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

PRINTED: 08/03/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	495226		07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	730 LUNENBURG HIGHW KEYSVILLE, VA 23947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/26/2022 through 07/28/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	Wayland Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/26/22 through 7/28/22. No complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 bed Medicare certified facility was 50 at the time of the survey. The survey sample included 25 current resident reviews and 4 closed record reviews.	F 000	Wayland Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Wayland Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;	F 622	On 7-26-22 the Director of Nursing assessed the record of resident # 12 to ensure no issues occurred r/t improper transfer documentation On 7-26 the Director of Nursing assessed the record of resident #29 to ensure no issues occurred r/t improper transfer documentation On 8-2-22, the Director of Nursing initiated an audit of resident transfers/discharges for the past 30 days This audit is to ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider to include but not limited to a copy of resident care plan goals. The DON addressed all areas of concern identified during the audit to include providing required written information to the receiving health care institution or provider. The audit will be completed by 9-1-22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: R. Wayne Cole — TITLE: Administrator — (X6) DATE: 8/11/22

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 622	Continued From page 1 (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)	F 622	On 8-11-22 the Director of Nursing developed a transfer document checklist to ensure proper documentation is being sent with the patient On 8-11-22, the ADON(Assistant Director of Nursing) initiated an in-service with all nurses, Social Workers, Admission Coordinator, Director of Nursing and Administrator regarding Required Notification/ Documentation Upon Discharge/Transfers with emphasis on documentation of transfer/ discharge in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider to include but not limited to a providing a copy of resident care plan goals. In-services will be completed by 9-1-22. After 9-1-22, any nurses, social worker, admission coordinator, DON and/or Administrator who has not worked or received the in-service will receive upon next scheduled work shift. All newly hired nurses, social worker, admission coordinator, DON and/or Administrator will be in-serviced by the SDC or designee during orientation regarding Required Notification/Documentation Upon Discharge/Transfers. The DON, ADON, QA(Quality Assurance) nurse or designee will complete an audit of 10% resident transfers/discharges utilizing the Notification Audit Tool weekly x 4 weeks then monthlyx 1 month. This audit is to ensure the facility documented reason for transfer/ discharge and all required information is communicated to the receiving health care institution or provider to include but not limited to a copy of resident care plan goals with documentation in the electronic record. The Director of Nursing will address all concerns identified during the audit to include education of staff and mailing of Notice of Transfer/Bed Hold Policy as indicated. The Administrator will review the Notification Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern have been addressed.	

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F 622	Continued From page 2 (i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence that all required clinical information was provided to the hospital staff for 2 out of 29 residents in the survey sample that were transferred to the hospital; Residents #29 and Resident #12.	F 622	The Administrator will forward the Notification Audit Tools to the Executive QAPI Committee monthly x 2 months. The Executive QAPI Committee will review the Tools monthly x 2 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 622	Continued From page 3 The findings include: 1. The facility staff failed to evidence provision of required resident clinical information to a receiving facility at the time of discharge for Resident #29. Resident #29 was transferred to the hospital on 6/21/22. Resident #29 was admitted to the facility on 3/19/20 with diagnosis that included but were not limited to: end stage renal disease, heart failure and discitis. 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 07 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the Section G-functional status coded the resident as requiring extensive assistance for transfer, dressing and hygiene; totally dependent for bed mobility, locomotion and bathing; supervision for eating. Section O-special procedures/treatments coded the resident as dialysis "yes". A review of the comprehensive care plan dated 2/26/22, which revealed, "FOCUS: End Stage Renal Disease: The resident is at risk for complications due to hemodialysis. INTERVENTIONS: Dialysis (Tuesday, Thursday, Saturday). Diet as ordered; 1000ml daily Fluid Restriction." A review of the nursing progress note dated 6/21/22 at 11:55 AM, revealed, "Time Resident Returned from Dialysis: 11:55. Condition of Shunt Site (dressing intact, bleeding, drainage,	F 622		

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F 622	Continued From page 4 etc.): intact. Bruit & Thrill: =/- Site: +. Condition & Mental Status upon return (alert, oriented, confusion, lethargy, other symptoms, etc.): lethargic. Instructions &/or Communication from Dialysis Center (pre/post weights, order changes, lab results, etc.): patient complained of upset stomach. Complained of not feeling well. Blood pressure within normal limits. Heart rate "tachycardia/irregular. Patient coughed and heart rate dropped within normal limits. 20 min later heart rate up to 129. Vital signs 112/82-118-18-98.1. Additional Comments (time dressing removed, MD notification & orders changes/verified, etc.). 12:30 resident complained of chest pain and left arm pain with nausea. Physician in room. Vital signs 159/83-90-16-95.9. O2 saturations at 85%. O2 applied via nasal cannula at 2 liters per minute. Order to send to emergency room. 12:43 911 called. 13:10 county rescue squad arrived. Resident left facility via stretcher and 2 attendants at 13:15. 13:20 report called to emergency room." There is no evidence of transfer documentation in the medical record. A request for clinical documents for the transfer of Resident #29 on 6/21/22 was made on 7/26/22 at 4:40 PM. On 7/27/22 at 7:35 AM, ASM (administrative staff member) #2, the director of nursing stated, there is no evidence of the clinical documentation for this resident for this transfer. An interview was conducted on 7/27/22 at 8:30 AM with LPN (licensed practical nurse) #1. When asked what information is provided to the hospital upon transfer of a resident, LPN #1 stated, there is some paperwork that we send. When asked if there is a checklist, LPN #1 stated, "We do not	F 622		

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F 622	Continued From page 5 have a checklist." On 7/27/22 at approximately 4:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, assistant director of nursing, were made aware of the findings. A review of the facility's "Discharge and Transfer" policy dated 8/12, reveals, "Discharge and/or transfer to other medical facilities will be effected only when medically appropriate as indicated by the attending physician. When a resident is transferred or discharged to a hospital or to a nursing home, a copy of an approved transfer and referral record and a copy of any additional medical information, as required by the facility receiving the resident, will accompany him/her." No further information was provided prior to exit. 2. The facility staff failed to provide Resident #12's (R12) comprehensive care plan goals to the hospital staff when R12 was transferred to the hospital on 6/20/22. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/9/22, the resident's cognitive skills for daily decision making were coded as severely impaired. A review of R12's clinical record revealed the resident was transferred to the hospital on 6/20/22 for abdominal distention and hypoactive bowel sounds. Further review of R12's clinical record failed to reveal evidence of the clinical documentation provided to hospital staff. On 7/27/22 at 9:14 a.m., an interview was	F 622		

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F 622	Continued From page 6 conducted with RN (registered nurse) #1 (the nurse who sent R12 to the hospital). RN #1 stated she provides hospital staff with a copy of residents' face sheets, a copy of monthly orders, a copy of telephone orders that are received after the monthly orders are signed, a copy of the physician's order to send the residents to the hospital, a copy of the bed hold and a do not resuscitate form if applicable. RN #1 stated sometimes she provides a piece of residents' care plans that is related to the problem but she did not provide any portion of the care plan or the comprehensive care plan goals when R12 was transferred to the hospital on 6/20/22. On 7/27/22 at 4:35 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 622		
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-	F 655	On 7-26-22, the MDS nurse updated the care plan for resident #149 for use of indwelling urinary catheter and provided a copy to the resident/resident representative. On 8-2-22 the Director of nursing initiated an audit of all admissions and/or readmissions for the past 30 days to include resident #149. This audit is to ensure all admissions or readmissions had a baseline care plan developed and implemented within 48 hours of admission to the facility that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care to include but not limited to use of indwelling urinary catheters and that the resident and/or resident representative was provided a copy of the care plan. All areas of concerns were immediately addressed by the Director of Nursing. Audit will be completed by 9-1-22.	9/01/2022

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F 655	Continued From page 7 (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (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 observation, staff interview, facility document review and clinical record review, the facility staff failed to develop a complete baseline care plan for one of 29 residents in the survey sample, Resident #149. The facility staff failed to include Resident #149's (R149) indwelling urinary catheter on the resident's baseline care plan.	F 655	On 8-11-22 100% in-service was initiated by the ADON (Assistant Director of Nursing) with all nurses, MDS Coordinator, and MDS nurse regarding Baseline Care Plans. Emphasis includes guidelines to develop and implement a baseline care plan for each new admission and/or readmission within 48hrs that includes instructions needed to provide effective and person-centered care of the resident, minimum healthcare information necessary to properly care for a resident to include but not limited to use of indwelling catheter, and that the facility must provide the resident and their resident representative with a summary of the baseline care plan. In-service will be completed by 9-1-22. After 9-1-22 all nurses, MDS Coordinator, and MDS who has not completed the in-service will complete in-service upon next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding All newly hired all nurses, MDS Coordinator, and MDS will be in-serviced regarding Baseline Care Plans during orientation. 10% audit of all admissions and/or readmissions to include resident #149 will be completed by the DON, ADON, QA nurse or designees utilizing the Baseline Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure all admissions or readmissions had a baseline care plan developed and implemented within 48 hours of admission to the facility that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care and that the resident and/or resident representative was provided a copy of the care plan. All areas of concerns will be immediately addressed by the Director of Nursing to include retraining of staff as indicated. The DON will review and initial the Baseline Care Plan Audit Tool weekly x 4	

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F 655	Continued From page 8 The findings include: On 7/27/22 at 8:14 a.m., R149 was observed lying in bed with an indwelling urinary catheter. A review of R149's clinical record revealed a physician's order dated 7/19/22 for a urinary catheter. R149's baseline care plan initiated on 7/20/22 failed to document information regarding an indwelling urinary catheter. On 7/27/22 at 12:45 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the purpose of a care plan is to drive the resident's plan of care. RN #1 stated she initiates a resident's baseline care plan if she is the admitting nurse and an indwelling urinary catheter should be included on the baseline care plan because a resident receives specialized care related to the catheter. On 7/27/22 at 4:35 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "RESIDENT CARE PLAN" documented, "The initiation of a baseline care plan will begin upon admission by the designated RN. Baseline care plans will include the instructions needed to provide effective and patient-centered care for residents that meet professional standards of quality care. No further information was presented prior to exit.	F 655	weeks then monthly x 1 month to ensure any areas of concerns have been addressed.The QA nurse will forward the results of Baseline Care Plan Audit Tool to the Executive Quality Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Baseline Care Plan Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657	On 7-27-22, the ADON(Assistant Director of Nursing) updated the care plan for resident #22 to reflect accurately safety interventions following a fall and risk for wandering.	9/01/2022

