is to keep the residents safe. When asked if all the residents had been assessed for safety, LPN #2 stated, I am not

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sure.

An interview was conducted on 7/6/22 at 10:50 AM with Resident #119. When asked if he was able to move throughout the facility freely, Resident #119 stated, "No, I have to wait for a staff person to enter the code. I can push the down button, but the door won't open until the staff comes to enter the code. We are not allowed to have the code. I don't understand why."

An interview was conducted on 7/6/22 at 1:00 PM with ASM (administrative staff member) #2, the director of nursing. When asked the purpose of the locked units, ASM #2 stated, "We have had an unusual number of elopements reported to the state, any patient that could leave the facility without a LOA (leave of absence) order and it is unsafe to do so. There is a door that takes you out in the parking lot." When asked what assessments are completed to determine if a resident requires placement on a locked unit, ASM #2 stated, "What we do have is a behavior assessment, if they have had behaviors they would have a behavior assessment. The security is designed so that all they need to do is to ask staff to get out. There are sign out books on each unit." When asked if a resident has not been assessed as a risk, why would the resident not be allowed that independence, ASM #2 stated, "It is because the residents would share the codes. We do not give the code to the resident. I believe it would lengthen your time to get off the unit since they have to ask the staff for the code." When asked if a resident says they want to come and go are they offered another room placement, ASM #2 stated, no, they are not. When asked how many residents on the 600 hall were

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assessed as exit seeking, ASM #2 stated, "I am not sure how many on the 600 hall are exit seeking. I will have to check on that." When asked how this impacts the residents ability for choice and rights, ASM #2 stated, "Other than the reasons I have already stated, I do not have anything else to offer."

An interview was conducted on 7/6/22 at 1:59 PM with ASM #2, the director of nursing. When asked who was responsible to the locked units, ASM #2 stated, that was not nursing, that was a plant operations. When asked who the plant operations contact is, ASM #2 stated, the administrator. When asked what discussions nursing has with plant operations regarding resident rights and independence, ASM #2 stated, "I state my case or speak for resident's rights, generally I would think the administrator would take it up to corporate. We discussed it thoroughly with the Ombudsman, another gentleman from another building. We need to do it for residents who are at risk. I personally did not want the locks, but I do not know that I specifically said that. I do not know that that I came down that hard. There are four residents on the 600 hall that are exit seeking." When asked their names, ASM #2 stated the resident names, Resident #120 and three other residents. When ASM #2 was informed that only Resident #120 had a behavior assessment that listed exit seeking as a behavior, ASM #2 stated, "These are the names I was given."

An interview was conducted on 7/6/22 at 2:43 PM with ASM #1, the administrator. When asked to tell us about the locked units, ASM #1 stated, they are not units for elopement risks, like the arcadia unit. We punch in a code for any resident

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that wants to come off the unit. Residents do not all have same cognition. They do not abide by the LOA policy and procedure. I have had to report quite a few elopements. If you want to go shopping, go with the activities department. Residents are free to come and go as you please. When asked do you consider the resident as independent if they have to have someone enter a code for them to leave the unit. ASM #1 stated, "Yes." When asked would you consider this as independent in your home, ASM #1 stated, "Yes, I have to enter a code to go into one of my rooms in my home." When asked what discussion does plant operations have with nursing regarding resident rights and independence, ASM #1 stated, "Yes, I am the one who talked with corporate. We are committed to making the elevator accessible to all residents at all time as long as they are appropriate to go down on the elevator and sign out in the book on each unit. Generally the residents just talk with the nurse and let them know where they are going. Anyone can have an acute episodic event, and we want to make sure that the resident is secure. We have seen residents elope from the facility and are doing our best to make sure the residents stay safe." When asked if behavior /exit seeking assessments were done on all residents on those locked units, ASM #1 stated, "No, we would not do elopement assessments on everyone because of an acute episodic events, those are completely unexpected and unpredictable. You cannot tell that something is not going to happen tomorrow that will not put the resident in harm's way."

On 7/6/22 at approximately 4:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate quality assurance coordinator were made aware of the findings.

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According to the facility's policy "Interdisciplinary Care Planning/Resident Rights/Person Centered Care/Quality of Life" dated 3/2018, which reveals, "Comprehensive Care Planning Requirements: The care plan must describe the following: the services that are to be furnished to maintain the patient's highest practicable physical, mental and psychosocial well-being."

No further information was provided prior to exit.
4. The facility staff failed to allow Resident #105 to attain their highest level of well-being.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/29/2022, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. Resident #105 (R105) was coded as making themselves understood and understanding others. In Section E - Behaviors, the resident was not coded as having had any behaviors during the look back period. In Section G - Functional Status, the resident was coded as requiring supervision with set up help only for walking in the room, walking in the hallway, locomotion on the unit and locomotion off the unit.

An interview was conducted with R105 on 7/6/2022 at 11:05 a.m. When asked how he gets off the unit, R105 stated they have to get a staff member to put in the code and open the door. When asked if the staff would give them the code to open the door, R105 stated, "No, it's like we are in a prison."

The Recreational Services note dated,

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11/22/2021, documented in part, "Resident admitted to the facility...he enjoys movies, cards, religious programs and TV."
The Recreational Services note dated, 2/17/2022 documented in part, "He pursues independent activities in room and is out to dialysis 3 days/week. He voices no need for additional activity supplies."
The Recreational Services note dated, 5/2/2022, documented in part, "No changes in activity interests. Current goal to be continued over next 90 days."

The Behavioral Symptoms Assessment, dated, 6/2/2022, documented in part: a check mark was documented next to, "Agitation, irritability, or hyperactivity." Exit seeking or wandering without intent or purpose was not checked.

The comprehensive care plan dated, 1/10/2022, documented in part, "Focus: (R105) enjoys country music, spades, news, outdoors, church, TV, computer and talking...Needs opportunities to pursue his interests." The "Interventions" documented. "Assist in planning and/or encourage to plan own leisure time activities. Encourage participation in group activities of interest. Provide supplies/materials for leisure activities as needed/requested."

