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	495283	A. BUILDING _____ B. WING _____	R 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL)	1719 BELLEVUE AVENUE RICHMOND, VA 23227

(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 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the federal monitoring survey conducted 05/17/2022 through 05/20/2022, was conducted 07/12/2022 through 07/13/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. No complaints were investigated during the survey. The census in this 128 certified bed facility was 88 at the time of the survey. The survey sample consisted of 15 resident reviews.	{F 000}		
{F 623} SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	{F 623}	1.Corrective Action Resident #114 no longer resides at the facility. 2.Like Residents/Areas The Administrator/Designee will review residents discharged to the acute setting since 7/12 to validate that a written notice was provided to the responsible party. 3.Systemic Change The Director of Nursing/Designee will educate the licensed nursing staff on providing a wirtten notice to the resident's responsible party when discharging to the acute care setting.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/1/22

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

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{F 623}	Continued From page 1 (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for	{F 623}	4. Monitoring The Administrator/Designee will audit residents that discharge to the acute setting weekly times four weeks to validate that the notice was provided to the responsible party. Results of the audits will be reviewed by the QAPI committee.	8-10-22

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{F 623}	Continued From page 2 the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide the resident representative with a completed written notice of a hospital transfer for 1 of 15 residents in the survey sample; Resident #114.	{F 623}		

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{F 623}	Continued From page 3 The facility staff provided an incomplete Notice of Discharge form to the resident representative. None of the listed discharge / transfer options were selected as the reason for the discharge as required, and the date of discharge was not completed. The findings include: Resident #114 was admitted to the facility on 6/20/22. On the most recent MDS (Minimum Data Set) an admission assessment dated 6/25/22, Resident #114 scored a 14 out of a possible 15 on the BIMS (Brief Interview for Mental Status) which indicated the resident was cognitively intact to make daily life decisions. A nurse's note dated 7/6/22 at 4:28 PM documented, "Resident's family was in to visit this shift and called the nurse to the room because the resident was difficult to arouse. Writer entered the room and and called the resident by [their] name and [they] did respond but was slower to answer than normal. Vital signs were taken as follows: BP 91/55, P 75. Family was very concerned and offered to call 911 themselves if we did not agree to send out resident. MD (medical doctor) was notified and agreed to send resident to ED (emergency department) to be evaluated. [The resident] left the facility at approximately 1630 (4:30 PM) and was accompanied by EMT's x2 (emergency medical technicians) and family x4." A nurse's note dated 7/6/22 at 10:48 PM documented, "Resident's RP (responsible party) - daughter, (name), aware as she was visiting here in facility at the time of transfer. RP also signed Behold Agreement prior to transfer."	{F 623}		

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{F 623}	Continued From page 4 A review of the clinical record revealed a paper copy of documentation that was provided. One was a "Notice of Discharge" form. This form documented: "This is your official notice of discharge from (facility). You are being discharged for the following reason(s) that are marked: _ Your needs cannot be met by the Facility. _your health has improved sufficiently so that you no longer need the services provided by the Facility. _The safety of other individuals in the Facility is endangered. _The health of other individuals in the Facility is endangered. _Your bill for services at the Facility has not been paid after reasonable and appropriate notice to pay. _ The Facility operation is ceasing. The date of your discharge is __. You will be discharged to Acute Care Facility / Hospital. The Facility will assist you and your family with discharge planning and arrangements...." In the above document, none of the discharge options were checked and the date was not filled in. The facility provided the resident representative with an incomplete notice that did not indicate the reason for the transfer as required, by failing to mark any of the listed reasons. On 7/13/22 at 12:47 PM, an interview was conducted with LPN #1 (Licensed Practical Nurse). When asked if the form should be completed prior to giving it to a resident / resident representative, she stated, "We should fill it out when we send it."	{F 623}		

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{F 623}	Continued From page 5 A review of the facility policy "Interdisciplinary care transition checklist" was conducted. This policy documented, "Transition from skilled Nursing Facility to Acute Care:...Notify the patient, family or representative. Issue the Facility-Initiated transfer or discharge notification per state-specific guidelines..." This policy did not specify how to complete the form first, prior to sending. On 7/13/22 at 2:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2, the Director of Nursing, and ASM #3, the Corporate Quality Assurance Coordinator were made aware of the findings. No further information was provided by the end of the survey.	{F 623}		
{F 660} SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be	{F 660}	1. Corrective Action Resident #111 no longer resides in the facility. The Social Worker followed up with Resident #111 to validate all needs have been met for discharge. 2.Like Residents/Areas The Administrator/Designee has reviewed current residents to validate that appropriate discharge planning is present.	