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F 657	Continued From page 9 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review, it was determined that facility staff failed to review or revise the comprehensive care plan for 2 of 29 residents in the survey sample, Residents #22 (R22) and (R29). The findings include:	F 657	On 7-28-22, the DON (Director of Nursing) (Assistant clarified the order and updated the care plan for resident #29 for fluid restrictions and monitoring. On 8-2-22, the DON completed an audit of falls for the past 30 days. This audit is to ensure the resident is care plan accurately reflects all safety interventions initiated following a fall and that safety interventions are in place. The Director of Nursing or designee will address all concerns identified during the audit to include updating care plan when indicated. Audit will be completed by 9-1-22 On 7-29-22, the ADON initiated an audit of all residents for at risk for wandering to ensure care plan accurately reflect residents' risk for wandering to include interventions in place. The Director of Nursing or designee will address all concerns identified during the audit to include assessment of the resident, initiating interventions and updating care plan when indicated with changes in resident's wandering status. Audit will be completed by 9-1-22 On 8-3-22 the Director of Nursing initiated an audit of all residents with fluid restriction orders. This audit is to ensure resident care plan accurately reflects fluid restriction and resident monitoring. The Director of Nursing or designee will address all concerns identified during the audit to include updating care plan when indicated. Audit will be completed by 9-1-22.On 8-11-22, the ADON initiated an in-service with all nurses regarding Care Plans. Emphasis is on ensuring care plan is updated timely and accurately with all aspects of resident care to include but not limited to safety interventions following a fall and fluid restriction. In-service will be completed by 9-1-22. After 9-1-22 any nurse who has not completed the in-service will complete in-service upon next scheduled work shift.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	730 LUNENBURG HIGHW KEYSVILLE, VA 23947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 10 1. The facility staff failed to update (R22) comprehensive care plan following (R22's) fall on 07/07/2022. (R22) was admitted to the facility with diagnosis that included but was not limited to: a history of falls. (R22's) most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/02/2022, coded (R22) as scoring a 13 on the brief interview for mental status (BIMS) which indicated the resident was cognitively intact for making daily decisions. The facility's progress note dated 07/07/2022 documented in part, "Called to resident's bathroom @ (at) 1305 (1:35 p.m.). Resident noted to be sitting on bottom on bathroom floor with back against wall. Assessed for injury, none noted. When asked what happened, she stated that she got dizzy and lost her balance. Assisted back into room into bed x2 assist. VS obtained ..." The facility's fall investigation for (R22) dated 07/707/2022 documented in part, "Incident Description. Nursing Description: Called to resident's bathroom @ (at) 1305 (1:35 p.m.). Resident noted to be sitting on bottom on bathroom floor with back against wall. Resident Description: stated that she got dizzy and lost her balance. Type of Injury: No injuries observed at time of incident." The comprehensive care plan for (R22) dated 02/10/2022 documented, "Focus: Problematic manner in which resident acts characterized by ineffective coping: Wandering and/or at risk for unsupervised exits from facility related to:	F 657	All newly hired nurses will be in-serviced during orientation regarding Care Plans. The Nurse Supervisor and MDS nurse will review care plans for 10% of residents to include resident #22 and #29 weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure care plans updated timely and accurately for safety interventions following a fall, residents on fluid restrictions and residents at risk for wandering or who have had changes in wandering status. The assigned Director of Nursing or designee will address all concerns identified during the audit to include updating care plans and/or re-training of staff. The Director of Nursing will review and initial the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns identified. The Director of Nursing will forward the results of the Care Plan Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the Care Plan Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 657	Continued From page 11 cognitive impairment, restlessness Date Initiated: 02/10/2022." Under "interventions" it documented, "At Risk Wandering Protocol Date Initiated: 02/10/2022, Document episodes of wandering per facility protocol Date Initiated: 02/10/2022, Wander guard alarm bracelet Date Initiated: 02/10/2022." Further review of the care plan failed to evidence documentation that that it was reviewed or revised regarding (R22's) fall on 07/07/2022. On 07/28/22 at approximately 8:00 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing, regarding the revision or review of (R22's) care plan following the fall on 07/07/2022. ASM #2 stated that the care plan was revised yesterday, 07/27/2022. They further stated that (R22's) medications were reviewed at the time of the fall by the physician but they failed to update the care plan at that time. When asked to describe the procedure for revising/ reviewing a resident's care plan ASM #2 stated that the care is reviewed/revised at the time of the new intervention. When asked to describe the purpose of a resident's care plan ASM #2 stated that the care plan makes a continuous continuity of care for the resident. The facility's policy "Resident Care Plan" documented in part, "The resident care plan will be an ongoing process and will include current problems and/or needs identified from a complete assessment including the Minimum Data Set (MDS) and Care Assessments (CAAs) relevant to the resident's response to aging, illness, and his/her general health status. Any new problem or need of the resident, which is identified between his/her scheduled care plan review, will	F 657		

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F 657	Continued From page 12 be addressed on the care plan by the appropriate disciplines and bought to the next scheduled care plan meeting to inform the ICP team of its addition." On 07/28/2022 at approximately 11:35 a.m., ASM #1, administrator and ASM #2, were made aware of the findings. No further information was provided prior to exit. 2. The facility failed to revise the comprehensive care plan to include correct fluid restriction for Resident #29. Resident #29 was admitted to the facility on 3/19/20 with diagnosis that included but were not limited to: end stage renal disease and heart failure. 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 07 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the Section G-functional status coded the resident as requiring extensive assistance for transfer, dressing and hygiene; totally dependent for bed mobility, locomotion and bathing; supervision for eating. Section O-special procedures/treatments coded the resident as dialysis "yes". A review of the comprehensive care plan dated 2/26/22, which revealed, "FOCUS: End Stage Renal Disease: The resident is at risk for complications due to hemodialysis. INTERVENTIONS: Dialysis (Tuesday, Thursday,	F 657		

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F 657	Continued From page 13 Saturday). Diet as ordered; 1000ml daily Fluid Restriction." A review of the physician's order dated 7/15/22, revealed, "Fluid restriction 1200 milliliters daily." On 7/27/22 at 12:00 PM, a request was made for evidence of 1200 milliliters daily fluid restriction monitoring for July 2022. A review of the nursing progress note dated 7/27/22 at 7:00 PM, revealed, "Physician called to clarify fluid restriction order for the resident." On 7/28/22 at 9:00 AM, ASM (administrative staff member) #2 stated, "We do not have any evidence of monitoring the fluid restriction at 1200 milliliters. Normally the order is more specific with dietary and nursing having specific set amounts." When asked if the care plan should have been revised to reflect the new order, ASM #2 stated, "It should have been revised. The care plan currently has the 1000 milliliters fluid restriction." On 7/28/22 at 9:30 AM, an interview was conducted with LPN (licensed practical nurse) #1. When asked the purpose of the care plan, LPN #1 stated the care plan is the plan of care specific for that resident. When asked if fluid restrictions should be on the care plan, LPN stated yes, it should. When asked if the care plan should be revised if the fluid restriction amount is changed, LPN #1 stated, if there is an amount on the care plan, it should be revised. On 7/27/22 at approximately 4:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, assistant director of nursing, were made	F 657		

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F 657	Continued From page 14 aware of the findings. A review of the facility's "Resident Care Plan" policy revised 11/17, reveals, "Review and/or modification of the plan will occur after each assessment, including the comprehensive and quarterly review assessments. Any new problem or need of the resident, which is identified between his/her scheduled care plan review, will be addressed on the care plan by the appropriate disciplines and brought to the next scheduled care plan meeting to inform the ICP (interdisciplinary care plan) team of its addition." No further information was provided prior to exit.	F 657		
F 689 SS=E	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 staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to provide adequate wanderguard monitoring for one of 29 residents, Residents #22; and failed to ensure safety protocols were in place per facility policy for 3 of 3 residents smoking, Residents #36, #38, and #5. The findings include:	F 689	On 7-28-22, the ADON(Assistant Director of Nursing) re-assessed resident #22 for wandering risk. Resident was not "at risk" for wandering based off assessment. Wander guard was removed, and care plan updated. On 7-27-22 the DON (Director of Nursing)assessed resident #36, #38 and #5 for any signs of injuries related to smoking in area without a fire extinguisher. There were no concerns identified. On 8-1-22 the DON assessed the all designated smoking areas to include the front porch smoking area to ensure that all the facility only allowed smoking in designated smoke areas that included ashtrays of non-combustible material and safe design, smoke aprons, smoking blanket and fire extinguishers are provided as safety measures. The Director of Nursing addressed all concerns identified during the audit to include provided required safety devices. Audit will be completed by 9-1-22 On 7-29-22, the ADON initiated an audit of all residents who are at risk for wandering. This audit is to ensure all residents at risk for wander were care planned for at risk for wandering, wandering interventions were initiated and that wander guards were monitored per facility protocol with documentation of monitoring.	9/01/2022

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F 689	Continued From page 15 1. The facility staff failed to check the placement of (R22's) wanderguard according to the physician's orders (R22) was admitted to the facility with diagnoses that included but were not limited to: dementia (1). (R22's) most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/2/2022, coded (R22) as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Section P "Restraints and Alarms" coded (R22) for a wander guard "Used daily." The physician's order for (R22) documented in part, "WANDERGUARD- Check Location and expiration every shift. Date Order: 07/11/2022." The comprehensive care plan for (R22) dated 12/04/2019 documented. "FOCUS: RESIDENT CARE GUIDE Date Initiated: 12/04/2019." Under "Interventions" it documented in part, "WANDERS - wander guard in place Date Initiated: 02/10/2022." The facility's "Wandering Risk Assessment" dated 05/10/2022 for (R22) documented in part, "Score: 5.0. I. NOTE: A resident who scores greater than 5 (five) is at risk for wandering." The facility's "Transmitter Testing Log" dated "June 22 (2022) documented, "Expiration Date: Oct (October) 23(2023)." Under the heading it documented, "Day of Month; Transmitter Test OK; Transmitter Tested By" and "Comments."	F 689	On 7-29-22 the Facility Consultant updated the Transmitter log book for all residents at risk for wandering. On 7-29-22 the DON developed an updated transmitter tracking log. On 8-11-22the ADON initiated an in-service with all staff regarding Safe Smoking with emphasis on ensuring residents are only allowed to smoke in designated smoke areas that included but not limited to ashtrays of non-combustible material and safe design, smoke aprons, smoking blanket and fire extinguishers. This in-service will be completed by 9-1-22. After 9-1-22 any staff who has not worked or received the in-service will complete in-service upon next scheduled work shift. All newly hired staff will be in-serviced during orientation regarding Safe Smoking. On 8-11-22, the ADON initiated an in-service with all nurses , the scheduler, the maintenance dept and manager on duty on the Residents at Risk for Wandering with emphasis on accurate completion of wandering assessments, initiating interventions for residents at risk for wandering to include wander guards, monitoring function of wander guard per facility protocol with documentation and updating care plan for residents at risk for wandering or with changes in wandering status/interventions. This in-service will be completed by 9-1-22. After 9-1-22 any nurses, schedulers, maintenance and managers on duty that have not worked or received the in-service will receive in-service prior to next scheduled work shift. All newly hired nurses, schedulers, maintenance or managers on duty will be in-serviced during orientation regarding Residents at Risk for Wandering.	