An interview was conducted with ASM #2, the director of nursing, on 7/6/2022 at 1:00 p.m. When asked why are the doors locked. ASM #2 stated the facility has had an unusual number of elopements reported to the state. It's an added security for patients, it's for any patient that leaves the facility. Residents that leave the facility without an LOA order, would be considered an elopement. When asked how the facility

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F 675	Continued From page 96 assesses the resident that need to be in an environment that is more secured, ASM #2 stated they assess through a behavioral assessment. When asked about residents on Station 2, ASM #2 stated if the resident has indicated behaviors, they would have an assessment. When asked if resident that reside on that unit (Station 2) and don't have behaviors, is that impacting them, that it's locked, ASM #2 stated the security is designed to let us be aware of where the residents are. When asked if a resident asked for the code, could they get it, ASM #2 stated, generally speaking, codes are shared. A resident is not allowed to be given the code. When asked if that infringes upon a resident's ability to attain their highest level of well-being, it would lessen the resident's time to get off the unit, ASM #2 stated this is not a secured unit, it's for the resident's safety. The residents can still go off the unit, they just need to ask. When asked if all of the residents on Station 2 considered an elopement risk, ASM #2 stated, no, Ma'am. When asked but you have them on a locked unit ASM #2 stated, yes. When asked why the residents can't go independently about the facility, ASM #2 stated, "I have nothing else to offer other that what I have already stated." ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/6/2022 at 4:29 p.m. No further information was provided prior to exit.	F 675		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	{F 684}	1.Corrective Action Resident #104 fluid restriction orders were updated so that licensed nurses can document validation of fluid intake each shift.	

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{F 684}	Continued From page 97 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to monitor a resident's fluid intake when the resident was ordered for a fluid restriction for one of 20 residents in the survey sample, Resident #104. Resident #104 (104) had a physician's order for a fluid restriction, but the staff did not document and monitor the resident's fluid intake. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/23/22, R104 was coded as having no cognitive impairment for making daily decisions. R104 was unavailable for interview during the survey. A review of R104's clinical record revealed the following order, dated 6/14/22: "Fluid restriction - total: 1500 mls (milliliters)/24 hours." A review of R104's MARs (medication administration records), TARs (treatment administration records), and POC (point of care) task records failed to review evidence of R104's fluid intake in any 24 hour period from 7/1/22	{F 684}	2. Like Residents/Areas The Director of Nursing/designee has reviewed residents with fluid restrictions to validate orders related to fluid intake monitoring each shift. 3.Systemic Change The Director of Nursing/designee has reeducated licensed nurses on the documentation of fluid intake validation for fluid restriction patients. 4. Monitoring The Director of Nursing/designee will audit patients with fluid restriction orders weekly times 4 weeks to ensure that documentation is present regarding fluid intake validation.	8-10-22

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{F 684}	Continued From page 98	{F 684}		

through 7/5/22.

Further review of R104's clinical record revealed a fluid restriction worksheet dated 6/14/22. This worksheet contained the following instructions: "Fluids Ordered 1500 mls...Fluid allocation nursing...Total fluid/24 hours: Nursing 240...Days 240, Evenings 180, Nights 120...Fluid allocation dietary...Total fluid/24 hours: Dietary 960." There were no specifications for how much fluid should be provided by dietary for each shift.

A review of R104's care plan, dated 5/22/19 and updated 10/31/19, revealed, in part: "Renal (kidney) insufficiencies related to ESRD (end stage renal disease)...Fluid restriction as ordered."

On 7/6/22 at 1:53 p.m., LPN (licensed practical nurse) #4 was interviewed. She stated she is aware R104 has an order for a fluid restriction. She stated she did not know how much fluid was allowed for each shift, but she could look it up. When asked where she documents R104's fluid intake, she stated: "It is on the MAR (medication administration record)." After looking at R104's MAR for July 2022, she stated: "Well, it's not here." She stated the fluid amounts were previously documented each shift on R104's MAR. She stated each shift nurse had documented how much fluid the resident took in. She stated: "I was just used to doing it, but I don't see the amounts anywhere."

On 7/6/22 at 1:00 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked how a resident's fluid intake on a fluid restriction is tracked, she stated the dietician writes the recommendation. She

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{F 684}	Continued From page 99	{F 684}		

stated dietary provides their amount on the resident's meal tray, and nursing provides their amount through medication passes. She stated she did not know where to look to see how much fluid a resident took in on a particular shift or a particular day.

On 7/6/22 at 2:00 p.m., ASM #2 stated that based on facility policy, fluid restrictions are entered as a total per 24 hours. She stated the dietician makes the recommendation for amounts each shift, but this information does not go on the MAR or TAR. She stated: "It can be viewed, but there is no documentation for it." When asked if this concern had been identified during facility audits during recent plan of correction implementation, she stated: "The only thing an audit can show is whether or not there is a fluid restriction."

On 7/6/22 at 3:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality assurance coordinator, were informed of these concerns. When asked about the fluid restriction documentation, ASM #3 stated there should be a fluid restriction worksheet completed by the dietician. This assessment tells the nurse how much fluid can be given to a resident on a shift.

On 7/7/22 at 9:08 a.m., ASM #3 stated she had received clarification on the fluid restriction documentation. She stated the fluid restriction worksheet tells the staff the amount of fluid a resident may receive. She stated: "The expectation is the resident does not receive more than that amount. We document by exception."