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{F 660}	Continued From page 6 updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent	{F 660}	3. Systemic Change The Administrator/Designee will re-educate the Social Worker on the discharge planning process to include timely documentation. 4. Monitoring The Administrator/Designee will audit patients with planned d/c dates weekly times four weeks to validate a documented discharge plan is present. Results will be reviewed by the QAPI committee.	8-10-22

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{F 660}	Continued From page 7	{F 660}		

the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and review of facility's documentation, it was determined that the facility failed to develop with the resident or the resident representative, a discharge plan for 1 of 15 residents in the survey sample, Resident #111. Resident #111 was discharged from the facility on 7/2/22.

The findings included:

Resident #111 was admitted to the facility on 9/1/21 with diagnosis that included but were not limited to: diabetes mellitus, atrial fibrillation, cerebrovascular disease and AICD (automatic implantable cardiac defibrillator).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/8/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score,

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indicating the resident was cognitively intact.

A review of the comprehensive care plan dated 9/1/21, which revealed, "FOCUS: Patient does not show potential for discharge to the community due to living conditions. INTERVENTIONS: Reassess care needs and potential for discharge as needed. Support patient, family and/or representative as needed."

A review of the physician's order dated 7/1/22, revealed, "Resident to discharge 7/2/22."

A review of the social services note dated 6/30/22 at 11:47 AM (late entry note entered 7/7/22 at 11:06 AM), revealed, "On 6/30 resident came to Social service office to express that he was unhappy with the food service he received. Resident stated that he had a procedure done and was supposed to be on a mechanical soft diet. Resident said that for dinner the day before he received a meal that did not meet the diet, therefore he was unable to eat. Social worker asked resident if his breakfast met his diet. Resident said no. Resident expressed that he no longer wanted to be at facility. Social worker informed resident that she will call the kitchen to assure that they have his slip with his diet. Social worker called the kitchen and confirmed that there was a slip for resident for mechanical soft diet. Social worker asked resident if he could see how lunch goes and come back and let her know."

A review of the social services note dated 6/30/22 at 12:48 PM, revealed, "Resident arrived to social service office to speak to her about his lunch. Resident stated that he was served beef, hard potatoes and a roll. Resident expressed that he

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{F 660}	Continued From page 9 wanted to leave facility. Social worker called nursing unit 1 and asked if the nurse practitioner could come to her office. Resident, nurse practitioner and social worker discussed resident discharging. Social worker asked resident where he would be discharging to. Resident stated that he will be discharging to the motel he stayed at previously. Social worker asked resident if he had the funds to pay for a hotel more than a few days. Resident stated that the motel offers monthly rates which he could afford to pay. Nurse practitioner stated that she would call physician to get her thoughts on the discharge and come back to social worker office. Resident stated that while nurse practitioner went to talk to the doctor, he was going to call the motel to see what they had available and return to social worker office." A review of the nursing progress note dated 7/1/22 at 12:43 PM, revealed, "Nurse Practitioner in facility today. Physician approved orders for resident to discharge from facility 7/2/22. A review of the nursing progress note dated 7/2/22 at 12:59 PM, revealed, "Resident was discharge today @ 12:59 pm. Discharge instructions explain to resident and given to him. Writer ask if he had any questions, stated no. resident left with no complaints of pain or discomfort voiced. No respiratory distress observed or reported by staff or resident." A review of the social services note dated 7/7/22 at 11:17 AM, revealed, "Resident returned to social worker office to inform her that the motel will have long stay rooms by the weekend. While resident was explaining what he was told by the motel, nurse practitioner returned and stated that the physician stated that resident was cognitively	{F 660}		

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able to make his own decisions. Physician deemed it a safe discharge. Due to resident not having a room number and home health was not set up, however nurse practitioner did call medication in to pharmacy."