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F 689	Continued From page 16 Review of the "Transmitter Testing Log" failed to document the facility's nursing shifts. Further review revealed missing check marks for transmitter tests on 06/04/2022, 06/11/2022, 06/12/2022, 06/18/2022, 06/19/2022, 06/25/2022 and on 06/26/2022. The facility's "Transmitter Testing Log" dated "July 22 (2022) documented, "Expiration Date: Oct (October) 23(2023)." Under the heading it documented, "Day of Month; Transmitter Test OK; Transmitter Tested By" and "Comments." Review of the "Transmitter Testing Log" failed to document the facility's nursing shifts. Further review revealed missing check marks for transmitter tests on 07/02/2022, 07/03/2022, 07/10/2022, 06/18/2022, 07/15/2022, 07/16/2022, 07/17/202, 07/23/2022 and on 07/24/2022. On 07/28/22 at approximately 8:04 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to explain "Expiration, location and every shift" written on the physician's order for the wander guard as stated above ASM # 2 stated that expiration referred to the expiration date of wander guard, location referred to the resident wearing the wander guard and every shift referred to all three nursing shifts, 7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m. and 11:00 p.m. to 7:00 a.m. When asked to interpret the blanks on the testing log as stated above ASM # 2 stated that they indicated it wasn't done. After reviewing the facility's "Transmitter Testing Logs" ASM # 2 stated that the location of (R22's) wander guard was being checked and not being done every shift. They further stated that the facility's form would need to be revised to reflect the physician's orders. After reviewing the comprehensive car	F 689	The Director of Nursing (DON), Assistant Director of Nursing (ADON) and Quality Assurance Nurse (QA) will monitor the smoking areas weekly for 4 weeks, then monthly x 1 month using Smoking Area Audit Tool. This audit is to ensure residents are only allowed to smoke in designated smoking areas with appropriate safety measure in place to include but not limited to ashtrays of non-combustible material and safe design, smoke aprons, smoking blanket and fire extinguishers. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and Quality Assurance Nurse (QA) will address all concerns identified during the audit to include providing appropriate safety measures and re-training of the staff. The Administrator will review the Smoking Area Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and Quality Assurance Nurse (QA) will monitor progress notes for signs of wandering behaviors or changes in wandering status 5 times a week x 4 weeks then monthly x 1 month utilizing the Wandering Audit Tool. This audit is to ensure residents at risk for wandering or who have changes in wandering status are assessed, interventions initiated when indicated with monitoring of interventions with documentation of monitoring and care plan updated for appropriate wandering status. The Director of Nursing or designee will address all concerns identified during the audit to include assessment of the resident, initiating interventions when indicated with monitoring of interventions with documentation of monitoring, updating care plan for changes in wandering status and re-training of staff. The DON will review the Wandering Audit Tool weekly x 4 weeks	

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F 689	Continued From page 17 plan for (R22's) wander guard as stated above ASM # 2 stated that the care plan should match the physician order for the wander guard. On 07/28/2022 at approximately 11:00 a.m., ASM # 1, administrator and ASM # 2, were made aware of the findings. No further information was provided prior to exit. 2. The facility staff failed to provide safety equipment specifically a fire extinguisher in the designated smoking area for Resident #36. A list of smoking times revealed smoking times of 10:30 AM, 1:30 PM and 3:30 PM. Designated smoking area front patio/carport and gazebo off of C Hall Dining room. Resident #36 was observed smoking on 7/26/22 at 1:30 PM in the front patio/carport area. Staff provided cigarettes and lighter to residents from the bag they brought with them. Three staff were present with residents as they smoked. Resident #36 did not exhibit any unsafe smoking behavior. Resident #36 wore a smoking apron. There was cigarette butt disposal containers available. There was no fire extinguisher available in the area. Resident #36 was admitted to the facility on 6/27/19 with diagnosis that included but were not limited to: congestive heart failure, diabetes and chronic kidney disease. The most recent MDS (minimum data set)	F 689	then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of the Smoking Area Audit Tool and the Wandering Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the Smoking Area Audit Tool and the Wandering Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 689	Continued From page 18 assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/20/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as being independent for bed, transfer, locomotion, dressing, eating, hygiene and bathing. The MDS annual assessment with ARD of 1/13/22, Section J: coded current tobacco use "yes". A review of the comprehensive care plan dated 8/23/20, revealed, "FOCUS: Resident is a smoker or user of tobacco products. Resident will continue to smoke safely in designated areas thru next review. INTERVENTIONS: Evaluate resident's continued ability to smoke safely on a consistent and regular basis. Assist resident in obtaining smoking materials from secured storage area upon request." A review of the smoking evaluation dated 4/25/22 at 11:24 AM, revealed the following, "Resident is an unsafe smoker and requires direct supervision while smoking." An interview was conducted on 7/26/22 at 12:00 PM with Resident #36. When asked how long he has smoked, while he has been a resident, Resident #36 stated, since I came here. On 7/26/22 at 1:45 PM, an interview was conducted with OSM (other staff member) #3, the activities aide. When asked what safe guards were in place for residents to smoke, OSM #3 stated, they have to wear aprons, we keep their cigarettes and lights. We have a fire extinguisher in the gazebo location, but there are too many	F 689		

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F 689	Continued From page 19 residents that smoke to use that location. This location is also covered and the residents have space between them. On 7/27/22 at approximately 4:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, assistant director of nursing, were made aware of the findings. According to the facility's policy "Smoking Policy" revision date 3/19, reveals, "This facility allows smoking only in designated outdoor areas. Designated Outside Smoking Areas: This facility provides appropriate designated outside smoking areas for all individuals who desire to smoke. All areas where smoking is permitted have ashtrays of non-combustible material and safe design. Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available in all areas where smoking is permitted. Additionally, smoking aprons, smoking blankets, and fire extinguishers are provided as safety measures." No further information was provided prior to exit. 3. The facility staff failed to provide safety equipment, specifically a fire extinguisher, in the designated smoking area for Resident #38. A list of smoking times revealed smoking times of 10:30 AM, 1:30 PM and 3:30 PM. Designated smoking area front patio/carport and gazebo off of C Hall Dining room. Resident #38 was observed smoking on 7/26/22 at 1:30 PM in the front patio/carport area. Staff provided cigarettes and lighter to residents from	F 689		

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F 689	Continued From page 20 the bag they brought with them. Three staff were present with residents as they smoked. Resident #38 did not exhibit any unsafe smoking behavior. Resident #38 wore a smoking apron. There was cigarette butt disposal containers available. There was no fire extinguisher available in the area. Resident #38 was admitted to the facility on 3/31/20 with diagnosis that included but were not limited to: congestive heart failure, chronic obstructive disease, atherosclerotic cardiovascular disease and tobacco use. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/24/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as being independent for bed, transfer, locomotion, walking, dressing, eating, hygiene and bathing. The MDS annual assessment with ARD of 12/15/21, Section J: coded current tobacco use "yes". A review of the comprehensive care plan dated 11/19/21, revealed, "FOCUS: Resident is a smoker or user of tobacco products. Resident will continue to smoke safely in designated areas thru next review. INTERVENTIONS: Evaluate resident's continued ability to smoke safely on a consistent and regular basis. Supervised Smoker-unsafe. Assist resident in obtaining smoking materials from secured storage area upon request."	F 689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	730 LUNENBURG HIGHW KEYSVILLE, VA 23947

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F 689	Continued From page 21 A review of the smoking evaluation dated 5/15/22 at 11:36 AM, revealed the following, "Resident is an unsafe smoker and requires direct supervision while smoking." An interview was conducted on 7/26/22 at 12:15 PM with Resident #38. When asked how long he has smoked, while he has been a resident, Resident #38 stated, for a while. When asked where he smokes, Resident #38 stated, we smoke out under the carport at the front of the building. On 7/26/22 at 1:45 PM, an interview was conducted with OSM (other staff member) #3, the activities aide. When asked what safe guards were in place for residents to smoke, OSM #3 stated, they have to wear aprons, we keep their cigarettes and lights. We have a fire extinguisher in the gazebo location, but there are too many residents that smoke to use that location. This location is also covered and the residents have space between them. On 7/27/22 at approximately 4:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, assistant director of nursing, were made aware of the findings. According to the facility's policy "Smoking Policy" revision date 3/19, reveals, "This facility allows smoking only in designated outdoor areas. Designated Outside Smoking Areas: This facility provides appropriate designated outside smoking areas for all individuals who desire to smoke. All areas where smoking is permitted have ashtrays of non-combustible material and safe design. Metal containers with self-closing cover devices	F 689		

