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	495398	A. BUILDING _____ B. WING _____	06/23/2022

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/21/2022 through 6/23/2022. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/21/2022 through 6/23/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code report will follow. The census in this sixty certified bed facility was 56 at the time of the survey. The survey sample consisted of fourteen (14) current resident reviews and two (2) closed record reviews.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		8/2/22

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

Electronically Signed | 07/07/2022

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F 656	Continued From page 1 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of sixteen residents in the survey sample. Resident #10 had no care plan regarding chronic lower extremity edema and use of support hose and/or wraps for management of lymphedema. The findings include: Resident #10 was admitted to the facility with diagnoses that included lymphedema, pneumonia, peripheral venous insufficiency,	F 656	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged	

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F 656	Continued From page 2 obesity, hypertension, congestive heart failure, COPD (chronic obstructive pulmonary disease) and respiratory failure. The minimum data set (MDS) dated 3/28/22 assessed Resident #10 as cognitively intact. On 6/21/22 at 2:35 p.m., Resident #10 was observed seated in a wheelchair in his room. The resident's lower legs were wrapped with elastic gauze dressings. Dry, scaly skin was visible on the toes of both feet. Resident #10 stated at this time that the wraps helped with swelling in his legs and he had experienced swelling in his feet/legs "for a long time." Resident #10's clinical record documented a current physician's order dated 5/26/22 for TED support hose on each morning and off each evening. The clinical record documented the resident had lymphedema of the lower legs with open wounds on the left foot/ankle. There was no order documented for use of the tubular gauze dressings. Resident #10's plan of care (revised 5/3/22) included no problems, goals and/or interventions regarding lymphedema or lower extremity edema. There was no mention the resident required and/or used TED support hose or any type of elastic dressings for management of the swelling. On 6/22/22 at 1:52 p.m., the director of nursing (DON) was interviewed about Resident #10's plan of care. The DON stated the clinical leaders that included the MDS coordinator, DON and wound nurse were responsible for care plan development. The DON stated the resident's lower extremity swelling and current interventions for management of the edema should have been	F 656	deficiencies cited have been or will be corrected by the date or dates indicated. 1. Resident #10 care plan has been reviewed and revised to include a chronic lower extremity edema and the use of treatment of lymphedema date 06/24/2022. Nursing will be educated on following the resident□s individualized plan of care for lower extremity edema and the use of support hose and/or wrap. 2. All residents are risk of not having comprehensive care-plan. 3. The DON or designee will educate licensed nurse on completing comprehensive person center care-plan 4. A)The DON or designee will review all current resident care plan who have lower extremity edema weekly x 4 weeks, findings will be reviewed quarterly through the center QAPI process. B) The DON or designee will review all current resident who have support hose and/or wraps to ensure they are present and proper application 3 x a week for 2 weeks, then monthly x 2. Findings will be reviewed quarterly through the center QAPI process. 5. Date of compliance August 2nd, 2022	

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F 656	Continued From page 3 included in the plan of care. This finding was reviewed with the administrator, DON and regional nurse consultant during a meeting on 6/22/22 at 1:30 p.m.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to follow physician orders for two of sixteen residents in the survey sample. Resident #10 had elastic tubular bandages in use for over two weeks without a physician's order. Resident #212 was not administered a medication as ordered by the physician. The findings include: 1. Resident #10 was admitted to the facility with diagnoses that included lymphedema, pneumonia, peripheral venous insufficiency, obesity, hypertension, congestive heart failure, COPD (chronic obstructive pulmonary disease) and respiratory failure. The minimum data set (MDS) dated 3/28/22 assessed Resident #10 as	F 684	1.Resident #10 physician order updated to include treatment of lymphedema on 6/24/22. Resident #212 medication was administered as order on 6/21/22. LPN #1 re-educated on medication administration policy that includes pulling medication from stat box. 2. All residents are risk of physician order note being followed or implemented. 3.The DON or designee will educate licensed nurse on the Medication Administration policy. 4.A) The DON or designee will review 10% of resident□s physician ordered treatment of lymphedema to ensure proper application of treatment 3 x a week for 2 weeks, then monthly x 2. Findings will be reviewed quarterly through the center QAPI process.	8/2/22