A review of Resident #111's "My Transition Home" form, revealed the nursing portion completed 7/2/22, the medication section partially completed, therapy and dietary completed 7/7/22, social services, activities, equipment, appointments and contact sections blank.

An interview was conducted on 7/13/22 at 11:45 AM, with ASM (administrative staff member) #2, the director of nursing. When asked if there was a discharge plan for Resident #111, ASM #2 stated, "I do not have any completed discharge plan on the resident. His discharge occurred suddenly, he came to the social worker's office. This is the progress note. The "My transition to home" form was started but not completed."

An interview was conducted on 7/13/22 at 12:46 PM, with LPN (licensed practical nurse) #1. When asked the process for nursing when discharging a resident, LPN #1 stated, "In discharging a resident, we notify the social worker. The social worker sets up home health and has the physician sign prescriptions. I do the transition home form and get the order for discharge and any therapy. Although I was not his nurse, I did have contact with him." When asked the length of time to complete the facility "My Transition Home" form, LPN #1 stated, it usually takes about 10-15 minutes. When asked what happens if the resident leaves before the form is completed, LPN #1 stated, "From my perspective, if the resident left before it was

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finished or they signed it, I would ask them to come back for the form or we could mail it to them. The majority of the residents do not have a problem with waiting for the form to be completed."

An interview was conducted on 7/13/22 at 1:25 PM with OSM (other staff member) #3, the director of social work. When asked social services involvement in the discharge planning process, OSM #3 stated, "I usually discuss the discharge plan with the resident and their family. Where they are discharging to, home health, equipment, upcoming appointments. Therapy lets me know if there is physical or occupational therapy needs." When asked if she remembered Resident #111, OSM #3 stated, "Yes, I do. The nurse practitioner was here and had a conversation with us to make sure there was a safe discharge. He had used that motel previously and knew the set up but he did not have a specific room assigned. I could not set up home health without a specific room. The nurse practitioner decided that this was not an AMA (against medical advice) discharge and was a safe discharge. Normally I would make sure that the medication list, home health company, home health name, phone number, doctor name, phone number and pharmacy address/phone number that they choose were all on the transition home form. The resident would get a completed copy. This resident was not a planned discharge. He left on a Saturday and we did not have all the information. He had stayed at that motel before. He had the conversation with us on a Thursday and left on Saturday." When asked if the form could have noted, home health agency number and that the social services would follow up, OSM #3 stated, "We did not do that. The form could

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{F 660}	Continued From page 12 have been filled out with some blank spaces and given to him." On 7/13/22 at approximately 2:30 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 "Social Services Guideline" dated 8/2021, which reveals, "The patient's transition from the center to the post discharge environment leaves a lasting impression on the patient, family, care management companies and continuing healthcare providers. Post discharge service providers and referral sources are constantly evaluating and refining care transition processes to ensure quality outcomes. Aligning our practices for post-discharge follow-up with community support services helps to ensure continuity of care and thereby reduce the potential for re-hospitalization. The "My Transition Home" form is the primary communication tool to the continuing care provide in identifying recapitulation of stay, discharge instructions, discharge plan of care and is provided to the patient at discharge to help with the transition" No further information was provided prior to exit.	{F 660}		
{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	{F 684}	1. Corrective Action Resident #109 medication order was clarified on 7/15/22.	

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{F 684}	Continued From page 13 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, clinical record review and facility document review it was determined that the facility staff failed to follow professional standards of practice for 1 of 15 residents in the survey sample; Resident #109. The facility staff failed to clarify a double order of scheduled Tylenol (1), resulting in the resident receiving 3500 mg every Friday, 1500 mg of which was at 5:00 PM when the two orders overlapped in schedule. The findings include: Resident #109 was admitted to the facility on 5/14/21. On the most recent MDS (Minimum Data Set), a quarterly assessment dated 6/10/22, Resident #109 scored a 12 out of a possible 15 on the BIMS (Brief Interview for Mental Status) which indicated the resident was moderately impaired in ability to make daily life decisions. A review of the clinical record revealed the following two orders: 1. Order dated 4/19/22 for Tylenol (Acetaminophen) Extra Strength Tablet 500 MG (milligrams), Give 500 mg by mouth in the afternoon every Tue, Fri (Tuesday and Friday) for pain. 2. Order dated 4/20/22 for Acetaminophen (Tylenol) Tablet 500 MG, Give 2 tablet (1000 mg) by mouth three times a day every Mon, Wed, Fri,	{F 684}	2. Like Residents/Areas The Director of Nursing/Designee will reviewe residents with orders for Tylenol to validate dosing is within recommended guidelines. 3.Systemic Change The Director of Nursing/Designee will re-educate the licensed nurses on physician order entry to include reaching out to the physician when clarification is needed. 4.Monitoring The Director of Nurisng/Designee will randomly audit 5 residents with orders for Tylenol weekly times four weeks. Results will be reviewed by the QAPI committee.	8-10-22