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F 689	Continued From page 22 into which ashtrays can be emptied are readily available in all areas where smoking is permitted. Additionally, smoking aprons, smoking blankets, and fire extinguishers are provided as safety measures." No further information was provided prior to exit. 4. The facility staff failed to provide safety equipment specifically a fire extinguisher in the designated smoking area for Resident #5. A list of smoking times revealed smoking times of 10:30 AM, 1:30 PM and 3:30 PM. Designated smoking area front patio/carport and gazebo off of C Hall Dining room. Resident #5 was observed smoking on 7/26/22 at 1:30 PM in the front patio/carport area. Staff provided cigarettes and lighter to residents from the bag they brought with them. Three staff were present with residents as they smoked. Resident #5 did not exhibit any unsafe smoking behavior. Resident #5 wore a smoking apron. There was cigarette butt disposal containers available. There was no fire extinguisher available in the area. Resident #5 was admitted to the facility on 7/22/19 with diagnosis that included but were not limited to: hemiplegia, hemiparesis, neuropathy and hypertension. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/7/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively	F 689		

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F 689	Continued From page 23 impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed, transfer, locomotion, walking, dressing, hygiene and bathing; supervision for eating. The MDS annual assessment with ARD of 12/13/21, Section J: coded current tobacco use "yes". A review of the comprehensive care plan dated 7/1/20, revealed, "FOCUS: Resident is a smoker at the facility and requires assistance to smoke safely. INTERVENTIONS: Evaluate resident's continued ability to smoke safely on a consistent and regular basis. Assist resident in obtaining smoking materials from secured storage area upon request." A review of the smoking evaluation dated 5/15/22 at 11:33 AM, revealed the following, "Resident is an unsafe smoker and requires direct supervision while smoking." An interview was conducted on 7/26/22 at 2:15 PM with Resident #5. When asked how long she has smoked, while she has been a resident, Resident #5 stated, since I have been here. When asked how frequent she smokes, Resident #5 stated, two or three times a day. On 7/26/22 at 1:45 PM, an interview was conducted with OSM (other staff member) #3, the activities aide. When asked what safe guards were in place for residents to smoke, OSM #3 stated, they have to wear aprons, we keep their cigarettes and lights. We have a fire extinguisher in the gazebo location, but there are too many residents that smoke to use that location. This location is also covered and the residents have space between them.	F 689		

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F 689	Continued From page 24 On 7/27/22 at approximately 4:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, assistant director of nursing, were made aware of the findings. According to the facility's policy "Smoking Policy" revision date 3/19, reveals, "This facility allows smoking only in designated outdoor areas. Designated Outside Smoking Areas: This facility provides appropriate designated outside smoking areas for all individuals who desire to smoke. All areas where smoking is permitted have ashtrays of non-combustible material and safe design. Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available in all areas where smoking is permitted. Additionally, smoking aprons, smoking blankets, and fire extinguishers are provided as safety measures." No further information was provided prior to exit.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690	On 7-27 and 7-28 the Facility Consultant assessed the position of the catheter bag of resident #11 and corrected the positioning of the bag On 7-29-22 the ADON (Assistant Director of Nursing)completed a 100% audit of all residents with indwelling catheters to ensure that all catheters bags were positioned properly and off the floor. The ADON addressed all concerns identified during the audit. On 8-11-22 the ADON initiated an in-service with all nurses and nursing assistants regarding Foley Catheters with emphasis on positioning of foley bags for safety and the prevention of infection. This in-service will be completed by 9-1-22. After 9-1-22 any .	9/01/2022

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F 690	Continued From page 25 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to provide care and services for an indwelling catheter for one of 29 residents in the survey sample, Residents #11 (R11). The facility staff failed to keep (R11's) catheter collection bag off the floor. The findings include: (R11) was admitted to the facility with diagnoses that included but were not limited to: neuromuscular dysfunction of the bladder (1).	F 690	nurse or nursing assistant who has not worked or received the in-service will complete upon next scheduled shift. All newly hired nurses and nursing assistants will be in-serviced during orientation regarding Foley CathetersThe DON(Director of Nursing), ADON, QA (Quality Assurance)nurse and designees will audit all residents with Foley catheters 3 times a week x 4 weeks then monthly x 1 month utilizing the Foley Catheter Audit Tool. This audit is to ensure Foley bags are positioned off the floor for safety and prevention of infection. The DON or designee will address all concerns identified during the audit to include re-positioning Foley bag when indicated and/or re-training of staff. The DON will review the Foley Catheter Audit Tool 3 times weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of the Foley Catheter Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the Foley Catheter Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 690	Continued From page 26 (R11's) most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/18/2022, coded (R11) as scoring a 3 (three) on the brief interview for mental status (BIMS) which indicated severely impaired cognition for making daily decisions. Section H "Bladder and Bowel" coded (R11) as having an indwelling catheter. On 07/26/22 at approximately 12:32 p.m., an observation of (R11) revealed they were sitting in their wheelchair with the catheter collection bag attached to the underside of the wheelchair. Observation of the catheter collection bag revealed that it was dragging on the floor under the wheelchair. On 07/26/22 at approximately 1:58 p.m., an observation of (R11) revealed they were sitting in their wheelchair with the catheter collection bag attached to the underside of the wheelchair. Observation of the catheter collection bag revealed that it was dragging on the floor under the wheelchair. On 07/26/22 at approximately 3:50 p.m., an observation of (R11) revealed they were sitting in their wheelchair with the catheter collection bag attached to the underside of the wheelchair. Observation of the catheter collection bag revealed that it was dragging on the floor under the wheelchair. The physician's order dated 05/22/2022 for (R11) documented in part, " ...indwelling urinary catheter to gravity drainage ..." The comprehensive care plan for (R11) dated	F 690		

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F 690	Continued From page 27 03/22/2022 documented in part, "Focus: Altered Pattern of Urinary Elimination with Indwelling Catheter ... - At Risk for Infection due to urinary retention Date Initiated: 03/22/2022." On 07/27/2022 at approximately 12:53 p.m. an interview was conducted with RN (registered nurse) #1. When asked how the catheter collection bag should be positioned when a resident is in a wheelchair RN #1 stated that the collection bag is hooked up underneath wheelchair and off the floor. When asked why it was important to keep the collection bag off the floor RN #1 stated that is was to prevent the spread of infection and discomfort for the resident. On 07/27/2022 at approximately 4:35 p.m., ASM #1, administrator and ASM #2, were made aware of the findings. No further information was provided prior to exit. References: (1) A problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from the website: https://medlineplus.gov/ency/article/000754.htm.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must	F 692	On 7-29-22, the DON(Director of Nursing) clarified the fluid restriction order for resident #29 and updated the care plan and medication administration record to reflect order for fluid restriction. Resident #29 was assessed by the DON and the physician notified of assessment with no new ordersOn 8-3-22, the DON initiated an audit of all residents with orders for fluid restriction to include resident #29. This audit is to ,	9/01/2022

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F 692	Continued From page 28 ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to provide monitoring for fluid restriction for one of 29 residents, Resident #29. The findings include: The facility failed to provide monitoring for fluid restriction for Resident #29. Resident #29 was admitted to the facility on 3/19/20 with diagnosis that included but were not limited to: end stage renal disease and heart failure. 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 07 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively	F 692	ensure residents are being monitored for fluid restriction per physician's order with documentation in the electronic record fluid intakeassessment of resident and notification of the physician if fluid intake exceeded for further recommendations. The Director of nursing or designee will address all concerns identified during the audit to include updating MAR and care plan for fluid restriction orders, assessment of the resident and notification of the physician for any resident who exceeds fluid restriction for further recommendation. Audit will be completed by 9-1-22 On 8-11-22, the ADON(Assistant Director of Nursing) initiated an in-service with all nurses and nursing assistants in regards to Fluid Restrictions with emphasis on monitoring fluid intake each shift with documentation in the electronic record and notification of the physician for further recommendations when resident exceeds fluid restriction parameters. In-service will becompleted by 9-1-22 After 9-1-22 any nurse or nursing assistant who has not worked or received the in-service will complete upon next scheduled shift. All newly hired nurses and nursing assistants will be in-serviced during orientation regarding Fluid Restriction. The DON,ADON, QA (Quality Assurance)nurse or designee will audit all residents with orders for fluid restriction to include resident #29 3 times a week x 4 weeks then monthly x 1 month utilizing the Fluid Restriction Audit Tool. This audit is to ensure residents are being monitored for fluid restriction per physician's order with documentation in the electronic record fluid intake, assessment of resident and notification of the physician if fluid intake exceeded for further recommendations.	

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F 692	Continued From page 29 impaired. A review of the Section G-functional status coded the resident as requiring extensive assistance for transfer, dressing and hygiene; totally dependent for bed mobility, locomotion and bathing; supervision for eating. Section O-special procedures/treatments coded the resident as dialysis "yes". A review of the comprehensive care plan dated 2/26/22, which revealed, "FOCUS: End Stage Renal Disease: The resident is at risk for complications due to hemodialysis. INTERVENTIONS: Dialysis (Tuesday, Thursday, Saturday). Diet as ordered; 1000ml daily Fluid Restriction." A review of the physician's order dated 7/15/22, revealed, "Fluid restriction 1200 milliliters daily." On 7/27/22 at 12:00 PM, a request was made for evidence of 1200 milliliters daily fluid restriction monitoring for July 2022. A review of the nursing progress note dated 7/27/22 at 7:00 PM, revealed, "Physician called to clarify fluid restriction order for the resident." On 7/28/22 at 9:00 AM, ASM (administrative staff member) #2 stated, we do not have any evidence of monitoring the fluid restriction at 1200 milliliters. Normally the order is more specific with dietary and nursing having specific set amounts. On 7/28/22 at 9:30 AM, an interview was conducted with LPN (licensed practical nurse) #1. When asked the purpose of fluid restriction, LPN #1 stated, the fluid restriction is for residents who are at risk for fluid overload such as those with	F 692	The DON or designee will address all concerns identified during the audit to include updating MAR and care plan for fluid restriction orders, assessment of the resident and notification of the physician for any resident who exceeds fluid restriction for further recommendation. The DON will review the Fluid Restriction Audit Tool.3 times weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of the Fluid Restriction Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the Foley Catheter Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring	