A review of the facility policy, "Hydration Quick

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{F 684}	Continued From page 100 Reference Guide," revealed no information related to documenting and monitoring a resident's fluid intake. No further information was provided prior to exit.	{F 684}		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to maintain a safe environment for one of 20 residents in the survey sample, Resident #107. The facility staff failed to remove a pack of cigarettes from Resident #107's (R107's) bedside table on two days of the survey, 7/5/22 and 7/6/22. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/31/22, R107 was coded as being moderately impaired for making daily decisions. On the most recent comprehensive MDS, an admission assessment with an ARD of	{F 689}	1.Corrective Action The smoking materials were removed in resident #107 room on 7-6-22. The facility reviewed the smoking guidelines with resident #107. 2.Like Residents/Areas The Director of Nursing/designee inspected resident rooms to validate that no smoking materials were present. 3. Systemic Change The Administrator/designee has reeducated facility staff on the smoking guidelines to include that no smoking materials should be present in the patient rooms. 4. Monitoring The Administrator/designee will audit resident rooms weekly times 4 weeks to validate that no smoking materials are present.	8-10-22

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8/21/21, R107 was coded as having no current tobacco use.

On the following dates and times, R107 was observed sitting up in bed: 7/5/22 at 3:27 p.m. and 4:16 p.m.; 7/7/22 at 8:50 a.m. and 11:40 a.m. At each observation, a pack of cigarettes was located on R107's bedside table, within the resident's reach.

On 7/6/22 at 11:43 a.m., R107 was asked about the cigarettes. She stated she had not smoked "in a while," but felt like she could use a cigarette at that moment. She stated she had not smoked in her room, and opened the pack of cigarettes. It was full.

A review of R107's clinical record revealed a Smoking Evaluation dated 8/4/21. Review of this document revealed, in part: "Determination: Safe Smoker: Capable and safe, requires no assistance to smoke - NO...Secure smoking materials at nurses' station or other designated area for storage."

A review of R107's care plan dated 8/6/21 and updated 8/18/21 revealed, in part: History of smoking in community/Inappropriate smoking...will remain compliant with center smoking procedure and individual smoking restrictions...secure smoking materials at nurses' station or other designated area for storage."

On 7/6/22 at 11:45 a.m., LPN (licensed practical nurse) #3, who was caring for R107, was asked to check R107's room for cigarettes. LPN #3 went in R107's room and returned to the nurse station holding the pack of cigarettes. She stated R107 was not supposed to have cigarettes at the

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{F 689}	Continued From page 102 bedside. She stated cigarettes at the resident's bedside is unsafe. She stated all cigarettes are supposed to be kept in a box at the nurse station, and kept there until the resident smoke breaks outside. She stated she had previously noticed the cigarettes at R107's bedside. On 7/6/22 at 1:00 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated residents are not allowed to have cigarettes in their room. She stated this is a safety precaution in order to prevent residents harming themselves or anyone else. On 7/6/22 at 3:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality assurance coordinator, were informed of these concerns. A review of the facility policy, "Smoking Guidelines," revealed, in part: "Retention, storage, and distribution of smoking accessories are to be kept under the control of center staff when not in use. This includes cigarettes, pipes, lighters, matches, lighter fluid, electronic cigarettes, etc. Staff members distribute smoking accessories to patients at center designated smoking times." No further information was provided prior to exit.	{F 689}		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 760	1. Corrective Action An incident report was created for resident 102 2.Like Resdients/Areas The Director of Nursing/designee has reviewed patients in the center with cardiac medicaitons with parameters to validate orders.	

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F 760	Continued From page 103 by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure one of 20 residents in the survey sample were free of a significant medication error, Resident #102 (R102). The findings include: On the most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/6/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired to make daily decisions. The physician order dated, 3/3/2022, documented, "Carvedilol Tablet - Coreg (used to treat high blood pressure and heart disease) (1) 3.125 MG (milligrams) - give 1 tablet by mouth every 12 hours every Tue (Tuesday), Thu (Thursday), Sat (Saturday), Sun (Sunday) for HTN (hypertension - high blood pressure) Hold for SBP (systolic blood pressure) < (less than) 120." The May 2022 MAR (medication administration record) documented the above order. On the following days and times, the medication was administered with the documented blood pressure: 5/1/2022 at 8:00 p.m. - 117/70 5/5/2022 at 8:00 a.m. - 117/71 5/7/2022 at 8:00 a.m. - 104/66 5/7/2022 at 8:00 p.m. - 107/67 5/8/2022 at 8:00 a.m. - 114/68 5/12/2022 at 8:00 a.m. - 112/78 5/14/2022 at 8:00 p.m. - 118/74	F 760	3. Systemic Change The Director of Nursing/designee has reeducated the licensed nurses on the medication administration guidelines to include following physician orders related to parameters. 4. Monitoring The Director of Nursing/designee will audit 5 residents with cardiac medication parameters weekly times 4 weeks to validate adherence to parameters.	8-10-22

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F 760	Continued From page 104 5/15/2022 at 8:00 p.m. - 112/73 5/17/2022 at 8:00 a.m. - 110/68 5/22/2022 at 8:00 p.m. - 108/72 5/28/2022 at 8:00 p.m. - 116/72 5/31/2022 at 8:00 p.m. - 80/55 Review of the May 2022 nurse's notes failed to evidence documentation regarding holding of the above blood pressures and doses of medication given. The June 2022 MAR documented the above order. On the following days and times, the medication was administered with the documented blood pressure: 6/5/2022 at 8:00 a.m. - 102/68 6/16/2022 at 8:00 a.m. - 95/56 6/23/2022 at 8:00 a.m. - 107/62 Review of the June 2022 nurse's notes failed to evidence documentation regarding holding of the above blood pressures and doses of medication given. The July 2022 MAR documented the above order. On the following day and time, the medication was administered with the documented blood pressure: 7/5/2022 at 8:00 p.m. - 118/77. Review of the July 2022 nurse's notes failed to evidence documentation regarding holding of the above blood pressure and dose of medication given. The comprehensive care plan dated, 8/18/2021, documented in part, "Focus: Cardiac disease related to HTN, heart failure." The "Interventions" documented in part, "Administer medication per	F 760		

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physician orders."