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F 684	Continued From page 4 cognitively intact. On 6/21/22 at 2:35 p.m., Resident #10 was observed seated in a wheelchair in his room. The resident's lower legs were wrapped with elastic gauze dressings. There were red/brownish stains scattered near the bottom of the wraps. Dry, scaly skin was visible on the toes of both feet. Resident #10 stated at this time that the wraps helped with swelling in his legs and he had experienced swelling in his feet/legs "for a long time." Resident #10's clinical record documented no order for the tubular gauze wraps observed on the resident on 6/21/22. The record documented a current physician's order dated 5/26/22 for TED support hose on each morning and off each evening. The clinical record documented the resident had lymphedema of the lower legs with open wounds on the left foot/ankle. The record documented a physician's order dated 4/1/22 to clean the left ankle wound with saline, Xeroform and dry dressing three times per week and an order dated 6/20/22 to clean the left foot wound with saline, Xeroform and dry dressing three times per week. Resident #10's treatment administration record for May 2022 and June 2022 included no order for the tubular gauze wraps. Nurses had signed off from 5/27/22 through 6/20/22 that TED support hose were applied each morning and off each evening. The clinical record documented no problems with the TED hose and made no mention of when or why the tubular gauze wraps were applied. A wound consultant report dated 6/20/22	F 684	B) The DON or designee will complete medication pass observation 2 x week x 12 weeks to ensure proper administration of physician ordered medication. 5.Date of compliance August 2nd, 2022	

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F 684	Continued From page 5	F 684		

documented the resident had a lymphademic wound on the left, lateral ankle and a venous ulcer on the left, dorsal foot. Recommended treatments included the Xeroform gauze with dry dressings three times per week. The wound consultation report of 6/20/22 made no mention and/or recommendation regarding TED support hose or the tubular gauze wraps.

On 6/22/22 at 8:30 a.m., Resident #10 was observed in bed. The resident had the tubular gauze wraps in place on both lower legs. Dry scaling skin was observed on the resident's toes.

On 6/22/22 at 10:54 a.m., the licensed practical nurse (LPN) #2 caring for Resident #10 was interviewed about the leg wraps and TED support hose. LPN #2 stated the resident usually had white colored wraps on the lower legs but she was not sure if they were support (TED) hose or wraps. LPN #2 reviewed the resident's clinical record and stated there was a current order for TED hose but no order for the gauze wraps.

On 6/22/22 at 10:56 a.m., accompanied by LPN #2, Resident #10 was observed in bed. There were no wraps or hose on the lower legs. The lower legs/feet were swollen with dry, flaky skin visible on the legs and the surrounding bed sheet. Dressings were in place on the two left foot wounds. Resident #10 stated at this time that the wound nurse had just removed the wraps.

On 6/22/22 at 11:02 a.m., LPN #3 responsible for wound care was interviewed about Resident #10's legs/feet. LPN #3 stated the resident had "tubigrip" wraps in place on his lower legs. LPN #3 stated the nurse practitioner ordered TED support hose for the resident on 5/26/22 but the

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largest size available was too tight. LPN #3 stated the resident's skin was dry and peeling and she did not want the skin to pull when removing TED hose. LPN #3 stated she did not know who initiated the tubular gauze wraps for the resident. LPN #3 stated she had not notified the nurse practitioner about the problems with the TED hose. LPN #3 reviewed the clinical record and stated there was no order for the tubular gauze wraps. LPN #3 stated she did not know how long the "tubigrip" wraps were used by the resident. LPN #3 stated she removed the wraps today (6/22/22) because the regional consultant thought the gauze wraps were contraindicated for the resident's condition of dry, scaling skin.

On 6/22/22 at 11:12 a.m., Resident #10 was interviewed again about the tubular gauze wraps. Resident #10 stated he used the support hose for awhile but the gauze wraps had been used for "at least several weeks." Resident #10 stated the nurses changed them at times but he did not recall the frequency. Resident #10 stated nurses changed the dressings on his foot wounds three times per week but did not always change the wraps when the wounds were dressed. The resident stated nurses pulled up the bottom portion of the wraps to change/apply the wound dressings.

On 6/22/22 at 11:17 a.m., LPN #4 that routinely cared for Resident #10 was interviewed. LPN #4 stated she cared for the resident yesterday (6/21/22) and the tubular gauze wraps were in place. LPN #4 reviewed the clinical record and stated she saw no order for the wraps.