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F 692	Continued From page 30 heart failure or renal failure. When asked how fluid restriction is monitored, LPN #1 stated, the restriction is split between dietary and nursing, the order usually specifies that division. On 7/28/22 at approximately 4:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, assistant director of nursing, were made aware of the findings. A review of the facility's "Intake and/or Output Monitoring" revised 11/12, reveals, "Residents may be placed on intake and/or output as the resident's condition warrants, at the discretion of the licensed nurse or as ordered by the physician. Consideration for monitoring the intake and/or output may include but is not limited to: fluid restrictions. Restricted Fluids: tray cards may contain fluid restrictions. MARs (medication administration record) may contain the fluid allowed with medication administration. Resident Care Guides may contain fluid restrictions." No further information was provided prior to exit.	F 692		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 700	On 7-27-22, the DON(Director of Nursing) completed an assessment of resident #21 for use of bed rails to include documentation of risk for entrapment, that resident was offered appropriate alternatives prior to use of bed rails, resident and/or resident representative was educated on risk and benefits for use of bed rails, informed consent was obtained and that the facility ensured correct installation, use and maintenance of bed rails to include ensuring the bed dimensions are appropriate for the residents size and weight.	9/01/2022

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F 700	Continued From page 31 §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to implement bed rail requirements for 4 of 29 residents in the survey sample, Residents #21, #149, #13 and #22. The findings include: 1. The facility staff failed to attempt alternatives prior to the use of Resident #21's (R21) bed rails, failed to assess R21 for the risk of entrapment from bed rails, failed to educate R21 or the resident's representative (RR) on the risks and benefits of bed rails and failed to obtain informed consent for the use of bed rails. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/24/22, the resident scored 5 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. On 7/26/22 at 3:58 p.m., R21 was observed lying in bed with bilateral quarter bed rails in the upright	F 700	On 7-27-22, the DON completed an assessment of resident #149 for use of bed rails to include documentation of risk for entrapment, that resident was offered appropriate alternatives prior to use of bed rails, resident and/or resident representative was educated on risk and benefits for use of bed rails, informed consent was obtained and that the facility ensured correct installation, use and maintenance of bed rails to include ensuring the bed dimensions are appropriate for the residents size and weight. On 7-27-22, the DON completed an assessment of resident #13 for use of bed rails to include documentation of risk for entrapment, that resident was offered appropriate alternatives prior to use of bed rails, resident and/or resident representative was educated on risk and benefits for use of bed rails, informed consent was obtained and that the facility ensured correct installation, use and maintenance of bed rails to include ensuring the bed dimensions are appropriate for the residents size and weight. On 7-27-22, the DON completed an assessment of resident #22 for use of bed rails to include documentation of risk for entrapment, that resident was offered appropriate alternatives prior to use of bed rails, resident and/or resident representative was educated on risk and benefits for use of bed rails, informed consent was obtained and that the facility ensured correct installation, use and maintenance of bed rails to include ensuring the bed dimensions are appropriate for the residents size and weight. On 8-11-22, the DON and designee initiated an audit of all residents utilizing bed rails to ensure resident was assessed with documentation in the electronic record for risk of entrapment, that resident was offered appropriate alternatives prior to use of bed rails, resident and/or resident representative	

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	495226		07/28/2022

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F 700	Continued From page 32 position. A review of R21's clinical record revealed a physical device evaluation dated 5/17/22 that failed to document the resident was offered appropriate alternatives prior to the use of bed rails, failed to document the resident was assessed for the risk of entrapment from bed rails, failed to document the risks and benefits of bed rails were reviewed with R21 or the RR, and failed to document informed consent was obtained. The evaluation documented n/a (not applicable) for all areas. R21's comprehensive care plan dated 5/18/22 documented, "Use of bed rails for increasing or maintaining current bed mobility or transfer ability. Muscle weakness, Paralysis." On 7/27/22 at 12:45 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated a physical device evaluation should be completed for all residents who use quarter bed rails. RN #1 stated she did not know the purpose of the evaluation but she completed the evaluation for all residents upon admission and she wasn't sure but thought someone completes the evaluation for all residents each quarter. RN #1 stated she does educate residents or RPs on the risks and benefits of bed rails and documents this on the evaluation. On 7/27/22 at 4:35 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 7/28/22 at 7:44 a.m., an interview was conducted with ASM #2. ASM #2 stated a	F 700	was educated on risk and benefits for use of bed rails, informed consent was obtained and that the facility ensured correct installation, use and maintenance of bed rails to include ensuring the bed dimensions are appropriate for the residents size and weight. The DON or designee will address all concerns identified during the audit to include assessment of resident with documentation in the electronic record of risk for entrapment, that resident was offered appropriate alternatives prior to use of bed rails, resident and/or resident representative was educated on risk and benefits for use of bed rails, informed consent was obtained and that the facility ensured correct installation, use and maintenance of bed rails to include ensuring the bed dimensions are appropriate for the residents size and weight. Audit will be completed by 9-1-22 On 8-11-22, the ADON(Assistant Director of Nursing) initiated an in-service with all nurses and maintenance staff in regards to Bed Rails with emphasis on assessment of resident with documentation in the electronic record for risk of entrapment, that resident was offered appropriate alternatives prior to use of bed rails, resident and/or resident representative was educated on risk and benefits for use of bed rails, informed consent was obtained and that the facility ensured correct installation, use and maintenance of bed rails to include ensuring the bed dimensions are appropriate for the residents size and weight. In-service will be completed by9-1-22. After 9-1-22, any nurse or maintenance staff who have not worked or received the in-service will receive upon next scheduled work shift. All newly hired nurses and maintenance staff will be in-serviced by the Staff Facilitator during	

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F 700	Continued From page 33 physical device evaluation should be done on admission and quarterly, and if criteria for use is met then quarter bed rails can be used. ASM stated some of the nurses may not realize quarter bed rails are classified as a physical device. ASM #2 stated residents should be assessed for other alternatives and this is sometimes done by the rehab staff (note- a review of R21's rehab documentation failed to reveal the rehab staff had assessed other alternatives). ASM #2 further stated residents should be assessed for the risk of entrapment, residents or their RPs should be provided education and informed consent should be obtained. ASM #2 stated this should be documented on the physical device evaluation. The facility policy titled, "SIDE RAIL GUIDELINES" documented, "Side rails may be used to enhance resident mobility and transfer to and from the bed...Resident injury or death is more likely to occur when attempts are made to get out of bed with the side rails raised. Injury may occur when a resident attempts to move through, between, or over side rails..." No further information was presented prior to exit. 2. The facility staff failed to attempt alternatives prior to the use of Resident #149's (R149) bed rails, failed to assess R149 for the risk of entrapment from bed rails, failed to educate R149 or the resident's representative (RR) on the risks and benefits of bed rails and failed to obtain informed consent for the use of bed rails. R149's admission minimum data set assessment was not complete. A nursing admission evaluation documented R149 communicates needs and can be understood.	F 700	orientation regarding Bed Rails. 10% audit of resident utilizing bed rails will be completed by the DON,ADON,QA(Quality Assurance) nurse and designees utilizing the Bed Rail Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure any resident utilizing bed rails has been assessed with documentation in the electronic record for risk of entrapment, that resident was offered appropriate alternatives prior to use of bed rails, resident and/or resident representative was educated on risk and benefits for use of bed rails, informed consent was obtained and that the facility ensured correct installation, use and maintenance of bed rails to include ensuring the bed dimensions are appropriate for the residents size and weight. The DON or designee will address all concerns identified during the audit. The DON will review the Bed Rail Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The DON will present the findings of the Bed Rail Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Bed Rail Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring	

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F 700	Continued From page 34 On 7/26/22 at 12:39 p.m., R149 was observed in bed with bilateral quarter bed rails in the upright position. On 7/27/22 at 10:54 a.m., an interview was conducted with R149. R149 stated no staff had talked to the resident regarding bed rails or explained the risks and benefits of bed rails. A review of R149's clinical record revealed a physical device evaluation dated 7/20/22 that failed to document the resident was offered appropriate alternatives prior to the use of bed rails, failed to document the resident was assessed for the risk of entrapment from bed rails, failed to document the risks and benefits of bed rails were reviewed with R21 or the RR, and failed to document informed consent was obtained. The evaluation was blank. R149's baseline care plan dated 7/26/22 documented, "Use of bed rails for increasing or maintaining current bed mobility or transfer ability. Muscle weakness." On 7/27/22 at 12:45 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated a physical device evaluation should be completed for all residents who use quarter bed rails. RN #1 stated she did not know the purpose of the evaluation but she completed the evaluation for all residents upon admission and she wasn't sure but thought someone completes the evaluation for all residents each quarter. RN #1 stated she does educate residents or RPs on the risks and benefits of bed rails and documents this on the evaluation.	F 700		

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F 700	Continued From page 35 On 7/27/22 at 4:35 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 7/28/22 at 7:44 a.m., an interview was conducted with ASM #2. ASM #2 stated a physical device evaluation should be done on admission and quarterly, and if criteria for use is met then quarter bed rails can be used. ASM stated some of the nurses may not realize quarter bed rails are classified as a physical device. ASM #2 stated residents should be assessed for other alternatives and this is sometimes done by the rehab staff (note- a review of R149's rehab documentation failed to reveal the rehab staff had assessed other alternatives). ASM #2 further stated residents should be assessed for the risk of entrapment, residents or their RPs should be provided education and informed consent should be obtained. ASM #2 stated this should be documented on the physical device evaluation. No further information was presented prior to exit. 3. The facility staff failed to attempt alternatives prior to the use of Resident #13's (R13) bed rails, failed to assess R13 for the risk of entrapment from bed rails, failed to educate R13 or the resident's representative (RR) on the risks and benefits of bed rails and failed to obtain informed consent for the use of bed rails. On the most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 5/9/22, the resident scored 10 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately cognitively impaired for	F 700		

