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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
E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite from 07/06/2022 through 07/08/2022. The facility was in compliance with E-0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced focused infection control and abbreviated Medicare/Medicaid survey was conducted on 07/06/2022 through 07/08/2022. Corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Seven (7) complaints were investigated during the survey. 1. VA00054743 - substantiated with a deficiency, 2. VA00054189 - substantiated, no deficiencies, 3. VA00054099 - substantiated, no deficiencies, 4. VA00053080 - unsubstantiated 5. VA00052877 - substantiated with a deficiency, 6. VA00051102 - substantiated with a deficiency, 7. VA00049872 - unsubstantiated. The census in this 120 certified bed facility was 74 at the time of the survey. The survey sample consisted of six (6) current resident reviews and five (5) closed record reviews.	F 000		
F 569 SS=D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for	F 569	1. Resident #10 no longer resides at the facility. The account funds have been dispensed. 2. Residents with resident fund accounts that have deceased or discharged in the last 180 days will be reviewed to identify potential refunds.	8/22/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: Administrator — (X6) DATE: 8/10/22

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 569	Continued From page 1 one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility document review and during the course of a complaint investigation the facility staff failed to convey personal funds within 30 days of a resident's discharge for one (1) of 11 residents reviewed. (Resident #10). For Resident #10 the facility staff failed to disperse the resident's funds within 30 days of the resident's death. The findings were: Resident #10's face sheet listed their diagnoses included but were not limited to acute respiratory disease (2019-nCov), chronic kidney disease stage 3, pneumonia, type 2 diabetes mellitus, severe protein-calorie malnutrition, dysphagia (difficulty swallowing), cognitive communication deficit, and wedge compression fracture of first	F 569	3. Education will be provided to the Business Office Manager regarding timely dispensing of resident funds. 4. The Business Office Manager/designee will complete weekly audits x 4 then monthly x 2 with results reported to the Quality Assurance and Performance Improvement Committee for further recommendations.	

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F 569	Continued From page 2 lumbar vertebra. Section C (cognitive patterns) of Resident #10's quarterly minimum data set with an assessment reference date of 08/12/2020 coded the resident as having a brief interview for mental status of 13 out of 15. On 07/07/2022 at 10:00 a.m., the current business office manager (BOM) was interviewed. He reported not being the BOM at the time of Resident #10's refund request but was able to provide documentation, which showed the then-BOM sent an email request for the resident's refund on 09/17/2020. The refund request was for $1,417.74 and had been sent to their corporate refund department. He provided a separate document, which noted on 09/24/2020, the BOM requested the refund be sent to the funeral home. All of these requests were within 30 days of Resident #10's discharge/death. The final document provided was a copy of the check, for $1,417.74, to be paid to the requested funeral home. The check was dated 03/09/2021. The BOM acknowledged the refund check was dated approximately six (6) months following Resident #10's discharge/death. On 07/07/2022 at 11:30 a.m., the administrator was informed of the above findings. The administrator acknowledged the refund had been sent after 30 days of Resident #10's discharge/death. No further information was provided prior to the exit conference. This was a complaint deficiency.	F 569		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes.	F 580	1. Resident #1 resides at the center and is in stable condition.	8/22/2022

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F 580	Continued From page 3 (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15)	F 580	2. Current resident records will be reviewed, and their responsible party updated on current medication and treatment records. 3. Licensed Nurses will be educated on the facility policy of resident change of condition which includes notification of patient responsible party. 4. Resident records with changes of orders will be audited by the DON/designee 5 days/week x 2 weeks, then 3 x week x 2 weeks, then monthly x 2 months with the results reported to the Quality Assurance and Performance Improvement Committee for further recommendations.	

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Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on family interview, staff interview, clinical record review, facility document review, and during the course of a complaint investigation, the facility staff failed to inform the resident representative of physician order changes for 1 of 11 residents in the survey sample, Resident #1.

For Resident #1, the facility staff failed to notify the resident representative of medication changes, end of therapy services, and the resident having loose teeth.