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{F 684}	Continued From page 14 Sun (Monday, Wednesday, Friday, and Sunday) for pain. A review of the MAR (Medication Administration Record) for July 2022 revealed that the first order was scheduled for 5:00 PM on Tuesdays and Fridays. A review of the MAR for July 2022 revealed that the second order was scheduled for 9:00 AM, 2:00 PM and 5:00 PM every Monday, Wednesday, Friday and Sunday. The above orders and schedule resulted in the resident getting 1500 mg all at once, at 5:00 PM every Friday when the two schedules overlapped. This is in addition to the other 2000 mg the resident received on Fridays prior to 5:00 PM, 1000 mg of which was at 2:00 PM, only 3 hours prior to getting the 1500 mg at 5:00 PM. A nurse's note dated 7/8/22 documented, "Tylenol Extra Strength Tablet 500 MG. Give 500 mg by mouth in the afternoon every Tue, Fri for pain. This is a double order that will be d/c'd." This was noted approximately 2 and 1/2 months after the orders were written and the resident had been receiving the unusual dosing schedule. There was no evidence of either order being discontinued, or that any physician clarification of the two orders was obtained since the orders were written 4/19/22 and 4/20/22 through the date of this survey on 7/13/22. On 7/13/22 at 12:47 PM, an interview was conducted with LPN #1. She stated that the Tylenol orders should have been clarified, especially given that the orders schedule	{F 684}		

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{F 684}	Continued From page 15 overlapped at 5:00 PM on Fridays, resulting in a higher dose being administered. When asked about the above note that indicated there was a double order, she stated that it looked like the nurse did not follow through with clarification of the orders. A review of the facility policy, "Medication and Treatment Administration Guidelines" was conducted. This policy did not specify direction for clarifying orders that may appear unusual, conflicting, or other possible concerns about an order. A review of the manufacturer's information (2) for Tylenol documented, "An estimated 50 million Americans use acetaminophen each week to treat conditions such as pain, fever and aches and pains associated with cold and flu. To help encourage the safe use of acetaminophen, the makers of TYLENOL® in 2011 lowered the maximum daily dose for single-ingredient Extra Strength TYLENOL® (acetaminophen) products sold in the U.S. from 8 pills per day (4,000 mg) to 6 pills per day (3,000 mg). The dosing interval has also changed from 2 pills every 4-6 hours to 2 pills every 6 hours." On 7/13/22 at 2:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2, the Director of Nursing, and ASM #3, the Corporate Quality Assurance Coordinator were made aware of the findings. No further information was provided by the end of the survey. 1. Tylenol is used for mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html	{F 684}		

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{F 684}	Continued From page 16 2. Manufacturer's Information obtained from https://www.tylenol.com/safety-dosing/dosage-for-adults	{F 684}		
{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: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to ensure that food was stored in a sanitary manner. A box of frozen pork sausage patties was not properly sealed to prevent exposure to the freezer environment. This deficient practice increased the risk of cross contamination with foodborne pathogens and could potentially affect 86 (out of a	{F 812}	1. Corrective Action The open item was removed from the freezer and thrown away on 7/12. 2. Like Residents/Areas The Administrator/Designee will complete a review of food storage in the kitchen to validate compliance. 3. Systemic Change The Administrator/Designee will re-educate the Dietary staff on proper storage of food . 4. Monitoring The Administrator /Designee will audit the kitchen daily for five days then weekly times 4 weeks to validate that items are properly stored. Results will be reviewed by the QAPI committee.	8-10-22