An interview was conducted with RN (registered nurse) #1 on 7/6/2022 at 10:08 a.m. When asked if a medication has a parameter attached to the order, what the nurse is to do, RN #1 stated if it's a blood pressure medications, the nurse should take the blood pressure first and based on the reading, give or not give the medication. When asked if it isn't given, what steps should the nurse take, RN #1 stated that if the nurse holds the medication, then they need to notify the resident, family and the doctor and document it in the progress notes.

An interview was conducted with LPN (licensed practical nurse) #3 on 7/6/2022 at 10:37 a.m. LPN #3 was asked to review the above order and MARS. When asked the process for administering this medication, LPN #3 stated you have to take the blood pressure first. Based on the reading you either give it or don't give it. LPN #3 stated that most of the time, the resident doesn't get it. When asked where that is documented, LPN #3 stated if you don't give it you go to a progress note and document it.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 7/6/2022 at 1:00 p.m. When asked the process for the nurse if a medication has parameters, ASM #2 stated if there is a parameter to check the blood pressure, then you check the blood pressure. If the reading is outside of the parameters, the nurse should follow the doctor's order. ASM #2 stated that since there are parameters, then there is no need to notify the doctor unless the reading is really out of whack.

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An interview was conducted with ASM #4, the nurse practitioner, on 7/6/2022 at 4:16 p.m. When asked why there are parameters for a blood pressure medication, ASM #4 stated it was because the biggest side effect is what it's supposed to do, lower the blood pressure, and it can go too low. ASM #4 stated what is supposed to be an advantage can be a disadvantage. When asked what the implications are when the blood pressure goes too low, ASM #4 stated, it's another illness all together. We are creating another problem for them (the resident), they can bottom out. ASM #4 stated we are trying to treat high blood pressure and cause low blood pressure, we can kill the patient. When asked about R102, ASM #4 stated R102 typically runs low, he needs the Coreg for his heart failure, not trying to turn him the other way, we are trying to get his blood pressure even.

The facility policy, "Medication and Treatment Administration Guidelines" documented in part, "Medications and treatments administered are documented immediately following administration or per state specific standards. Vital signs are taken and recorded prior to the administration of vital sign dependent medications in accordance with medical practitioner's orders. Medications not administered according to medical practitioner's orders are reported to the attending medical practitioner and documented in the clinical record including the name and dose of the medication
and reason the medication was not administered. The licensed nurse is responsible for validating documentation is completed for any medication administered during the shift."

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F 760	Continued From page 107 ASM #1, the administrator, ASM #2, ASM #3, the quality assurance consultant, were made aware of the above concern on 7/6/2022 at 4:29 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697042.html.	F 760		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to maintain sufficient dietary staff to meet the needs of the residents at the lunch meal	F 802	1. Corrective Action The dietary staff working on 7-5-22 were reeducated on recipe compliance. 2.Like Residents/Areas The Dietary Manger has validated menus to ensure that menu item ingredients are available. The schedules were also reviewed to ensure adequate dietary staff is present. 3.Systemic Changes The Administrator has reeducated the dietary manager on F802 to ensure adequate staff is present each day. 4.Monitoring The Dietary manager/designee will review dietary schedules weekly times 4 weeks to validate adequate staffing levels.	8-10-22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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on 7/5/22 in one of one facility kitchens. There was insufficient staff from the dietary department working at lunch on 7/5/22, resulting in residents' receiving food which had not been prepared according to the therapeutic menu and recipe.

The findings include:

On 7/5/22 at 12:01 p.m., lunch service from the tray line in the kitchen was observed. At 12:27 p.m., the employee serving the lunch used a white scoop to serve turkey/rice mixture. The mixture was primarily rice, with small pieces of onion, mushroom, red and yellow pepper, and broccoli. Tiny bits of turkey could be seen in the rice mixture, as well. The turkey pieces were smaller in diameter than a thumbnail. The employee placed less than a full scoop onto each resident's Styrofoam tray. OSM (other staff member) #5, the temporary dietary manager, was asked how much volume a white scoop served. OSM #5 stated the white scoop was a six ounce serving. When asked if the turkey/rice stir fry mixture was a full six ounces, he stated: "No, it's not." When asked how much turkey was supposed to be served to each resident as a part of the turkey/rice stir fry, he stated: "Two ounces of meat." When asked if residents were being served a full two ounces of turkey in each serving of turkey/rice stir fry, he stated: "No, that's not two ounces of meat." OSM #5 and OSM #6 worked together to prepare another steam table pan of "stir fry." They placed pre-cooked white rice in the commercial steamer. They poured a bag of frozen mixed vegetables in a pan and placed it in the commercial steamer. OSM #6 began cutting a pre-cooked turkey breast into larger bite-size chunks. When the rice and vegetables had finished cooking in the steamer, they added the

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turkey chunks and vegetables to the rice, and stirred them together. At no time did OSM #5 or #6 add soy sauce or other seasonings to the rice and vegetables. OSM #5 replaced the turkey/rice stir fry mixture on the steam table, and served a new white scoop full portion to R116's Styrofoam container.

A review of the facility menu for lunch on 7/6/22 revealed, in part: "Regular: Turkey Stir Fry 2 oz (ounces) [turkey]...6 oz [total serving]...1/2 cup brown rice, Japanese vegetables."

A review of the recipe for Turkey Stir Fry 2 Oz revealed, in part: "Combine soy sauce, cornstarch, and pepper in a bowl. Pulled turkey meat [ounces determined by number of resident servings] Dice turkey and add to soy mixture. Cover and refrigerate for 20 minutes. Hold at 41 [degrees] F (Fahrenheit) or lower...Combine chicken stock, soy sauce, corn start, and ginger, set aside...Japanese Vegetable Blend [ounces determined by number of servings]...Coat tilt skillet with vegetable oil spray, heat. Place vegetable in tilt skillet, stir fry for 3 minutes. Add cooked vegetables and soy mixture. Cook stirring over low heat for 3 minutes. Internal temperature of final product must reach at least 165 for 15 seconds. Hold at minimum required temperature or higher."