Resident #1's diagnosis list indicated diagnoses, which included, but not limited to Epilepsy, Generalized Anxiety Disorder, Essential Hypertension, Hypothyroidism, Dysphagia, Psychotic Disorder with Delusions, Adult Failure to Thrive, Pseudobulbar Affect, and Contractures of the Right Knee, Left Knee, Right Elbow, Right Hand, Right Wrist.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 4/01/22 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems.

On 7/06/22 at approximately 12:45 pm, surveyor

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spoke with Resident #1's responsible party (RP) who stated they have not been notified of many past medication changes and the resident having loose teeth in which a dental consult was ordered.

Surveyor reviewed Resident #1's clinical record for medication changes requiring RP notification and identified 18 separate occasions from 6/23/21 through 7/06/22 in which the resident's RP was not notified. These physician ordered medication changes included:
- Nystatin Powder 100,000 unit/gram one application twice a day for cutaneous candida (start date 6/23/21)
- Doxycycline Hyclate 100 mg twice a day for right arm cellulitis (start date 6/24/21)
- Klonopin increased to 0.5 mg three times a day for agitation/anxiety (start date 7/21/21)
- Klonopin increased to 1 mg two times a day for agitation/anxiety (start date 8/05/21)
- Cyclobenzaprine 5 mg twice a day for muscle spasms (start date 9/13/21)
- Bactrim DS 800-160 mg twice a day for urinary tract infection (start date 11/01/21)
- Nuedexta 20-10 mg once a day for PBA (Pseudobulbar Affect) (start date 11/20/21)
- Ipratropium-Albuterol 0.5 - 3 mg nebulization solution every 6 hours as needed for wheezing (start date 1/10/22)
- Doxycycline Hyclate 100 mg twice daily for Bacterial Upper Respiratory Infection (start date 1/13/22)
- Lasix 40 mg 1 dose for Congestive Heart Failure (start date 1/14/22)
- Ceftriaxone 1 gram for 7 days for pneumonia (start date 1/15/22)
- Lasix 40 mg per day for two days for wheezing and edema (start date 1/19/22)

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- Hydrocodone-Acetaminophen 7.5-325 mg twice a day for pain (start date 1/31/22)
- Ipratropium-Albuterol 0.5-3 mg nebulization solution every six hours (start date 2/08/22)
- Amlodipine increased to 7.5 mg once a day for hypertension (start 2/10/22)
- Lasix 20 mg once a day for three days (start date 3/24/22)

On the morning of 7/08/22, surveyor notified the administrator that they were unable to locate responsible party (RP) notification for the aforementioned medication changes. On 7/08/22 at 11:36 am, the Assistant Director of Nursing (ADON) returned to the surveyor and stated they were also unable to find RP notification of the medication orders.

Surveyor was also unable to locate RP notification of the end of physical therapy (PT) services on 7/13/21 and the end on occupational therapy (OT) services on 4/30/21 and 8/12/21. On 7/07/22 at 2:42 pm, surveyor spoke with the Director of Rehab Services (DOR) who verified there was no documentation of RP notification for the end of PT and OT services for those dates. DOR stated they self-identified a problem with RP notification of the end of therapy services in September 2021 and a plan was put into place.

A nursing progress note dated 6/07/22 at 12:36 pm stated "Received new order for dental eval (evaluation) due to loose teeth". Surveyor was unable to locate documentation of RP notification regarding the resident's loose teeth.

Surveyor requested and received the facility policy entitled "Change in a Resident's Condition or Status" which read in part "Our facility shall

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F 580 SS=D	Continued From page 7 notify the resident, his or her Attending Physician, and/or the resident representative of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, resident rights, etc.)". On 7/08/22 at 11:32 am, surveyor met with the administrator, director of nursing, ADON, DOR, and unit manager and discussed the concern of Resident #1's RP not being notified of multiple medication changes, end of therapy services, and the observation of loose teeth. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/08/22.	F 580		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services.	F 655	1. Resident #2 has a current person-centered care plan in place. Resident #7 no longer resides at the facility. 2. Current residents will be reviewed to ensure that there is a current person-centered care plan in place. 3. Licensed Nurses will be educated on the policy of development of a baseline person centered care plan with 48 hours of admission. 4. New admissions will be audited by the DON/designee 5 x week for 4 weeks, then weekly x 4, then monthly x 1 with results forwarded to the Quality Assurance and Performance Improvement Committee for further recommendations.	8/22/2022

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(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on interviews, review of documents, and during the course of a complaint investigation, it was determined the facility staff failed to develop and implement a baseline plan of care to address the needs of two (2) of eleven (11) sampled residents, Resident #5 and Resident #7. For Resident #5 and Resident #7, the facility staff failed to develop and implement a baseline care plan within 48 hours of admission.