On 6/23/22 at 8:04 a.m., the DON stated she worked the floor on 6/4/22 and 6/5/22 and

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Resident #10 had TED support hose in use during that weekend. The DON stated she talked with the nurses that had cared for the resident since then and an agency nurse reported the TED hose became soiled so he removed and replaced them with the elastic tubular gauze. The DON stated the agency nurse should have contacted the provider and obtained an order prior to use of the tubular gauze. The DON stated the other nurses interviewed stated they knew the resident had something in place on his legs but did not verify that the TED hose were in use and no one had questioned the use of the tubular gauze dressings. The DON stated the tubular gauze dressings most likely had been in use since 6/6/22.

These findings were reviewed with the administrator, director of nursing (DON) and regional nurse consultant during a meeting on 6/22/22 at 1:30 p.m.

2. Resident #212's diagnoses included, acute kidney disease, morbid obesity, high blood pressure, hypothyroidism, osteoarthritis, and gout.

The resident's most recent MDS (minimum data set) was an admission assessment dated 06/21/22 (still in progress). The resident was assessed as having a cognitive score of 15, indicating the resident was intact for daily decision making.

On 06/22/22 at 8:15 AM, a medication pass and pour was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 prepared medications for Resident #212. The LPN prepared eight pills, a

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medicated gel, and Miralax for Resident #212. After the LPN had completed this, the medications were confirmed by name and number of pills with LPN#1. The LPN administered the medications to Resident #212.

At approximately 8:50 AM, the medication reconciliation for Resident #212 was completed. The resident's current physician's orders revealed an order for, "Allopurinol Tablet 300 MG Give 1 tablet by mouth one time a day for Gout...Active (order date) 06/21/2022 (start date)06/22/2022..." LPN #1 did not administer an Allopurinol 300 mg tablet to Resident #212 during the medication pass and pour observation.

The resident's MARs (medication administration records) were then reviewed. LPN #1 had signed off/initialed that the Allopurinol tablet had been administered, when the medication had not.

At approximately 9:00 AM, LPN #1 was asked to review the medications administered to Resident #212 against the physician's orders and the empty pill packs for confirmation. The LPN stated, "What are you looking for?" The LPN was made aware that the resident had a medication listed on the physician's order set that was not administered. The LPN stated, "Allopurinol?" The LPN was made aware that was the medication in question. The LPN stated that, that was a new medication and that it's been ordered. The LPN stated that it was ordered yesterday and she didn't have it to give and she would have to go to the medication room to get it from the stock box. The LPN was asked why was the medication signed off as administered when in fact it was not. The LPN stated, "I guess I was clicking too fast" and then stated that she had just

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F 684	Continued From page 9 went back and unchecked it. The LPN did not provide a response as to why the medication was not retrieved and administered during the medication pass and pour observation. The LPN looked in the resident's pill pack bag for the following day 06/23/22 and stated that the medication was not in that bag to be administered either and wasn't sure why the medication was not delivered. The LPN then went to the stock room, retrieved three 100 mg tablets of Allopurinol and stated, "She will get three to equal 300 mg." The LPN then took the medication to Resident #212 and administered the medication. At approximately 11:00 AM, a policy was requested on medication administration and following physician orders. The policy titled, "Medication Administration" documented, "...If a medication is unavailable, contact the pharmacy and document accordingly...return to the medication cart and document medication with initials on the medication administration record immediately after administering medication to each resident..." On 06/22/22 at approximately 1:45 PM, the administrator, DON (director of nursing) and the corporate nurse were made aware of the above information in a meeting with the survey team. No further information and/or documentation was presented prior to the exit conference on 06/23/22.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		8/2/22

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F 686	Continued From page 10 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to perform skin assessments for 1 of 16 residents in the survey sample, Resident #9. Resident #9 who was identified as being at risk for the development of pressure ulcers did not have a weekly skin assessment completed. The findings include: Resident #9 was admitted to the facility with diagnoses that included stage 4 pressure ulcer to the buttock, adult failure to thrive, GERD, vitamin d deficiency, type 2 diabetes, stage 2 chronic kidney disease, aphasia, and enteral feeding (tube feeding). The most recent minimum data set (MDS) dated 03/25/22 was a significant change and assessed Resident #9 as severely impaired for daily decision making with a score of 4 out of 15. Under Section G - Functional Status, the MDS assessed Resident #9 as total dependent with one personal physical assistance for transfers, dressing, hygiene, bathing, locomotion, and toileting and extensive	F 686	1. Resident #9 body audit completed 6/22/22. 2. All residents are risk of not having skin assessment completed. 3. The DON or Designee will educate licensed nurses on skin assessment policy. 4. The DON or Designee will audit 10% of resident body audit to ensure completion 3 x a week for 2 weeks, then monthly x 2. Findings will be reviewed quarterly through the center QAPI process. 5. Date of compliance August 2nd, 2022	

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assistance with one person physical assistance for eating and bed mobility. Under Section M - Skin Conditions, the MDS assessed Resident #9 as at risk for pressure ulcers/injuries.