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F 700	Continued From page 36 making daily decisions. On 7/26/22 at 12:31 p.m., R13 was observed in bed with bilateral quarter bed rails in the upright position. A review of R13's clinical record revealed a physical device evaluation dated 5/2/22 that failed to document the resident was offered appropriate alternatives prior to the use of bed rails, failed to document the resident was assessed for the risk of entrapment from bed rails, failed to document the risks and benefits of bed rails were reviewed with R13 or the RR (resident representative), and failed to document informed consent was obtained. The evaluation documented none and n/a (not applicable) for these areas. R13's comprehensive care plan dated 5/3/22 documented, "Use of bed rails for increasing or maintaining current bed mobility or transfer ability. Muscle weakness, Safety in transfers." On 7/27/22 at 12:45 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated a physical device evaluation should be completed for all residents who use quarter bed rails. RN #1 stated she did not know the purpose of the evaluation but she completed the evaluation for all residents upon admission and she wasn't sure but thought someone completes the evaluation for all residents each quarter. RN #1 stated she does educate residents or RPs on the risks and benefits of bed rails and documents this on the evaluation. On 7/27/22 at 4:35 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the	F 700		

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F 700	Continued From page 37 above concern. On 7/28/22 at 7:44 a.m., an interview was conducted with ASM #2. ASM #2 stated a physical device evaluation should be done on admission and quarterly, and if criteria for use is met then quarter bed rails can be used. ASM stated some of the nurses may not realize quarter bed rails are classified as a physical device. ASM #2 stated residents should be assessed for other alternatives and this is sometimes done by the rehab staff (note- a review of R13's rehab documentation failed to reveal the rehab staff had assessed other alternatives). ASM #2 further stated residents should be assessed for the risk of entrapment, residents or their RPs should be provided education and informed consent should be obtained. ASM #2 stated this should be documented on the physical device evaluation. No further information was presented prior to exit. 4. The facility staff failed to attempt alternatives prior to the use of Resident #22's (R22) bed rails and failed to assess R22 for the risk of entrapment from bed rails. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/2/22, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. On 7/26/22 at 2:02 p.m., R22 was observed lying in bed with bilateral quarter bed rails in the upright position. On 7/27/22 at 8:00 a.m., an interview was	F 700		

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F 700	Continued From page 38 conducted with R22. R22 stated the resident doesn't use the bed rails unless the resident is about to fall. R22 stated the staff had explained the risks and benefits of bed rails to the resident. A review of R22's clinical record revealed a physical device evaluation dated 5/2/22 that failed to document the resident was offered appropriate alternatives prior to the use of bed rails, failed to document the resident was assessed for the risk of entrapment from bed rails, failed to document the risks and benefits of bed rails were reviewed with R13 or the RR (resident representative), and failed to document informed consent was obtained. The evaluation documented none and n/a (not applicable) for these areas. R22's comprehensive care plan dated 12/4/19 documented, "Use of bed rails for increasing or maintaining current bed mobility or transfer ability. Muscle weakness, Safety in transfers." On 7/27/22 at 12:45 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated a physical device evaluation should be completed for all residents who use quarter bed rails. RN #1 stated she did not know the purpose of the evaluation but she completed the evaluation for all residents upon admission and she wasn't sure but thought someone completes the evaluation for all residents each quarter. RN #1 stated she does educate residents or RPs on the risks and benefits of bed rails and documents this on the evaluation. On 7/27/22 at 4:35 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 700		

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F 700	Continued From page 39 On 7/28/22 at 7:44 a.m., an interview was conducted with ASM #2. ASM #2 stated a physical device evaluation should be done on admission and quarterly, and if criteria for use is met then quarter bed rails can be used. ASM stated some of the nurses may not realize quarter bed rails are classified as a physical device. ASM #2 stated residents should be assessed for other alternatives and this is sometimes done by the rehab staff (note- a review of R22's rehab documentation failed to reveal the rehab staff had assessed other alternatives). ASM #2 further stated residents should be assessed for the risk of entrapment. No further information was presented prior to exit.	F 700		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the	F 756	On 4/7/22 and 5-7-22 the DON(Director of Nursing) faxed pharmacy review and recommendations to the Hospice Physician for resident #25 with no change in order On 8-11-22 the ADON (Assistant Director of Nursing) initiated an audit of all pharmacy recommendations for the past 60 days. This audit is to ensure the Director of Nursing (DON) provided the pharmacy recommendations to the physician for review and a written response documented in the electronic record following review. The ADON or designee will address all concerns identified during the audit to include but not limited to assessment of resident when indicated, providing pharmacy recommendations to the provider for review and initiating new orders as directed by the physician with documentation in the electronic record. Audit will be completed by 9-1-22 On 7-29-22, the DON initiated an audit of all residents receiving psychotropic medication.	9/01/2022

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F 756	Continued From page 40 attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to act upon pharmacy recommendations for one of 29 residents in the survey sample, Resident #25. The facility staff failed to follow up on pharmacy recommendations dated 3/30/22 and 4/29/22 for the reduction of Resident #25's (R25) antipsychotic medication, Seroquel (1). The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/1/22, the resident's cognitive skills for daily decision making was coded as severely impaired.	F 756	This audit is to ensure there is adequate clinical indication for use of psychotropic medications, the facility attempted a gradual dose reduction per physician orders/pharmacy recommendations and/or documentation of a clinical rational by the physician that GDR is contraindicated. On 8-11-22 the ADON initiated an in-service with the Director of Nursing and regarding Pharmacy Recommendations with emphasis on ensuring the physician is provided a copy of the pharmacy recommendations monthly for review, that a written response is received timely, and orders are initiated when indicated with documentation in the electronic record. In-service will be completed by 9-1-22All newly hired DON will be in-serviced during orientation regarding Pharmacy Recommendations. The Facility Consultant will review pharmacy recommendations monthly x 2 months utilizing the Pharmacy Recommendations/Psychotropic Medication Audit Tool. This audit is to ensure the physician is provided a copy of the pharmacy recommendations monthly for review, that a written response is received timely, and orders are initiated when indicated with documentation in the electronic record. The Facility Consultant will address all concerns identified during the audit to include re-training of staff. The Administrator will review the Pharmacy Recommendations/Psychotropic Medication Audit Tool monthly x 2 months to ensure all concerns were addressed. The Administrator will present the findings of the Pharmacy Recommendations/ Psychotropic Medication Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI	

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F 756	Continued From page 41 A review of R25's clinical record revealed a physician's order dated 3/3/22 for Seroquel 25 mg (milligrams) twice a day. Further review of R25's clinical record revealed pharmacist consultant progress notes dated 3/30/22 and 4/29/22 that documented, "Medication regimen review completed. Recommendation to PCP (primary care physician)." A pharmacist consultant progress note dated 5/9/22 documented, "MD (Medical Doctor) reviewed Pharmacy recommendation. Resident is being cared for by Hospice, PCP will refer recommendations to Hospice MD to evaluate. Recommendations faxed to (name) Hospice. " A pharmacy recommendation with a medication regimen review date of 3/30/22 documented, "Please add the indication for use to the directions for Seroquel. Please consider tapering off. Change to Seroquel 25 mg (milligrams) qhs (every hour of sleep) x 14 days, then d/c (discontinue)." There was no physician/prescriber response except for the medical director's note that R25 was not under her care. A pharmacy recommendation with a medication regimen review date of 4/29/22 documented, "Please add the indication for use to the directions for Seroquel. Please consider tapering off. Change to Seroquel 25 mg (milligrams) qhs (every hour of sleep) x 14 days, then d/c (discontinue)." There was no physician/prescriber response except that R25 was on hospice. On 7/28/22 at 11:35 a.m., an interview was conducted with ASM (administrative staff	F 756	committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Pharmacy Recommendations/Psychotropic Medication Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring	

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WAYLAND NURSING AND REHABILITATION CENTER	730 LUNENBURG HIGHW KEYSVILLE, VA 23947

(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 756	Continued From page 42 member) #2 (the director of nursing). ASM #2 stated the pharmacist completes monthly reviews then sends recommendations to her. ASM #2 stated she gives the recommendations to the physician who evaluates what she is going to do. ASM #2 stated the physician writes her orders then gives the recommendations with a follow up response back to ASM #2. ASM #2 stated she gives the recommendations with response to the medical records employee who scans the recommendations into the computer. ASM #2 stated R25's recommendations were provided to the medical director but R25 is not under her care so the recommendations were faxed to hospice. ASM #2 stated she could not provide evidence that the hospice physician responded to the recommendations. On 7/28/22 at 12:04 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. The facility policy titled "CONSULTANT PHARMACIST'S RESPONSIBILITIES" documented, "A report shall be prepared monthly and sent to the Administrator reporting the Medication Regimen Review and any significant irregularities. The Director of Nursing will review this report monthly and document action taken on the recommendations of the Consultant Pharmacist." No further information was presented prior to exit. Reference: (1) "Quetiapine (Seroquel) tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental	F 756		

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F 756	Continued From page 43 illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder...Important warning for older adults with dementia: Studies have shown that older adults with dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) such as quetiapine have an increased risk of death during treatment. Quetiapine is not approved by the Food and Drug Administration (FDA) for the treatment of behavioral problems in older adults with dementia." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758	On 7-29, the DON(Director of Nursing) clarified with Hospice agency indication for use of psychotropic medication for resident #25. On 7-29-22, the DON initiated an audit of all residents receiving psychotropic medication. This audit is to ensure there is adequate clinical indication for use of psychotropic medications, the facility attempted a gradual dose reduction per physician orders/ pharmacy recommendations and/or	9/01/2022

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F 758	Continued From page 44 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758	documentation of a clinical rational by the physician that GDR is contraindicated. The Director of Nursing or designee will address all concerns identified during the audit to include clarification with physician on indication for use, obtaining order for GDR when indicated and/or documentation of a clinical rational by the physician that GDR is contraindicated. Audit will be completed by 9-1-22 On 8-11-22, the ADON(Assistant Director of Nursing) initiated an in-service with the all nurses and physician regarding Psychotropic Medications with emphasis on ensuring all orders for psychotropic medications have an adequate clinical indication for use, a GDR is attempted per physician order/pharmacy recommendation and/or documentation of a clinical rational by the physician that GDR is contraindicated. In-service will be completed by 9-1-22. All newly hired DON or nurses will be in-serviced during orientation regarding Psychotropic Medications. The DON, ADON, QA(Quality Assurance) nurse or designees will review 10% of residents receiving psychotropic medications weekly x 4 weeks then monthly x 1 months utilizing the Pharmacy Recommendations/ Psychotropic Medication Audit Tool. This audit is to ensure all orders for psychotropic medications have an adequate clinical indication for use, a GDR is attempted per physician order/pharmacy recommendation and/or documentation of a clinical rational by the physician that GDR is contraindicated. The Facility Consultant will address all concerns identified during the audit to include re-training of staff. The Administrator will review the Pharmacy Recommendations/ Psychotropic Medication Audit Tool monthly x 2 months to ensure all concerns were addressed.	