The findings included:

1. Resident #5's clinical documentation failed to include a baseline/interim care plan.

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Resident #5's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 6/1/22, was dated as completed on 6/29/22. Resident #5 was assessed as sometimes able to make self understood and as usually understands others. Resident #5's Brief Interview for Mental Status (BIMS) summary score was documented as a three (3) out of 15; this indicated severe cognitive impairment. Resident #5 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #5's diagnoses included, but were not limited to: anemia, heart failure, high blood pressure, Alzheimer's disease, and lung disease.

The following information was found in a facility policy titled "Care Plans - Baseline" (with a revised date of January 2020): "To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission."

On 7/7/22 at 4:36 p.m., during a survey team interview with the facility's Administrator, Director of Nursing (DON), ADON, and the facility's Unit Manager, a copy of Resident #5's baseline/interim care plan was requested. No baseline care plan was found by or provided to the surveyor for Resident #5.

The failure of the facility staff to complete a baseline/interim care plan for Resident #5 was discussed for a final time during a survey team meeting, on 7/8/22 at 4:14 p.m., with the facility's Administrator, Director of Nursing (DON), ADON, Director of Therapy, and the Unit Manager. No

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additional information was provided related to this issue.

2. Resident #7's diagnosis list indicated diagnoses, which included, but not limited to Chronic Kidney Disease Stage 3, Type 2 Diabetes Mellitus, Generalized Anxiety Disorder, Heart Failure, Atrial Fibrillation, Essential Hypertension, Polyneuropathy, Syncope and Collapse, Urinary Tract Infection, and Major Depressive Disorder.

The 5-day minimum data set (MDS) with an assessment reference date (ARD) of 3/16/21 assigned the resident a brief interview for mental status (BIMS) summary score of 13 out of 15 indicating the resident was cognitively intact. The resident was coded as requiring extensive assistance with bed mobility and limited assistance with transfers, dressing, toileting, and personal hygiene.

According to Resident #7's demographic face sheet, the resident has admitted to the facility on 3/11/21 and discharged on 3/17/21.

Surveyor reviewed Resident #7's clinical record and was unable to locate a completed baseline care plan. On 7/07/22 at 8:17 am, surveyor spoke with the assistant director of nursing (ADON) who stated Resident #7 did not have a baseline care plan.

On 7/07/22 at 9:14 am, surveyor spoke with the MDS Coordinator who stated a full comprehensive care plan had not been completed for Resident #7 and they have 21 days

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F 655	Continued From page 11 from admission to do a full comprehensive care plan. MDS Coordinator stated they believe nurses on the unit or the unit manager completes baseline care plans using a paper form that is then scanned into the resident's record. Surveyor requested and received the facility policy entitled "Care Plans - Baseline" which read in part: 1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. 3. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. On 7/07/22 at 4:35 pm, surveyor met with the administrator, director of nursing (DON), director of rehab (DOR), and the ADON and asked why Resident #7 did not have a baseline care plan in the clinical record, no answer was given. On 7/08/22 at 4:16 pm, surveyor met with the administrator, DON, DOR, ADON, and Unit Manager and discussed the concern of Resident #7 not having a completed baseline care plan. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/08/22.	F 655		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686	1. Resident #1's pressure ulcer has healed. 2. Current resident's skin will be inspected to identify presence of any wounds.	8/22/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 12 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 family interview, staff interview, and clinical record review, the facility staff failed to ensure residents with pressure ulcers receive necessary treatment and services to promote healing for 1 of 11 residents in the survey sample, Resident #1. For Resident #1, the facility staff failed to begin treatment when a wound was noted during a bed bath on 2/09/22. The findings included: Resident #1's diagnosis list indicated diagnoses, which included, but not limited to Epilepsy, Generalized Anxiety Disorder, Essential Hypertension, Hypothyroidism, Dysphagia, Psychotic Disorder with Delusions, Adult Failure to Thrive, Pseudobulbar Affect, and Contractures of the Right Knee, Left Knee. Right Elbow, Right Hand, Right Wrist. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 4/01/22 coded the resident as being severely impaired in cognitive skills for daily decision	F 686	3. Licensed Nurses will be educated on the facility policy of obtaining physician treatment orders upon immediate identification of a wound. 4. Resident skin inspections will be completed by charge nurse weekly and audit will be performed by the DON/designee weekly x 12 weeks with validation of presence of orders for treatment. Results will be reported to the Quality Assurance and Performance Improvement Committee for further recommendations.	