Resident #9's electronic medical record (EMR) was reviewed on 06/21/22. Observed on the order summary report was the following: "Pro Stat AWC (Advanced Wound Care) two times a day for Altered skin integrity. Prostat AWC 30 ml (milliliters) twice daily, flush with water 100 cc before and after. Order Date: 01/15/2022. Start Date: 01/16/2022."

Resident #9's care plans included a focus area for pressure ulcer/skin integrity including goals and interventions that included, "...administer treatments as ordered and monitor for effectiveness. Resident needs monitoring..."

Observed on the "Assessment Tab" in Resident #9's EMR was the following "Next Assessment Due: Body Audits: 5 days overdue - 6/17/2022." A review of the body audits documented the last body audit/skin assessment was completed on 06/10/2022. The clinical record included the most recent "Braden Scale For Predicting Pressure Score Risk" dated 06/21/2022 that documented Resident #9 was at moderate risk for pressure scores with a score of 14.

On 06/22/2022 at 11:23 a.m., the licensed practical nurse (LPN #2) who routinely provided care for Resident #9 was interviewed about the body audits/skin assessments. LPN #2 stated skin assessments were completed weekly and Resident #9's skin assessments were scheduled on each Friday during the 3 p.m.- 11 p.m. shift. LPN #2 was asked how staff was notified and/or

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F 686	Continued From page 12 reminded the assessments were due. LPN #2 stated the EMR system would alert the nurse when the assessments were due. LPN #2 was advised Resident #9's EMR showed an alert that the body audits/skin assessment was overdue as of 6/17/2022. LPN #2 reviewed Resident #9's EMR and stated the body audit was past due. On 06/22/2022 at 1:44 p.m., the above findings were reviewed during a meeting with the administrator, DON, and corporate consultant. The facility's staff was asked how often were skin assessments completed. The corporate consultant stated, "it is our expectation and standard of practice they are to be completed weekly." A review of the facility's "Skin Assessment (6/1/21)" policy documented the following: "...1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter..." No additional information was provided to survey team prior to exit on 06/23/2022 at 8:45 a.m.	F 686		
F 814 SS=C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §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, the facility staff failed to ensure waste was properly disposed of in garbage and refuse containers located outside of the main kitchen.	F 814	1. The dumpster was cleaned and all dumpster lids closed and secure on 6/21/22. Re-educated dietary manager on proper disposal of garbage and refuse containers 07/05/2022 2. All residents are at risk of disposal of	8/2/22

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F 814	Continued From page 13 Findings include: On 06/21/22 at 11:00 AM, a tour of the dumpster refuse area outside of the main kitchen was toured with the DM (dietary manager). The facility had two sets of dumpsters. Two for trash and two for cardboard boxes. The two dumpsters for trash were located in an enclosed area. These two dumpsters were observed with their lid/door opened. The DM closed the lid/door to each dumpster. In the enclosed area scattered on the ground, were six plastic gloves and a large piece of a black trash bag laying on the ground. The DM picked them up and stated that housekeeping is responsible for the dumpster area. The other two dumpsters (for cardboard/boxes) were then observed (not enclosed). Observed on the ground around the dumpster was a surgical mask, scattered pieces of paper and debris and small plastic cup. On 06/21/22 at approximately 3:00 PM, the administrator was asked for a policy regarding dumpster/refuse disposal. The policy was presented titled, "Disposal of Garbage and Refuse", which documented, "...properly dispose of kitchen garbage and refuse...garbage shall be disposed of in refuse containers...covered when not in use...refuse containers and dumpsters kept outside the facility shall be designated and constructed to have tightly fitting lids, doors, or covers...covered when not being loaded...surrounding area shall be kept clean...Maintenance Director and Dietary Manager are responsible for monitoring dumpster enclosures and receptacles to make sure they	F 814	garbage if refuse is not clean and maintained. 3. The Administrator or designee will re-educate housekeeping, maintenance and dietary of proper disposal of garbage and maintaining refuse containers. 4. The Administrator or designee will complete audit of garbage refuse area to ensure garbage disposed of properly and refuse is maintained 3 x a week for 2wks, then monthly x 2. Findings will be reviewed quarterly through the center QAPI process. 5. Date of compliance August 2nd, 2022.	