On 7/6/22 at 2:11 p.m., OSM #5 was interviewed. When asked the process for following the prescribed menu and recipe for resident meals, he stated the company supplying the food provides the approved recipe. The cook is responsible for following the recipe. He stated when he and OSM #6 prepared the turkey/rice stir fry, there was not a trained cook in the

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F 802	Continued From page 110 kitchen. He stated he did not follow the recipe because he did not have time. He stated when he arrived at the facility at 9:00 a.m., no one else was in the kitchen. He stated the staff "just did not show up." He stated he did not have time to do any of the normal process for preparing the lunch. He stated the staff member serving the resident Styrofoam trays was not even a dietary staff member. He stated he was aware the residents were not receiving enough of the turkey. He said there is no scale to weigh the turkey anywhere in the kitchen. On 7/6/22 at 3:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality assurance coordinator, were informed of these concerns. A review of the facility policy, "F Tag 802 - Sufficient Dietary Support Personnel," failed to reveal anything other than the language contained in the federal regulations. No further information was provided prior to exit.	F 802		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed;	F 803	1. Corrective Action Resident #116 was assesed by the dietician to validate dietary interventions. 2.Like Residents/Areas The Dietary Manager reviewed the menus to ensure items were available to provide appropirate nutrition to each resident. 3.Systemic Change The Dietary Manager/designee has reeducated the dietary staff on F803 to ensure adequate portions are served with each meal. 4. Monitoring The Dietary Manager/designee will audit 5 resident trays weekly times 4 weeks to validate appropriate diet and portions are present.	8-10-22

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§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;

§483.60(c)(5) Be updated periodically;

§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow the menu for one of 20 residents in the survey sample, Resident #116 (R116).

The facility staff failed to serve R116 the recommended amount of turkey/rice stir fry on 7/5/22, and failed to prepare the turkey/rice stir fry according to the approved recipe.

The findings include:

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/27/22, R116 was coded as being moderately impaired for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status).

A review of R116's physician's orders revealed

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F 803	Continued From page 112	F 803		

the following order dated 6/22/22: "Regular diet, regular texture."

On 7/5/22 at 12:01 p.m., lunch service from the tray line in the kitchen was observed. At 12:27 p.m., the employee serving the lunch used a white scoop to serve turkey/rice mixture. The mixture was primarily rice, with small pieces of onion, mushroom, red and yellow pepper, and broccoli. Tiny bits of turkey could be seen in the rice mixture, as well. The turkey pieces were smaller in diameter than a thumbnail. The employee placed less than a full scoop onto each resident's Styrofoam tray. OSM (other staff member) #5, the temporary dietary manager, was asked to open R116's Styrofoam tray. OSM #5 was asked how much volume a white scoop served. OSM #5 stated the white scoop was a six ounce service. When asked if the turkey/rice stir fry mixture was a full six ounces, he stated: "No, it's not." When asked how much turkey was supposed to be served to each resident as a part of the turkey/rice stir fry, he stated: "Two ounces of meat." When asked if R116's tray contained two ounces of turkey, he stated: "No, that's not two ounces of meat." OSM #5 instructed OSM #6, a dietary aide, to prepare additional turkey to add to the turkey/rice stir fry mixture. OSM #5 and OSM #6 worked together to prepare another steam table pan of "stir fry." They placed pre-cooked white rice in the commercial steamer. They poured a bag of frozen mixed vegetables in a pan and placed it in the commercial steamer. OSM #6 began cutting a pre-cooked turkey breast into larger bite-size chunks. When the rice and vegetables had finished cooking in the steamer, they added the turkey chunks and vegetables to the rice, and stirred them together. At no time did OSM #5 or #6 add soy sauce or

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other seasonings to the rice and vegetables. OSM #5 replaced the turkey/rice stir fry mixture on the steam table, and served a new white scoop full portion to R116's Styrofoam container.

A review of R116's care plan dated 6/27/22 revealed, in part: "[R116] is at risk for nutrition/hydration imbalance r/t (related to multiple medical dx (diagnoses), adult FTT (failure to thrive), dementia, lung cancer with malignancy...provide/serve diet as ordered."

A review of the facility menu for lunch on 7/6/22 revealed, in part: "Regular: Turkey Stir Fry 2 oz (ounces) [turkey]...6 oz [total serving]...1/2 cup brown rice, Japanese vegetables."

A review of the recipe for Turkey Stir Fry 2 Oz revealed, in part: "Combine soy sauce, cornstarch, and pepper in a bowl. Pulled turkey meat [ounces determined by number of resident servings] Dice turkey and add to soy mixture. Cover and refrigerate for 20 minutes. Hold at 41 [degrees] F (Fahrenheit) or lower...Combine chicken stock, soy sauce, corn start, and ginger, set aside...Japanese Vegetable Blend [ounces determined by number of servings]...Coat tilt skillet with vegetable oil spray, heat. Place vegetable in tilt skillet, stir fry for 3 minutes. Add cooked vegetables and soy mixture. Cook stirring over low heat for 3 minutes. Internal temperature of final product must reach at least 165 for 15 seconds. Hold at minimum required temperature or higher."

On 7/6/22 at 2:11 p.m., OSM #5 was interviewed. When asked the process for following the prescribed menu and recipe for resident meal, he stated the company supplying the food provides

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F 803	Continued From page 114 the approved recipe. The cook is responsible for following the recipe. He stated when he and OSM #6 prepared the turkey/rice stir fry, there was not a trained cook in the kitchen. He stated he did not follow the recipe because he did not have time. He stated when he arrived at the facility at 9:00 a.m., no one else was in the kitchen. He stated the staff "just did not show up." He stated he did not have time to do any of the normal process for preparing the lunch. He stated the staff member serving the resident Styrofoam trays was not even a dietary staff member. He stated he was aware the residents were not receiving enough of the turkey. He said there is no scale to weigh the turkey anywhere in the kitchen. On 7/6/22 at 3:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality assurance coordinator, were informed of these concerns. A review of the facility policy, "Portion Control Equipment," revealed, in part: "Identify portion control equipment needed by checking recipes and the diet spreadsheet...Set the food slicer to give uniform size servings of foods such as meats, tomatoes and cucumbers...Review serving sizes on recipes and menus with staff before meal preparation and service." No further information was provided prior to exit.	F 803		
{F 804} SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides-	{F 804}	1. Corrective Action The dietary staff on 7-5 and 7-6 were reeducated on F804 to ensure meals are prepared in a palatable manner and at preferred temps. 2.Like Residents/Areas The Dietary Manager has reviewed the facility monthly menu to validate all items are available.	