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making with short-term and long-term memory problems. Resident #1 was coded as being totally dependent on staff for bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing. The resident was coded for the presence of an impairment on one side of the upper extremities and both lower extremities that interfered with daily functions or placed resident at risk of injury. Resident #1 was coded as always being incontinent of bowel and bladder. The resident was also coded for the presence of an unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar.

On 7/06/22 at approximately 12:45 pm, surveyor met with Resident #1's responsible party (RP) who stated the resident developed a pressure area from the bed but it has since healed.

Surveyor reviewed Resident #1's clinical record and a progress note dated 2/14/22 at 2:15 pm stated "CNA (certified nursing assistant) notified this nurse of left heel concerns. Left heel 4 x 7 cm DTI (deep tissue injury) with 2.5 cm intact blister. Spoke with PT (physical therapy) and determined that chair is not causing pressure. Betadine ordered daily. Prevalon boot applied to left heel. Right heel offloaded with use of pillow under calf. Resident moves frequently while in bed. Daughter, (name omitted) was called and notified. NP (nurse practitioner) notified". A subsequent progress note dated 2/14/22 at 2:19 pm stated "Wound noted during bed bath on 2/9 and placed in wound care book. Resident unable to keep heels off loaded on pillows due to constant involuntary movement. Iron level checked and notified NP of low iron. Resident ordered iron at this time. Wound care nurse notified this nurse of DTI new orders in place.

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(Name omitted) NP notified and will assess on 2/15, (RP name omitted) notified".

A physician's order with a start date of 2/14/22 stated "Left heel DTI: Apply betadine daily". According to Resident #1's February 2022 treatment administration record (TAR), the resident received the first treatment of betadine on 2/14/22 and prevalon boot was applied to the left heel on 2/14/22.

Resident #1 was seen by the NP on 2/15/22, the progress note stated in part "The patient is seen today for a DTI. Per staff, the patient has developed a DTI to her left heel ...Paint area with betadine as per wound care. Heel to be offloaded with boot; however, the patient does often move legs causing pillows/boots to move/shift. She is also at increased risk for PI (pressure injury) secondary to iron deficiency/hypoalbunemia ..."

On 7/08/22 at 12:27 pm, surveyor met with the administrator, director of nursing, assistant director of nursing, unit manager, and the director of rehab and discussed the concern of the area to Resident #1's left heel identified on 2/09/22, however, treatment was not started until 2/14/22. The ADON stated that was true and they adjusted their processes after that. ADON stated the area has since resolved. Surveyor asked the reason for the delay in starting treatment and the ADON stated the resident's area was added to the wound book and the NP was notified on 2/09/22 but the NP did not order anything prior to 2/14/22. Surveyor requested supporting documentation of this, however, none was provided prior to the close of the survey.