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F 758	Continued From page 45 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure a resident was free of unnecessary medication for one of 29 residents in the survey sample, Resident #25. The facility staff failed to ensure there was an adequate clinical indication for Resident #25's (R25) continued use of the medication Seroquel (1) and failed to attempt a gradual dose reduction or document a clinical rational for the contraindication of a gradual dose reduction. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/1/22, the resident's cognitive skills for daily decision making was coded as severely impaired. A hospital discharge summary dated 3/2/22 documented, "While Seroquel was started for her and Scopolamine (2), these could be weaned off and see how she does apart from these. Defer to hospice and facility providers. Scopolamine helped with patient handling her secretions and Seroquel was utilized because of anxiety and possibly paranoia." A review of R25's clinical record revealed a physician's order dated 3/3/22 for Seroquel 25 mg (milligrams) twice a day (no diagnosis for the medication was documented). Further review of R25's clinical record revealed pharmacist consultant progress notes dated 3/30/22 and	F 758	The Administrator will present the findings of the Pharmacy Recommendations/ Psychotropic Medication Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Pharmacy Recommendations/ Psychotropic Medication Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring	

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F 758	Continued From page 46 4/29/22 that documented, "Medication regimen review completed. Recommendation to PCP (primary care physician)." A pharmacist consultant progress note dated 5/9/22 documented, "MD (Medical Doctor) reviewed Pharmacy recommendation. Resident is being cared for by Hospice, PCP will refer recommendations to Hospice MD to evaluate. Recommendations faxed to (name) Hospice. " A pharmacy recommendation with a medication regimen review date of 3/30/22 documented, "Please add the indication for use to the directions for Seroquel. Please consider tapering off. Change to Seroquel 25 mg (milligrams) qhs (every hour of sleep) x 14 days, then d/c (discontinue)." There was no physician/prescriber response except for the medical director's note that R25 was not under her care. A pharmacy recommendation with a medication regimen review date of 4/29/22 documented, "Please add the indication for use to the directions for Seroquel. Please consider tapering off. Change to Seroquel 25 mg (milligrams) qhs (every hour of sleep) x 14 days, then d/c (discontinue)." There was no physician/prescriber response except that R25 was on hospice. Another physician's order dated 7/14/22 documented an order for Seroquel 25 mg twice a day for vascular dementia without behavior disturbance. A review of R25's MARs (medication administration records) revealed R25 received Seroquel 25 mg twice a day March 2022 through	F 758		

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F 758	Continued From page 47 July 2022. On 7/26/22 at 12:41 p.m., 7/26/22 at 3:58 p.m. and 7/27/22 at 8:11 a.m., R25 was observed quietly lying in bed. R25's hospice physician was not available for interview during the survey. On 7/28/22 at 11:35 a.m., an interview was conducted with ASM (administrative staff member) #2. ASM #2 stated R25's pharmacy recommendations were provided to the medical director but R25 is not under her care so the recommendations were faxed to hospice. ASM #2 stated she could not provide evidence that the hospice physician responded to the recommendations. On 7/28/22 at 10:43 a.m., an interview was conducted with ASM #6 (the medical director). ASM #6 stated the indications for Seroquel use include: hallucinations, depression, and aggressive behaviors with worsening dementia. ASM #6 stated paranoia is an adequate indication for use and Seroquel can be used for anxiety but there are medications with less toxic effects that can be used for the elderly. ASM #6 stated she doesn't typically like to use Seroquel but a lot of residents are admitted on the medication so she tries to taper off the medication per the pharmacy recommendations. In regards to R25's Seroquel use, ASM #6 stated hospice manages R25's care but she has interacted with the resident. ASM #6 stated R25 does not present with any behaviors except for calling out when CNAs (certified nursing assistants) give care. ASM #6 stated R25 used to not do this.	F 758		

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F 758	Continued From page 48 On 7/28/22 at 11:08 a.m., another interview was conducted with ASM #2. ASM #2 stated R25 presents with agitation as evidenced by scooting and moving in bed. ASM #2 stated R25 does not present with hallucinations, delusions, paranoia, verbal behaviors or physical behaviors. On 7/28/22 at 12:04 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. The facility policy titled, "ANTIPSYCHOTIC DRUG MONITORING POLICY" documented, "It will be the policy of the facility to discourage the use of antipsychotic drugs in residents for whom such therapy is NOT supported by: 1. An acceptable clinical diagnosis or indication for use." No further information was presented prior to exit. Reference: (1) "Quetiapine (Seroquel) tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with	F 758		

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F 758	Continued From page 49 bipolar disorder...Important warning for older adults with dementia: Studies have shown that older adults with dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) such as quetiapine have an increased risk of death during treatment. Quetiapine is not approved by the Food and Drug Administration (FDA) for the treatment of behavioral problems in older adults with dementia." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html (2) Scopolamine is used to prevent nausea and vomiting. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682509.html	F 758		
F 839 SS=D	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and employee record review, it was determined that the facility staff failed to evidence	F 839	On 7-28-22 the DON (Director of Nursing)verified certification of NA #1. NA #1 certification was current until 2/28/2023.On 7-28-22,the AP (Accounts Payable) staff initiated an audit of all professional staff licenses, registration and certifications. This audit is to ensure all professional staff have the require license, registration or certification in accordance with applicable state laws and the facility is monitoring license/certifications per facility protocol. The DON or Administrator will address all concerns identified during the audit to include but not limited to immediately removing staff from the schedule who do not meet qualifications until license, certification or registration is current. The audit will be completed by 9-1-22	9/01/2022

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F 839	Continued From page 50 maintenance of required certification for one of one CNA (certified nursing assistant) record reviews. The facility staff failed to provide the evidence of required certification for one CNA that was employed for greater than one year, CNA #1. The findings include: On 7/27/22 at approximately 12:00 PM, ASM (administrative staff member #1, the administrator and OSM (other staff member) #4 the personnel/payroll manager stated that the facility has only 1 (one) CNA that has been employed greater than one year, CNA #1. A request was made for CNA #1's performance evaluation/annual review, CNA license and mandatory required education (abuse, neglect and dementia training). On 7/27/22 at approximately 3:00 PM, ASM #2, the director of nursing provided CNA #1's certification. In a review of the certification for CNA #1, there was evidence of license lookup from the Virginia Department of Health Professionals dated 11/17/21 with the CNA certification expiration date as 2/28/22. Evidence was shown that license lookup dated 7/27/22 at 2:15 PM, with the expiration date of 2/28/23. Also provided was an online licensing payment receipt for CNA #1 for renew license process dated 5/24/22 at 2:34 PM. An interview was conducted on 7/27/22 at approximately 3:00 PM with ASM #2. When asked what CNA #1 had worked between 2/28/22 and 5/24/22, ASM #2 stated, she is as needed	F 839	On 8-11-11, the ADON(Assistant Director of Nursing) initiated an in-service with the Administrator, Director of Nursing, Staff Facilitator and Payroll regarding Staff Qualifications with emphasis on the responsibility of the facility to ensure professional staff are licensed, certified or registered in accordance with applicable state laws. In-service will be completed by 9-1-22. All newly hired Administrator, Director of Nursing, Staff Facilitator and Payroll will be in-serviced during orientation regarding Staff Qualifications The AP will be monitoring all professional staff requiring license, certification or to be registered weekly x 4 weeks then monthly x 1 month utilizing the Staff Qualification Audit Tool. This audit is to ensure all staff who require license or certification are current in accordance with applicable state laws and the facility is monitoring license/certifications per facility protocol. The DON or Administrator will address all concerns identified during the audit to include but not limited to immediately removing staff from the schedule who do not meet qualifications until license, certification or registration is current. The Administrator will review the Staff Qualification Audit Tool weekly x 4 weeks then monthly x 1 month. The Administrator will present the findings of the Staff Qualification Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Staff Qualification Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring	

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F 839	Continued From page 51 staff, she did not work much. On 7/27/22 at 4:45 PM, a request was made to provide the time cards/payroll for CNA #1 from 2/28/22 through 5/24/22. On 7/28/22 at approximately 11:00 AM, ASM #1, the administrator and OSM (other staff member) #4, the personnel/payroll manager provided the payroll information for CNA #1. A sticky note was attached to the sheets revealing 293.75 hours. OSM #4 stated those are the hours worked for that time period. On 7/28/22 at 11:50 AM, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, a consultant, ASM #5, a consultant, and RN (registered nurse) #2, the infection prevention nurse were made aware of the findings. The facility's policy "Validation of Nursing License" dated 1/16, revealed, "Validation of Unlicensed Nursing Personnel Qualifications: All Nursing Assistants will provide the information specified below for verification of current listing, at the time of hire and upon renewal, as applicable." No further information was provided prior to exit.	F 839		
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must	F 909	On 7-28-22 the Maintenance Director completed a maintenance inspection of resident # 43 bed frames, mattresses and bed rails to identify any areas of possible entrapment. There were no concerns identified. On 7-28-22 , the Maintenance Director completed a maintenance inspection of resident # 22 bed frames, mattresses and bed rails to identify any areas of possible entrapment. There were no concerns identified.	9/01/2022