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{F 804}	Continued From page 115 §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to serve food at a palatable taste and temperature from one of one kitchen. The food on the test tray at the lunch meal on 7/5/22 was unpalatable in both taste and temperature. The findings include: On 7/5/22 at 12:01, observation was made of the lunch serving line in the kitchen. At approximately 12:54 p.m., OSM (other staff member) #5, the temporary dietary manager, instructed OSM #6, a dietary aide, to prepare additional turkey for a new pan of turkey/rice stir fry mixture. OSM #5 and OSM #6 worked together to prepare another steam table pan of "stir fry." They placed pre-cooked white rice in the commercial steamer. They poured a bag of frozen mixed vegetables in a pan and placed it in the commercial steamer. OSM #6 began cutting a pre-cooked turkey breast into larger bite-size chunks. When the rice and vegetables had finished cooking in the steamer, they added the turkey chunks and vegetables to the rice, and stirred them together. OSM #6 placed a sanitary thermometer in this new turkey/rice stir fry dish before it was placed directly in the steam table for service. The temperature was 138.5 [degrees Fahrenheit]. At 1:30 p.m., a test tray was requested. The test tray	{F 804}	3.Systemic Change The Food Service Director/designee will reeducate the facility cooks on F804 to ensure that meals are prepared in a palatable manner and temp. 4. Monitoring The Food Service Director/designee will complete a test tray audit weekly times 4 weeks.	8-10-22

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{F 804}	Continued From page 116	{F 804}		

was served at 1:33 p.m. The test tray contained a serving of turkey/rice stir fry from the above referenced steam table prepared at 12:54 p.m. The test tray also included a hot dog (holding temperature of 165); hamburger (holding temperature of 164), mashed potatoes (holding temperature of 178.5), pureed beef (heated in the microwave as an individual portion to 184), and pureed stir fry (heated in the microwave as an individual portion to 190). The test tray left the kitchen at 1:35 p.m., and arrived on the unit at 1:39 p.m. The last tray from the meal cart was served at 2:05 p.m., and at 2:06 p.m., OSM #5 obtained the following food temperatures: regular turkey/rice stir fry - 88.3; grilled cheese sandwich - 86.6; puree stir fry 90.1, hot dog - 89.5, hamburger - 91.5, puree beef - 94.6, and mashed potatoes - 99.2, puree rice - 88.3. The food was taste and temperature tested by two surveyors and OSM #5. All of the food was too cold to be palatable. The mashed potatoes were overly starchy and without any potato flavor. The grilled cheese sandwich was burned black on one side, and was soggy. OSM #5 agreed with these assessments of the taste and temperature of the food.

On 7/6/22 at 2:11 p.m., OSM #5 was interviewed. He stated when he and OSM #6 prepared the turkey/rice stir fry, there was not a trained cook in the kitchen. He stated he did not follow the recipe because he did not have time. He stated when he arrived at the facility at 9:00 a.m., no one else was in the kitchen. He stated the staff "just did not show up." He stated he did not have time to do any of the normal process for preparing the lunch meal because he did not have enough staff.

On 7/6/22 at 3:54 p.m., ASM (administrative staff

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{F 804}	Continued From page 117 member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality assurance coordinator, were informed of these concerns. A review of the facility policy, "Customer Service - Meal Satisfaction," revealed, in part: "Food and Drinks - Each resident receives, and the facility provides (1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (2) Food that is palatable, attractive, and at a safe and appetizing temperature..." No further information was provided prior to exit.	{F 804}		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to honor the resident's food preferences for two of 20 residents in the survey sample, Residents #115 and #102. The findings include:	F 806	1. Corrective Action Resident #102 and #115 food preferences were updated. 2. Life Residents/Areas The facility reviewed/updated resident food preferences. 3.Systemic Change The Dietary Manager/designee reeducated the dietary staff on the review and implementation of food preferences listed on the residents dietary cardex. 4.Monitoring The Dietary Manager/designee will audit 5 resident trays weekly times 4 to validate preferences are honored.	8-10-22

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1. The facility staff failed to provide Resident #115 (R115) double portions per the resident's preference at lunch on 7/5/22.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/13/22, R115 was coded as being moderately impaired for making daily decisions, having scored 10 out of 15 on the BIMS (brief interview for mental status).

A review of R115's clinical record revealed the following order dated 9/30/21: "Regular diet. Regular texture for nutrition, double entree portions per preference."

On 7/5/22 at 12:01 p.m., lunch service from the tray line in the kitchen was observed. At 12:27 p.m., the employee serving the lunch used a white scoop to serve turkey/rice mixture. The mixture was primarily rice, with small pieces of onion, mushroom, red and yellow pepper, and broccoli. Tiny bits of turkey could be seen in the rice mixture, as well. The turkey pieces were smaller in diameter than a thumbnail. The employee placed less than a full scoop onto each resident's Styrofoam tray. OSM (other staff member) #5, the temporary dietary manager, was asked to open R115's Styrofoam tray, which had already been served and placed on the meal cart going to the floor. OSM #5 was asked how much volume a white scoop served. OSM #5 stated the white scoop was a six ounce service. When asked if the turkey/rice stir fry mixture was a double portion, he stated: "No, it's not." When asked if R116 was supposed to receive a double portion, OSM #5 checked R115's meal preferences and stated: "Yes." OSM #5 instructed

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another staff member to serve R115's tray an additional white scoop of turkey/rice stir fry.