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F 686	Continued From page 15 No further information regarding this concern was presented to the survey team prior to the exit conference on 7/08/22.	F 686		
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 interviews, facility document review, and clinical record review, the facility staff failed to ensure a resident's needs were addressed related to falls and fall risk for one (1) of eleven (11) residents, Resident # 5. No documentation of an admission fall risk assessment and no care plan to address fall risk was found prior to Resident #5 experiencing a fall on or around 3/4/22. The findings include: Resident #5's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 6/1/22, was dated as completed on 6/29/22. Resident #5 was assessed as sometimes able to make self understood and as usually understands others. Resident #5's Brief Interview for Mental Status (BIMS) summary score was documented as a three (3) out of 15; this indicated severe cognitive impairment. Resident #5 was documented as requiring	F 689	1. Resident #5 remains in the facility and is stable. 2. Current residents will be reviewed for presence of fall risk assessments, nursing fall notes, and presence of care plans. 3. Licensed Nurses will be re-educated on the facility policy of completing Nursing documentation, developing person-centered care plans within 48 hours and fall risk assessments. 4. The DON/designee will perform weekly audits for new admissions, 5 x week x 12 weeks and will report to the Quality Assurance and Performance Improvement Committed for further recommendations.	8/22/2022

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assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #5's diagnoses included, but were not limited to: anemia, heart failure, high blood pressure, Alzheimer's disease, and lung disease.

Resident #5's nursing progress notes included the following documentation dated 3/4/22 at 3:05 p.m.: "Neuro (neurological) assessment completed for resident per fall protocol. Resident just returned from ER, resting in bed at this time with no s/s of distress noted ..." This was the first nursing progress note documented for Resident #5. No nursing progress note was found detailing the resident's assessment and findings at the time of the fall referenced in this note. No note was found to detail at what time Resident #5 had fallen.

The facility's Assistant Director of Nursing (ADON) was asked about the fall referenced in the aforementioned 3/4/22 nursing note. On 7/7/22 at 4:12 p.m., the ADON reported this documentation was for another resident; the ADON reported it was incorrectly placed in Resident #5's chart. The ADON was asked for documentation of resident that had actually fallen. It was later confirmed Resident #5 had experienced a fall and was subsequently sent to an emergency department for treatment on 3/4/22.

Resident #5's clinical record did not contain a fall risk assessment that was completed prior to the resident fall referenced in the aforementioned 3/4/22 nurse's note. On 7/8/22 at 1:42 p.m., the Administrator reported a fall risk assessment had not been completed for Resident #5 prior to the fall referenced in the 3/4/22 nurse's note. The

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Administrator reported Resident #5 had been admitted directly from the facility's assisted living facility (ALF) and if the resident had had interventions for fall risk in place while in the ALF that those interventions would have continued when admitted to the facility. (The ALF was part of the same building as the facility being surveyed; The ALF also shared the same administrative team as the facility being surveyed.)

The following information was found in a facility policy titled "Fall Risk Assessment" (with a revised date of March 2018):
- "The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information."
- "Upon admission, the nursing staff and the physician will review a resident's record for a history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time."
- "Assessment data shall be used to identity underlying medical conditions that may increase the risk of injury from falls (such as osteoporosis)."
- "The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable."

The following information was found in a facility policy titled "Admission Notes" (with a revised date of September 2012):
- "Preliminary resident information shall be

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documented upon a resident's admission to the facility."
- "When a resident is admitted to the nursing unit, the admitting Nurse must document the following information (as each may apply) in the nurses' notes, admission form, or other appropriate place, as designated by facility protocol: ... A brief description of any disabilities (i.e., blind, deaf, hemiplegia, speech impairment, paralysis, mobility, etc.) ..."

On 7/8/22 at 1:42 p.m., the ADON reported no admission nursing note was found documented for Resident #5.

The following information was found in a facility policy titled "Care Plans - Baseline" (with a revised date of January 2020): "To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission."

On 7/7/22 at 4:36 p.m., during a survey team interview with the facility's Administrator, Director of Nursing (DON), ADON, and the facility's Unit Manager, a copy of Resident #5's baseline/interim care plan was requested. No baseline care plan was found by or provided to the surveyor.