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F 814	Continued From page 14 are clear of debris..." On 06/22/22 at approximately 1:45 PM, the administrator, DON (director of nursing) and the corporate nurse were made aware of the above information in a meeting with the survey team. No further information and/or documentation was presented prior to the exit conference on 06/23/22.	F 814		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		8/2/22

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representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

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F 842	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to ensure an accurate clinical record for one of sixteen residents in the survey sample. Resident #10's clinical record documented use of TED support hose for over two weeks when the hose were not in use. The findings include: Resident #10 was admitted to the facility with diagnoses that included lymphedema, pneumonia, peripheral venous insufficiency, obesity, hypertension, congestive heart failure, COPD (chronic obstructive pulmonary disease) and respiratory failure. The minimum data set (MDS) dated 3/28/22 assessed Resident #10 as cognitively intact. On 6/21/22 at 2:35 p.m., Resident #10 was observed seated in a wheelchair in his room. The resident's lower legs were wrapped with elastic gauze dressings. Dry, scaly skin was visible on the toes of both feet. Resident #10 stated at this time that the wraps helped with swelling in his legs and he had experienced swelling in his feet/legs "for a long time." Resident #10's clinical record documented no order for the tubular gauze wraps in use by the resident on 6/21/22. The record documented a current physician's order dated 5/26/22 for TED support hose on each morning and off each evening. The clinical record documented the resident had lymphedema of the lower legs with open wounds on the left foot/ankle. The record documented a physician's order dated 4/1/22 to	F 842	1. Resident #10 clinical record updated to include discontinuation of TED support hose on 6/21/22 2. All residents have the risk of inaccurate medical record 3. The DON or Designee will re-educate license nurse on complete and accurate medical record documentation and refusal of physician ordered care. 4. The DON or Designee will audit physician ordered support hose or devices to ensure application per physician orders 3 x a week for 2weeks, then monthly x 2. Findings will be reviewed quarterly through the center QAPI process. 5. Date of compliance August 2nd, 2022.	

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clean the left ankle wound with saline, Xeroform and dry dressing three times per week and an order dated 6/20/22 to clean the left foot wound with saline, Xeroform and dry dressing three times per week.

Resident #10's treatment administration record (TAR) for May 2022 and June 2022 included no order for the tubular gauze wraps. Nurses had signed off from 5/27/22 through 6/20/22 that TED support hose were applied each morning and off each evening. The clinical record made no mention of when or why the tubular gauze wraps were applied.

On 6/22/22 at 10:54 a.m., the licensed practical nurse (LPN) #2 caring for Resident #10 was interviewed about the leg wraps and TED support hose. LPN #2 stated the resident usually had white colored wraps on the lower legs but she was not sure if they were support (TED) hose or wraps. LPN #2 reviewed the resident's clinical record and stated there was a current order for TED hose but no order for the gauze wraps. LPN #2 stated she did not know why the TAR indicated TED support hose each day when the wraps were in use.

On 6/22/22 at 11:02 a.m., LPN #3 responsible for wound care was interviewed about Resident #10's legs/feet. LPN #3 stated the resident had "tubigrip" wraps in place on his lower legs. LPN #3 stated the nurse practitioner ordered TED support hose for the resident on 5/26/22 but the largest size available was too tight. LPN #3 stated the resident's skin was dry and peeling and she did not want the skin to pull when removing TED hose. LPN #3 stated she did not know who initiated the tubular gauze wraps for the resident.

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LPN #3 stated she had not notified the nurse practitioner about the problems with the TED hose. LPN #3 reviewed the clinical record and stated there was no order for the tubular gauze wraps. LPN #3 stated she did not know how long the "tubigrip" wraps were used by the resident. LPN #3 stated she removed the wraps today (6/22/22) because the regional consultant thought the gauze wraps were contraindicated due to the resident's dry, scaling skin.