A review of R115's care plan dated 8/5/21 and updated 4/13/22 revealed, in part: "[R115] has the potential for nutrition/hydration imbalance...Excessive caloric intake...large portions per preference...provide/serve diet as ordered...honor food preference."

On 7/6/22 at 2:11 p.m., OSM #5 was interviewed. When asked the process for following a resident's food preferences, he stated that either the dietary manager or dietician assesses and documents the resident's food preferences around the time the resident is first admitted. He stated the resident's meal ticket contains information regarding the resident's food preferences. He stated R115's meal ticket contained the information regarding her preference for double/large portions. He stated the staff member serving lunch on 7/5/22 was not a dietary department employee, and was not reading the meal tickets at all to determine food preferences. He stated there were not enough staff members to double check the resident trays for accuracy on 7/5/22.

On 7/6/22 at 3:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality assurance coordinator, were informed of these concerns.

A review of the facility policy, "Food Preferences," revealed, in part: "Patients may be visited by the food service director, dietetics professional, registered dietitian or designee on admission, during regular meal rounds or as needed to

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 120 determine food preferences...This information is entered into Dietary eKardex. Dislikes and allergies/sensitivities print on the tray card for reference during meal service...Patient requests for specific foods to be served on a regular basis are entered under extra items preferences in the Dietary eKardex meal profile. Items can be entered for any combination of meals and days. The specific meal preferences will print on the tray card for reference during meal service. The Dietary eKardex Extra Items Tally report can be referenced to determine the number of tray line extras or items served in addition to the menu." No further information was provided prior to exit. 2. The facility staff failed to honor Resident #102's preference for foods served. On the most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/6/2022, Resident #102 (R102) scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired to make daily decisions. An interview was conducted with R102 on 7/5/2022 at 2:55 p.m. When asked about the food, the resident stated his breakfasts are not good. They get served white bread, not toasted. eggs and if available a small bowl of cereal. R102 stated they would like the eggs, either hard boiled or fried. They would like toast in the morning, not white untoasted bread. R102 stated the jelly falls off the toast making it very hard to eat. R102 stated they are a dialysis patient and is a diabetic and needs to eat something substantial	F 806	1.Corrective Action The stove and food warmer were cleaned. The items identified in the walk in freezer	

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F 806	Continued From page 121	F 806		

before going to dialysis three times a week. R102 stated he only gets two turkey sandwiches for dinner most nights. They stated they do not eat beef or pork.

A request was made on 7/5/2022 at 5:00 p.m. to ASM (administrative staff member) #1, the administrator, for a copy of the resident's food preferences and their meal ticket from their dietary food system.

Observation was made on 7/6/2022 at 8:00 a.m. of R102 sitting up in the wheelchair, no breakfast. The resident had to leave the facility at 8:45 a.m. for dialysis. Breakfast arrived at 8:08 a.m. The breakfast consisted of two pieces of white bread, untoasted, two hard boiled eggs, a container of milk, a container of cranberry juice, and a small bowl of bran cereal. R 102 stated he couldn't eat the bran cereal if he was going to be sitting on a dialysis machine for three hours. When the CNA (certified nursing assistant) opened the hard boiled eggs, they were not fully cooked and runny. When asked what they got for dinner last night, R102 stated they got two turkey sandwiches. They stated what happened to tuna salad or chicken salad. R102 stated they get two peanut butter and jelly sandwiches to go with them on dialysis days, but wondered if there was something other than turkey and peanut butter and jelly. R102 stated they missed getting vegetables. They like vegetables. When asked if they got anything else with the turkey sandwiches, R102 stated, no.

The menu was reviewed on 7/6/2022 at approximately 9:00 a.m. On 7/5/2022 for dinner, pork was to be served. The alternate was fish.

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F 806	Continued From page 122	F 806		

The comprehensive care plan dated, 5/28/2021, documented in part, "Focus: (R102) Has the potential for nutrition/hydration imbalance r/t (related to) multiple medical dx (diagnoses)." The "Interventions" documented in part, "Honor food preferences."

The "Patient Summary" documented the following:
Diet - regular
Fluid restriction - none
Beverages - Grape or Apple Juice
Extra Items - oatmeal, tuna or chicken salad sandwich, toast, yogurt, eggs scram (scrambled)
Additional Directions - early breakfast tray
Dislikes: sausage, gravy, red meat, Pork, bacon, beef ground, grilled cheese sandwich, corned beef, meatballs, meatloaf, and sloppy joe.
Special Instructions: Turkey sandwich or salad as alternate to main meal.

An interview was conducted with OSM (other staff member) #5, the temporary dietary manager, on 7/6/2022 at 2:10 p.m. When asked how resident food preferences are handled, OSM #5 stated the dietician or dietary manager puts them in the system, it's not (initials of electronic charting system). When asked if there are other sandwiches available except peanut butter and jelly and turkey, such as tuna salad or chicken salad, OSM #5 stated the facility had chicken salad in house and was unsure if they had tuna salad in house. When asked if there was a problem with the toaster, OSM #5 stated it was broken before he got there and a new on is on order. When asked if the two slice toaster observed by another surveyor during the kitchen observation was used to make toast, OSM #5 stated, no Ma'am. When asked when the toaster

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F 806	Continued From page 123	F 806		

broke, OSM #5 stated he didn't know but the new one is coming on 7/14/2022 he believed. When asked if the staff could toast bread in the oven, OSM #5 stated, "That is a possibility." When asked what information is on the meal tickets, OSM #5 stated, the diet, texture, dislikes and allergies. When asked who is responsible for that, OSM #5 stated the cook is. When asked who is responsible for the resident to get the alternate when there is a dislike or allergy, OSM #5 stated it's normally the first person on the tray line who puts the order up. OSM #5 was asked to review the "Patient Summary" document for R102. When asked if the resident would automatically get the alternate if the dinner was one of the resident's dislikes, OSM #5 stated, yes. When asked does the paper tell you to give this resident a turkey sandwich every night, OSM #5 stated, "That's an alternate to the main meals. When asked if he knew R102, OSM #5 stated, no. When asked how often preferences are done, OSM #5 stated he truly didn't know.