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{F 812}	Continued From page 17 census of 88) residents who consumed food prepared in the facility's kitchen. The findings include: On 7/12/22 at 10:41 AM an inspection was conducted of the facility kitchen. In the walk-in freezer, a box of pork sausage patties was observed having been opened and the inner plastic bag that contained the patties was not sealed to protect the patties from the freezer environment. On 7/12/22 at 10:45 AM an interview was conducted with OSM #1 (Other Staff Member) the dietary manager. He stated that it should have been sealed, and was previously sealed but that someone went in to check the contents of the box and put it back on the shelf and did not properly reseal the bag. On 7/12/22 at 10:45 AM a policy regarding food storage in the freezer was requested from OSM #1. The facility policy "Storage of Food" was reviewed. This policy documented, "14. Seal and label open frozen foods...." On 7/13/22 at 2:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2, the Director of Nursing, and ASM #3, the Corporate Quality Assurance Coordinator were made aware of the findings. No further information was provided by the end of the survey.	{F 812}		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842	1. Corrective Action LPN #2 was re-educated on the timely documentation of non-pharmalogical interventions.	

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F 842	Continued From page 18 §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 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	F 842	2. Like Residents/Areas The Director of Nursing/Designee will audit patients on PRN medication to ensure non-pharmalogical interventions was documented timely. 3. Systemic Change The Director of Nursing/Designee will re-educate the licensed nurses on timely documentation of a non-pharmalogical intervention. 4. Monitoring The Director of Nursing/Designee will randomly audit 5 residents per week times four weeks to validate residents have appropriate documentaiton of a non-pharmalogical intervention. Results will be reviewed by the QAPI committee.	8-10-22

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F 842	Continued From page 19 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. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to ensure a complete and accurate clinical record for 1 of 15 residents in the survey sample; Resident #109. The facility staff failed to document non-pharmacological interventions attempted on 7/11/22 prior to administering a PRN (as-needed) pain medication (Tramadol)(1).	F 842		

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F 842	Continued From page 20 The findings include: Resident #109 was admitted to the facility on 5/14/21. On the most recent MDS (Minimum Data Set), a quarterly assessment dated 6/10/22, Resident #109 scored a 12 out of a possible 15 on the BIMS (Brief Interview for Mental Status) which indicated the resident was moderately impaired in ability to make daily life decisions. A review of the clinical record revealed a physician's order dated 5/17/22 for Tramadol 50 mg (milligrams) every 8 hours as needed for pain. A review of the July 2022 MAR (Medication Administration Record) revealed that on 7/11/22, Resident #109 received a PRN dose of Tramadol at 6:47 PM. There were no documented non-pharmacological interventions documented. On 7/13/22 at 4:03 PM an interview was conducted with LPN #2 (Licensed Practical Nurse). She stated that the resident wanted to go to bed because they were uncomfortable. She stated that she took the resident to bed and the resident said they wanted Tramadol because of their whole body hurting, as they had been up in chair all day which was their choice. She stated that she told the resident, "Lets try other things" and then repositioned the resident in bed. She stated the resident continued to ask for the Tramadol so she then administered it. She stated that she should have documented the non-pharmacological interventions in the clinical record. A review of the facility policy "Requirements and Guidelines for Clinical Record Content" documented, "A clinical record is compiled as a	F 842		

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F 842	Continued From page 21 confidential medical legal document containing sufficient data to identify the patient, justify the diagnosis and treatment, document results and reflect the condition of the patient throughout the stay in the center from admission to discharge. A complete record contains an accurate and functional representation of the actual experience of the patient in the center and reflects an interdisciplinary approach to assessment, care planning and care delivery. Review of clinical record documentation is an important aspect of the Quality Assurance and Performance Improvement (QAPI) process." On 7/13/22 at 2:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2, the Director of Nursing, and ASM #3, the Corporate Quality Assurance Coordinator were made aware of the findings. No further information was provided by the end of the survey. 1. Tramadol is used for moderate to moderately severe pain. Information obtained from https://medlineplus.gov/druginfo/meds/a695011.html	F 842		