The following information was found in a medical provider note, with a date of service (DOS) of 3/4/22: "The patient is seen today at the request of the staff for a change in mental status. The patient is a poor historian and more difficult to arouse than usual. There is some concern about the patient having a fall last night per staff . The circumstances and the nature of the fall are

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F 689	Continued From page 19 unclear." This note was signed electronically on 3/4/22 at 9:51 a.m. A survey team meeting was held with the facility's Administrator, Director of Nursing (DON), ADON, Director of Therapy, and the Unit Manager on 7/8/22 at 4:14 p.m. Discussions during this meeting included the failure of the facility staff to: (a) to complete a fall risk assessment on Resident #5 at the time of admission; (b) to develop a baseline/interim care plan to address Resident #5's fall risks; (c) the absence of an admission nursing assessment for Resident #5; and (d) the absence of documentation detailing the assessment and findings related to Resident #5's fall which was referenced in a 3/4/22 nurse note and a 3/4/22 medical provider note.	F 689		
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	F 842	1. Resident #5 remains stable in the facility. 2. The facility policy for EHR was implemented but was not followed. 3. Licensed Nurses will be re-educated on the facility policy of EHR downtime, with paper documentation being completed during downtime. 4. The DON/designee will perform audits daily during downtime with results reported to the Quality Assurance and Performance Improvement Committee for further recommendations.	8/22/2022

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(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 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;

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(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and otherlicensed 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 interviews, facility document review, and clinical record review, the facility staff failed to ensure complete and/or accurate clinical records for one (1) of eleven (11) sampled residents, Resident #5.

The findings include:

Resident #5's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 6/1/22, was dated as completed on 6/29/22. Resident #5 was assessed as sometimes able to make self understood and as usually understands others. Resident #5's Brief Interview for Mental Status (BIMS) summary score was documented as a three (3) out of 15; this indicated severe cognitive impairment. Resident #5 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #5's diagnoses included, but were not limited to: anemia, heart failure, high blood pressure, Alzheimer's disease, and lung disease.

The following information was found in a medical provider note, with a date of service of 3/4/22: "The patient is seen today at the request of the staff for a change in mental status. The patient is a poor historian and more difficult to arouse than usual. There is some concern about the patient

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having a fall last night per staff. The circumstances and the nature of the fall are unclear." This note was signed electronically on 3/4/22 at 9:51 a.m.

Resident #5's nursing progress notes included the following documentation dated 3/4/22 at 3:05 p.m.: "Neuro (neurological) assessment completed for resident per fall protocol. Resident just returned from ER, resting in bed at this time with no s/s of distress noted ..." This was the first nursing progress note documented for Resident #5. No nursing progress note was found detailing the resident's assessment and findings at the time of the fall referenced in this note. No note was found to detail at what time Resident #5 had fallen.

On 7/7/22 at 2:36 p.m., the facility's Assistant Director of Nursing (ADON) was asked about the absence of Resident #5's admission nursing assessment and fall documentation.

On 7/7/22 at 4:36 p.m., during a survey team interview with the facility's Administrator, Director of Nursing (DON), ADON, and the facility's Unit Manager, copies of Resident #5's admission nursing assessment; baseline/interim care plan; and nursing documentation related to the fall documented as occurring on or around 3/4/22 were requested.

The following information was found in a facility policy titled "Admission Notes" (with a revised date of September 2012):
- "Preliminary resident information shall be documented upon a resident's admission to the facility."
- "When a resident is admitted to the nursing unit,

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the admitting Nurse must document the following information (as each may apply) in the nurses' notes, admission form, or other appropriate place, as designated by facility protocol: a. The date and time of the resident's admission; b. The resident's age, sex, race, and marital status; c. From where the resident was admitted (i.e., hospital, home, other facility); d. Reason for the admission; e. The admitting diagnosis; f. The general condition of the resident upon admission; g. The time the Attending Physician was notified of the resident's admission; h. The time the physician's orders were received and verified ..."
- "The nurses' [sic] original note must remain on the resident's chart maintained at the nurses' station."

The following information was found in a facility policy titled "Charting and Documentation" (with a revised date of July 2017):
- "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care."
- "The following information is to be documented in the resident [sic] medical record: ... Objective observations ... Events, incidents or accidents involving the resident ..."
- "Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate."

On 7/8/22 at 7:56 a.m., the ADON reported the facility's electronic health record (EHR) system was in downtime from 3/1/22 - 3/4/22. It was

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during this downtime that Resident #5's admission nursing assessment; baseline/interim care plan; and nursing documentation related to a fall would have been documented. The ADON referred the surveyor to medical records to ask about Resident #5's admission nursing assessment and documentation related to a fall referenced in the aforementioned 3/4/22 medical provider note and the aforementioned 3/4/22 nurse's note.