On 7/6/2022 at 4:43 p.m. OSM #5 returned and stated he had met with R102. OSM #5 stated the resident expressed to him he likes boiled eggs and fried eggs. He doesn't like red meat or pork. OSM #5 stated he asked the resident about pancakes and the resident stated he liked them. OSM #5 stated the resident informed him that no one has spoken to him about his preferences for food. OSM #5 presented a "Food and Beverage Preference List" dated 7/6/2022, completed by OSM #5. Review of this document provided revealed the resident had only the following dislikes of food:
Roast beef, hamburger, meatloaf, hot dogs, pork chops, pork roast, ham, lamb, veal, liver, sausage, bacon, and cream of wheat, grits, and

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F 806	Continued From page 124 no bran cereal. Special food requests documented, "pancakes, French toast, waffles." Documented for dialysis days, "Breakfast: Toast, 2 fried eggs. Lunch: 2 PB&J (peanut butter and jelly)." The other notes documented, "Likes salads." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/6/2022 at 4:29 p.m. No further information was provided prior to exit.	F 806		
{F 812} SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	{F 812}	1. Corrective Action The Stove and food warmer were cleaned. The items identified in the walk in refrigerator and walk in freezer were immediatly removed. 2.Like Residents/Area The Administrator has completed an audit of the kitchen to validate cleanliness and food storage guidelines. 3. Systemic Change The Dietary Manger has reeducated the dietary staff on daily cleaning tasks and appropriate food storage. 4.Monitoring The Dietary Manager will audit the kitchen for cleanliness and food storage weekly times 4 weeks.	8-10-22

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{F 812}	Continued From page 125	{F 812}		

Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to prepare and store food in a sanitary manner in one of one kitchen. The stove top and inside of the warmer were dirty, and expired, unlabeled items were stored in both the walk in refrigerator and walk in freezer.

The findings include:

On 7/5/22 at 10:36 a.m., observation was made of the kitchen. OSM (other staff member) #5, the temporary dietary manager, was part of the observation process. The stove contained heavy amounts of debris on the stove top and in the wells of the burners. Some of the debris was burned on; some of the debris was greasy; some of the debris was composed of particles of old food; some of the debris was the consistency of ash. The bottom of the food warmer contained heavy amounts of cooked on food and debris. OSM #5 stated both the stove and the warmer were available for use. OSM #5 stated the stove was not clean. He stated he has only been at the facility for a week, and was not aware the stove had been cleaned since he arrived. He stated he had not even opened the bottom of the warmer to check for cleanliness. He agreed that the warmer was not clean. He stated the stove should be cleaned a minimum of once a week, and the warmer should be wiped out daily, and cleaned at least once a week. The walk in refrigerator contained a quart of chicken salad dated 6/28/22; a two quart steam table pan of beef vegetable soup dated 6/29/22; a quart of canned tomatoes dated 6/29/22, and an open, undated bag of five romaine lettuce heads. The walk in freezer contained an open, undated bag of three loaves of garlic bread. OSM #5 stated all food should be

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{F 812}	Continued From page 126 dated and labeled when placed in the refrigerator and freezer. He stated the aides for the evening meal are responsible for throwing out expired food before they leave for the evening. He stated there have been no dietary aides at the facility for the last two evenings. On 7/6/22 at 3:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality assurance coordinator, were informed of these concerns. A review of the facility policy, "Storage of Food," revealed, in part: "Store food and stock products in National Sanitation Foundation approved sanitary storage containers with lids, or in food quality plastic bags, and label as to contents and date where appropriate....Discard food that has exceeded the expiration date or when use-by date is unclear..." A review of the facility policy, "Range Cleaning Procedure," revealed, in part: "Be sure to wipe up any spills or boil-overs immediately. This prevents soils from baking on and will make cleaning easier...Lift grates from stove top. Remove hard soil from grates with dull metal scraper or brush. Scrub grates in pot sink, run through dish machine and air dry...Remove hard soil from stationary parts with dull metal scraper or brush. Remove control knobs and clean behind them. Empty drip pan and clean." No further information was provided prior to exit.	{F 812}		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)	F 814	1. Corrective Action The facility dumpster area was cleaned and tops closed on 7-6-22.	

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F 814	Continued From page 127 §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility failed to maintain dumpsters in a sanitary manner for two of two dumpsters. Both dumpsters were uncovered, and two bags of trash were on the ground outside the dumpsters. Multiple vinyl gloves were on the ground around the dumpsters. The findings include: On 7/5/22 at 11:52 a.m., observation was made of the two facility dumpsters. OSM (other staff member) #5, the temporary dietary manager, was present during the observation. Both dumpsters were open to air. A bag of kitchen trash was on the ground by the left dumpster. A bag of trash containing wipes, disposable briefs, and vinyl gloves was on the ground by the right dumpster. Multiple single vinyl gloves were scattered around and between both dumpsters. OSM #5 stated: "Uh oh. Those dumpsters should be closed." He stated the bags of trash and the scattered vinyl gloves should have been placed in the dumpsters. He stated the open dumpsters and bags of trash on the ground were "not sanitary," and could attract animals. On 7/6/22 at 3:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality assurance coordinator, were informed of these concerns. A review of the facility policy, "F Tag 814 - Dispose of Garbage and Refuse Properly," failed	F 814	2. Like Residents/Areas The Administrator has inspected the dumpster area to validate cleanliness and items for cleaning are readily available. 3.Systemic Change The Dietary Manager/designee will reeducated the dietary staff on F814 to include disposing of garbage properly and keeping the dumpster area clean. 4.Monitoring The Administrator/designee will audit the dumpster area weekly times 4 weeks to validate cleanliness.	8-10-22

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F 814	Continued From page 128 to reveal anything other than the language contained in the federal regulations. No further information was received prior to exit.	F 814		