On 6/22/22 at 11:12 a.m., Resident #10 was interviewed again about the tubular gauze wraps. Resident #10 stated he used the support hose for awhile but the gauze wraps had been in use for "at least several weeks." Resident #10 stated the nurses changed them at times but he did not recall the frequency. Resident #10 stated nurses changed the dressings on his foot wounds three times per week but did not always change the wraps when the wounds were dressed.

On 6/22/22 at 11:17 a.m., LPN #4 that routinely cared for Resident #10 was interviewed. LPN #4 stated she cared for the resident yesterday (6/21/22) and the tubular gauze wraps were in place. LPN #4 reviewed the clinical record and stated she saw no order for the wraps. LPN #4 stated she did not know why nurses signed that the TED hose were in use when the wraps were in place.

On 6/23/22 at 8:04 a.m., the DON stated she worked the floor on 6/4/22 and 6/5/22 and Resident #10 had TED support hose in use during that weekend. The DON stated she talked with the nurses that had cared for the resident since then and an agency nurse reported the TED hose became soiled so he removed and

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F 842	Continued From page 19 replaced them with the tubular gauze. The DON stated the agency nurse should have contacted the provider and obtained an order prior to use of the tubular gauze. The DON stated the other nurses interviewed stated they knew the resident had something in place on his legs but did not verify that the TED hose were in use and no one had questioned the use of the tubular gauze dressings. The DON stated the tubular gauze dressings most likely had been in use since 6/6/22 and she had no explanation of why the nurses documented use of the TED hose when they were not in use. These findings were reviewed with the administrator, director of nursing (DON) and regional nurse consultant during a meeting on 6/22/22 at 1:30 p.m.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		8/2/22

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F 880	Continued From page 20 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 21 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to follow infection control protocols during meal distribution on one of three units and failed to follow infection control practices during a medication pass on one of three units. A staff person failed to perform hand hygiene between residents during meal distribution on unit 2. A nurse failed to follow infection control practices during medication preparation on unit 1. The findings include: 1. Meal distribution was observed on 6/21/22 starting at 12:23 p.m. on unit 2. A temporary nurse aide (TNA #1) was observed distributing trays from the meal cart to residents in their rooms. TNA #1 entered room 202 and moved resident items from the bed table, handled the bed remote, unwrapped the utensils and then exited the room. Without any hand hygiene, TNA #1 prepared and served the next tray to room 205. TNA #1 moved this resident's personal items from the bed table, opened food items and touched the resident's utensils during the meal setup. Without performing hand hygiene, TNA #1 retrieved the next tray from the cart and served it to room 204. TNA #1 touched the resident's television remote, unwrapped utensils, opened	F 880	1. Staff re-educated on handwashing procedure with meal tray delivery. LPN#1 re-educated on infection control practices during medication pass. 2. All residents are risk if staff fail to follow infection prevention control standards related to handwashing and medication pass. 3. A) The DON or designee will re-educate licensed nursing on medication administration policy and infection control practice standards. B) The DON or designee will educate all staff on handwashing and meal delivery service. 4.A) THE DON or designee will conduct hand washing/hygiene observations during meal pass 1 time weekly for 12 weeks. Findings will be reviewed in QAPI x 3 months for any trends. B) The DON or designee will conduct 3 random medication observations per week to ensure proper infection control techniques are used weekly x 12 weeks findings will be reviewed quarterly through the center QAPI process. 5. Date of compliance August 2nd, 2022.	

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food containers and then put a straw into the resident's mug. Without hand hygiene, TNA #1 exited the room, retrieved the next lunch tray and served it to the resident in room 207. TNA #1 handled this resident's napkin, straw, applied salt/pepper to food and unwrapped and positioned utensils prior to exiting the room.

On 6/21/22 at 12:39 p.m., TNA #1 was interviewed about hand hygiene between residents. TNA #1 stated she tried to use hand sanitizer between residents. TNA #1 stated she was supposed to use hand sanitizer between contact with residents and/or their personal items.

On 6/22/22 at 1:52 p.m., the facility's registered nurse infection preventionist (RN #1) was interviewed about hand hygiene during meal distribution. RN #1 stated staff members were supposed to perform hand hygiene prior to the start of meal service and were supposed to use hand sanitizer or wash hands between residents. RN #1 stated staff had been educated in June 2022 about the importance of hand hygiene.