On 7/8/22 at 9:06 a.m., a medical records employee (Staff Member (SM) #21) was interviewed about Resident #5's missing admission nursing assessment and fall documentation. SM #21 reported, with the Administrator present, they were unable to find Resident #5's admission nursing assessment and fall documentation. SM #21 reported the EHR downtime process was that each resident had a file folder at the nurse's station where the resident's documentation was kept during the EHR downtime. SM #21 reported each resident's documentation from the file folder was scanned into the EHR, the EHR was checked twice to make sure the scanning was complete, and then the scanned documents were shredded.

On 7/8/22 at 1:28 p.m., the Administrator reported there was not written policy and procedure to address EHR downtime.

The failure of the facility staff to maintain a complete and accurate clinical record for Resident #5 was discussed for a final time during a survey team meeting, on 7/8/22 at 4:14 p.m., with the facility's Administrator, Director of Nursing (DON), ADON, Director of Therapy, and the Unit Manager. The Administrator and the

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F 842	Continued From page 25 ADON, with a surveyor present, checked the office of the previous DON for the absent documentation; Resident #5's aforementioned missing documentation was not found.	F 842		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for	F 886	1. Employee #3 was educated on proper testing procedure following identification of improper technique. 2. Department heads will monitor their employees testing. 3. Department heads will be re-educated on proper testing procedures per manufacturer's instructions and demonstrate competency. 4. The DON/designee will perform weekly visual audits x 12 weeks with results reported to the Quality Assurance and Performance Improvement Committee for further recommendations.	8/22/2022

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F 886	Continued From page 26 conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed andthe results of each staff test; and (ii) Document in the resident records thattesting was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and document review, the facility staff failed to properly implement COVID-19 testing processes as part of the plan to prevent transmission. Observations of one (1) staff member, completing their own COVID-19 testing, revealed the specimen collection was not obtained according to manufacturer's instructions.	F 886		

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The findings include:

On 7/7/22 at 9:13 a.m., Staff Member (SM) #3 was observed to complete their own COVID-19 test. SM #3 was observed to collect their nasal swab sample by inserting the swab for less than five (5) seconds into each of their nares. SM #3 reported they rotated the swab for three (3) times in each nostril. SM #3 report they had not been provided instructions about a length of time required for the specimen collection.

The following information was found in the manufacturer's instructions for use: "Anterior Nasal (Nares) Swab ... Only the swab provided in the kit is to be used for nasal swab collection. To collect a nasal swab sample, carefully insert the entire absorbent tip of the swab (usually ½ to ¾ of an inch (1 to 1.5 cm) into the nostril. [sic] Firmly sample the nasal wall by rotating the swab in a circular path against the nasal wall 5 times or more for a total of 15 seconds, then slowly remove from the nostril. Using the same swab, repeat sample collection in the other nostril." These instruction were provided to the surveyor by SM #3; they came from the box that contained the COVID-19 test used by SM #3. SM #3 reported they were provided training/education by nursing staff on how to complete the COVID-19 tests.

On 7/7/22 at 9:33 a.m., the Administrator was informed of the aforementioned observation of SM #3's COVID-19 test specimen collection. The Administrator was also shown the COVID-19 test's manufacturer's instructions for use; the Administrator stated the survey team could keep the copy of the COVID-19 test instructions.

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F 886	Continued From page 28 The facility's policy titled "Coronavirus Disease (COVID-19) - Testing Staff" (with a revised date of September 2021) included the following information: "Staff in this facility, including all paid and unpaid individuals with potential for direct or indirect exposure to residents or infectious materials, are tested for the SARS-CoV-2 virus to detect the presence of current infections (viral testing) and to help prevent the transmission of COVID-19 in the facility." On 7/7/22 at 4:36 p.m., the observations of SM #3 failing to correctly obtain their COVID-19 test specimen was discussed with the facility's Administrator, Director of Nursing (DON), ADON, and the facility's Unit Manager.	F 886		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees;	F 888	1 CNA #1 and CNA #2 were educated on proper N95 usage related to vaccine exemption. 2 Staff records have been reviewed and those who are not up to date on vaccinations will be given written guidelines of expectations. 3 Staff will be re-educated on accommodations for exempt staff policy. 4 The DON/designee will perform weekly visual audits x 12 weeks with results reported to the Quality Assurance and Performance Improvement Committee for further recommendations.	8/22/2022