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F 909	Continued From page 52 ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence documentation of current bed/side rail inspection for 4 of 29 residents in the survey sample, Residents #43 (R43), #22 (R22), #35 (R35), and #13 (R13). The findings include: 1. (R43) was observed lying in bed with the right and left upper bed rails raised on 07/26/22 at 2:28 p.m. and on 07/27/22 at 8:45 a.m. (R43) was admitted to the facility with diagnosis that included but was not limited to: a history of falls. (R43's) most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/27/2022, coded (R43) as scoring a 14 out of 15 on the brief interview for mental status (BIMS) which indicated the resident was cognitively intact for making daily decisions. On 7/27/22 at 12:23 p.m., an interview was conducted with OSM (other staff member) #5, maintenance director. OSM #5 presented a work history report that documented monthly bed inspections; the last inspection was done on 7/4/22. OSM #5 stated he conducts a monthly inspection of all beds that consists of making sure the electrical portion of the head and foot works, checking to see if the mattress needs to be replaced, inspecting the frames and making sure	F 909	On 7-28-22, the Maintenance Director completed a maintenance inspection of resident # 35 bed frames, mattresses and bed rails to identify any areas of possible entrapment. There were no concerns identified. On 7-28-22, the Maintenance Director completed a maintenance inspection of resident # 13 bed frames, mattresses and bed rails to identify any areas of possible entrapment. There were no concerns identified. On 8-11-22, the Maintenance Director initiated an audit of all resident's bed frames, mattresses and bed rails if any to identify any areas of possible entrapment. The Maintenance staff will address all concerns identified during the audit. Audit will be completed by 9-1-22 On 8-11-22 the Administrator in-serviced the Maintenance staff regarding Routine Inspection of Beds with emphasis on routinely inspecting bed frames, mattresses and bed rails if any to identify any areas of possible entrapment. The in-service will be completed by 9-1-22. All newly hired Maintenance staff will be in-serviced during orientation regarding Routine Inspection of Beds. The Administrator will audit Maintenance records weekly x 4 weeks then monthly x 1 month utilizing TELs report to ensure maintenance staff are routinely inspecting routinely inspecting bed frames, mattresses and bed rails if any to identify any areas of possible entrapment and corrective measures have been initiated for all concerns identified. The Administrator will address all concerns identified during the Audit. The Administrator will review the TELs report weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.	

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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 909	Continued From page 53 the rails move up. OSM #5 stated he does not inspect the beds for any possible areas of entrapment. OSM #5 stated an outside company inspects the beds and completes a report every six months but he did not know if the company inspects the beds for possible areas of entrapment. A copy of the most recent report was requested. On 7/27/22 at 1:20 p.m., ASM (administrative staff member) #2, director of nursing, provided a copy of the bed inspection report from the outside company. The report was dated 2/26/19 and did not contain documentation that the company inspected any beds for possible areas of entrapment. On 07/28/2022 at approximately 11:00 a.m., ASM # 1, administrator and ASM # 2, were made aware of the findings. No further information was provided prior to exit. 2. (R22) was observed lying in bed with the right and left upper bed rails raised on 07/26/22 at 2:02 p.m. and on 07/27/22 at 8:50 a.m. (R22) was admitted to the facility with diagnosis that included but was not limited to: a history of falls. (R22's) most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/02/2022, coded (R22) as scoring a 13 out of 15 on the brief interview for mental status (BIMS) which indicated the resident was cognitively intact for making daily decisions. On 7/27/22 at 12:23 p.m., an interview was	F 909	The Administrator will present the findings of the TELs Report to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the TELs Report to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring	

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	495226		07/28/2022

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F 909	Continued From page 54 conducted with OSM (other staff member) #5, maintenance director. OSM #5 presented a work history report that documented monthly bed inspections; the last inspection was done on 7/4/22. OSM #5 stated he conducts a monthly inspection of all beds that consists of making sure the electrical portion of the head and foot works, checking to see if the mattress needs to be replaced, inspecting the frames and making sure the rails move up. OSM #5 stated he does not inspect the beds for any possible areas of entrapment. OSM #5 stated an outside company inspects the beds and completes a report every six months but he did not know if the company inspects the beds for possible areas of entrapment. A copy of the most recent report was requested. On 7/27/22 at 1:20 p.m., ASM (administrative staff member) #2, director of nursing, provided a copy of the bed inspection report from the outside company. The report was dated 2/26/19 and did not contain documentation that the company inspected any beds for possible areas of entrapment. On 07/28/2022 at approximately 11:00 a.m., ASM # 1, administrator and ASM # 2, were made aware of the findings. No further information was provided prior to exit. 3. (R35) was observed lying in bed with the right and left upper bed rails raised on 07/27/22 at 8:08 p.m. and at 11:05 a.m. (R35) was admitted to the facility with diagnosis that included but was not limited to: dementia.	F 909		

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F 909	Continued From page 55 (R35's) most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/18/2022, coded (R35) as scoring a 4 out of 15 on the brief interview for mental status (BIMS) which indicated the resident was severely impaired of cognition for making daily decisions. On 7/27/22 at 12:23 p.m., an interview was conducted with OSM (other staff member) #5, maintenance director. OSM #5 presented a work history report that documented monthly bed inspections; the last inspection was done on 7/4/22. OSM #5 stated he conducts a monthly inspection of all beds that consists of making sure the electrical portion of the head and foot works, checking to see if the mattress needs to be replaced, inspecting the frames and making sure the rails move up. OSM #5 stated he does not inspect the beds for any possible areas of entrapment. OSM #5 stated an outside company inspects the beds and completes a report every six months but he did not know if the company inspects the beds for possible areas of entrapment. A copy of the most recent report was requested. On 7/27/22 at 1:20 p.m., ASM (administrative staff member) #2, director of nursing, provided a copy of the bed inspection report from the outside company. The report was dated 2/26/19 and did not contain documentation that the company inspected any beds for possible areas of entrapment. On 07/28/2022 at approximately 11:00 a.m., ASM # 1, administrator and ASM # 2, were made aware of the findings.	F 909		

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F 909	Continued From page 56 No further information was provided prior to exit. 4. 3. (R13) was observed lying in bed with the right and left upper bed rails raised on 07/26/22 at 12:31 p.m. (R13) was admitted to the facility with diagnosis that included but was not limited to: thoracic (upper and middle back) vertebrae compression fracture. (R13's) most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 05/09/2022, coded (R13) as scoring a 10 out of 15 on the brief interview for mental status (BIMS) which indicated the resident was moderately impaired of cognition for making daily decisions. On 7/27/22 at 12:23 p.m., an interview was conducted with OSM (other staff member) #5, maintenance director. OSM #5 presented a work history report that documented monthly bed inspections; the last inspection was done on 7/4/22. OSM #5 stated he conducts a monthly inspection of all beds that consists of making sure the electrical portion of the head and foot works, checking to see if the mattress needs to be replaced, inspecting the frames and making sure the rails move up. OSM #5 stated he does not inspect the beds for any possible areas of entrapment. OSM #5 stated an outside company inspects the beds and completes a report every six months but he did not know if the company inspects the beds for possible areas of entrapment. A copy of the most recent report was requested. On 7/27/22 at 1:20 p.m., ASM (administrative	F 909		

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F 909	Continued From page 57 staff member) #2, director of nursing, provided a copy of the bed inspection report from the outside company. The report was dated 2/26/19 and did not contain documentation that the company inspected any beds for possible areas of entrapment. On 07/28/2022 at approximately 11:00 a.m., ASM # 1, administrator and ASM # 2, were made aware of the findings. No further information was provided prior to exit.	F 909		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review	F 947	On 8-2-22 the DON initiated an audit of training hours for all nursing assistants to include NA #1. This audit is to ensure the all nursing assistants completed no less than 12 training hours per year to include but not limited to abuse, neglect and dementia training. The DON will address all concerns identified during the audit to include providing required training to identified staff. Audit will be completed by 9-1-22 On 8-11-22 the Administrator initiated an in-service with the Director of Nursing, Assistant Director of Nursing and Staff Facilitator regarding Training Hours for Nursing Assistants with emphasis on the training of nursing assistants with no less than 12 hours of training time to include but not limited to abuse, neglect and dementia. The in-service will be completed by 9-1-22. All newly hired Director of Nursing, Assistant Director of Nursing and Staff Facilitator will be in-serviced during orientation regarding Training Hours for Nursing Assistants. he DON,ADON(Assistant Director of Nursing) QA(Quality Assurance) nurse or designee will review training records for 5 nursing assistants weekly x 4 weeks then monthly x 1 month to utilizing the Training Hours for Nursing Assistants Audit Tool.	9/01/2022

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F 947	Continued From page 58 and employee record review, it was determined that the facility staff failed to provide annual required training for one of one CNAs (certified nursing assistants). The facility staff failed to provide the required mandatory training for abuse, neglect, and dementia training for CNA #1. The findings include: On 7/27/22 at approximately 12:00 PM, ASM (administrative staff member #1, the administrator and OSM (other staff member) #4 the personnel/payroll manager stated that the facility has only one CNA that has been employed greater than one year, CNA #1. A request was made for CNA #1's performance evaluation/annual review, CNA license and mandatory required education (abuse, neglect and dementia training). On 7/27/22 at approximately 3:00 PM, ASM #2, the director of nursing provided CNA #1's performance review dated 2/24/22, education record and CNA certificate. In a review of the records for CNA #1, there were 1.50 hours of education from 11/22/21 through 4/20/22. There was no evidence of abuse, neglect and dementia training. ASM #2 stated on 7/27/22 at approximately 3:00 PM, she (CNA #1) is behind on her education. She does not have those courses. On 7/28/22 at 11:50 AM, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM	F 947	This audit is to ensure the all nursing assistants completed no less than 12 training hours per year to include but not limited to abuse, neglect and dementia training. The DON or designee will address all concerns identified during the audit to include providing required training to identified staff. The Director of Nursing will review the Training Hours for Nursing Assistants Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will present the findings of the Training Hours for Nursing Assistants Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Training Hours for Nursing Assistants Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 947	Continued From page 59 #4, a consultant, ASM #5, a consultant and RN (registered nurse) #2, the infection prevention nurse were made aware of the findings. The facility assessment dated 1/31/22, revealed, "Staff training/education and competencies: all staff-required in-service training. Evidence of application based on annual training requirement. Requirements (in part) include training on abuse/neglect/resident abuse prevention, dementia management, and combative residents." The facility's "Principle Mandatory Education-CNA 12 hours minimum, new orientation and annually" reveals, "Principle Dementia, A Day in the Life of Henry: A Dementia Experience and Resident Rights' are among courses listed. No further information was provided prior to exit.	F 947		