The facility's policy Hand Hygiene (dated 6/1/21) documented, "All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors...Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice...Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to...Between resident contacts...After handling contaminated objects..."

This finding was reviewed with the administrator, director of nursing and regional nurse consultant

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during a meeting on 6/22/22 at 1:30 p.m.

2. Resident #212's diagnoses included, acute kidney disease, morbid obesity, high blood pressure, hypothyroidism, osteoarthritis, and gout.

The resident's most recent MDS (minimum data set) was an admission assessment dated 06/21/22 (still in progress). The resident was assessed as having a cognitive score of 15, indicating the resident was intact for daily decision making.

On 06/22/22 at 8:15 AM, a medication pass and pour was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 prepared medications for Resident #212. As LPN #1 began to dispense pills in the medication cup, the LPN dropped one pill onto the medication cart and then picked up the pill with a bare hand and put it into the medication cup. The LPN prepared the remainder of the medications and administered the medications to Resident #212.

At approximately 8:35 AM, LPN #1 was made aware of the above observation. LPN #1 did not provide comment.

At approximately 11:30 AM, a policy was requested on infection control practices during medication administration.

The policy titled, "Medication Administration" documented, "...Never touch any of the medication with fingers..."

The administrator, DON (director of nursing) and corporate nurse were made aware in meeting

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F 880	Continued From page 24 with the survey team on 06/22/22 at approximately 1:30 PM. No further information and/or documentation was presented prior to the exit conference.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-	F 883		8/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495398	A. BUILDING _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DINWIDDIE HEALTH AND REHAB CENTER	46 DIAMOND DRIVE PETERSBURG, VA 23803

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F 883	Continued From page 25 (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on the infection control influenza/pneumococcal immunization review, clinical record review, staff interview and facility document review, the facility staff failed to follow policies and procedures to ensure one of five residents (Resident #8) was offered the influenza vaccine during the 2021-2022 flu season. Findings include: Resident #8's diagnoses included, but were not limited to: Diabetes Mellitus, morbid obesity, anxiety, chronic kidney disease and major depressive disorder.	F 883	1. Resident #8 was offered flu vaccine and consented, will be given during upcoming flu season 2. All residents without the recommended Influenza vaccine are at risk. 3. The DON and designee will educate the licensed nurses on Flu vaccine policy. 4. The DON and designee will review each admission to ensure flu vaccine offered 3 x a week for 2 weeks, then monthly x 2. Findings will be reviewed quarterly through the center QAPI process. 5. Date of compliance August 2, 2022	

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F 883	Continued From page 26	F 883		

The most recent MDS (minimum data set) for Resident #8 was a quarterly assessment dated 03/23/22. This MDS assessed the resident with a cognitive score of 13, indicating the resident was intact for daily decision making skills. In Section O0250. C. If influenza vaccine not received, state reason: documented that the vaccine was "Not offered."

On 06/22/22 at approximately 9:00 AM, a review was conduced of the facility's infection control influenza/pneumococcal immunization program. Five resident's were selected for review.

Of the five resident reviews, it was found that Resident #8 had been admitted to the facility on 03/31/20 and had received an influenza vaccine in the fall of 2020, per the resident's clinical records. The clinical records were further reviewed, but did not reveal that the resident received the influenza vaccine for the October 1 (2021) through March 31 (2022) annual vaccine period.

The resident's clinical records did not evidence that influenza education was provided to the resident and/or family of the resident and did not evidence that a consent/declination had been obtained for Resident #8.

At approximately 11:30 AM, the administrator, DON (director of nursing) and the corporate nurse were asked for assistance in locating any information regarding Resident #8's influenza vaccination status, consent, education and/or refusal.

At approximately 1:15 PM, the corporate nurse stated that they did not have anything for

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F 883	Continued From page 27 Resident #8 to evidence the resident was offered the influenza vaccine. The facility policy titled, "Influenza Vaccination" documented, "...minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents...annual immunizations against influenza...vaccinations will be routinely offered annually from October 1st through March 31st unless medically contraindicated, the individual has already been immunized during this time period, or refuses...will be provided a copy of CDC's current vaccine information...relative to the influenza vaccine...the resident's medical record will include documentation that the resident and/or...representative was provided education...benefits...potential side effects...and that the resident received or did not receive the immunization due to medical contraindication or refusal..." No further information and/or documentation was presented prior to the exit conference on 06/23/22.	F 883		