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(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff :
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care , treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff

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who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;

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F 888	Continued From page 31 (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility document review, the facility staff failed to implement infection control and prevention program processes, related to the vaccination status of agency staff members, as part of the plan to decrease the risks of the development and transmission of COVID-19. The facility failed to have written guidance and/or policies to address the specific requirements for staff members who had not received the COVID-19 vaccination due to an exemption. The findings include:	F 888		

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On 7/6/22 at 1:10 p.m., Certified Nurse Aide (CNA) #1 and CNA #2 were observed to be wearing a surgical face mask (not an N95 mask). CNA #1 and CNA #2 was asked if the facility had any face mask requirements for staff who had not received the COVID-19 vaccination; both denied being aware of any specific face mask requirements for staff who had not received the COVID-19 vaccination. CNA #1 and CNA #2's COVID-19 vaccine documentation indicated both had approved exemptions for the COVID-19 vaccination.

On 7/7/22 at 11:20 a.m., the facility's Assistant Director of Nursing (ADON) was interviewed about expectations for staff members who have not received the COVID-19 vaccination. The DON reported the unvaccinated staff members have to be tested weekly and have to wear a N95 mask.

On 7/7/22 at 11:23 a.m., CNA #1 was interviewed again about the facility's masking requirements for staff who had not received the COVID-19 vaccination. CNA #1 stated they were not aware if a N95 mask was required but they could ask someone to find out.

The following information was found in a facility policy titled "Coronavirus Disease (COVID-19) - Vaccination of Staff" (dated November 2021): "Accommodations for Exempt Staff ... 1. Staff who are deemed lawfully exempt for medical or religious reasons are provided with infection prevention and control accommodations which serve as alternatives to vaccination. 2. Abiding by such accommodations is required. Refusal to abide is grounds for disciplinary action, up to and including termination of employment. 3. Infection

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prevention and control standards for unvaccinated employees may include: a. weekly COVID- 19 testing; b. reassignment to a position that minimizes direct contact with residents and other staff; c. physical distancing; and d. source control at all times."

On 7/7/22 at 3:16 p.m., the facility's policy addressing contingency plans for staff members who are not fully vaccinated was discussed with the facility's Administrator and ADON. The Administrator and ADON reported they would expect any staff member who was not fully vaccinated to have weekly COVID-19 tests (preferably twice-a-week) and to wear a N95 mask for source control. It was reported the facility did not have a written policy detailing the aforementioned expectations for staff members who are not fully vaccinated. The Administrator reported these expectations are shared verbally with the staff members who are not fully vaccinated; the Administrator reported these expectations are not provided in writing to the staff members who are not fully vaccinated.

CNA #1 and CNA #2's COVID-19 testing documentation was reviewed with the facility's ADON on 7/8/22 at 12:49 p.m. CNA #1 and CNA #2 was observed to be working on the afternoon of 7/6/22. CNA #1 had COVID-19 test results documented for 6/28/22 and 7/7/22; CNA #2 had COVID-19 test results documented for 6/28/22. The ADON reported they would have expected both CNA #1 and CNA #2 to have had COVID-19 tests completed prior to working on 7/6/22.

On 7/7/22 at 4:36 p.m., the observations of CNA #1 and CNA #2 not wearing a N95 mask was discussed with the facility's Administrator, Director

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F 888	Continued From page 34 of Nursing (DON), ADON, and the facility's Unit Manager. On 7/8/22 at 4:14 p.m., a survey team meeting occurred with the facility's Administrator, Director of Nursing (DON), ADON, Director of Therapy, and the Unit Manager. The failure of facility staff to consistently implement contingency plans, for staff members who are not fully vaccinated for COVID-19, was discussed during this meeting.	F 888		