STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 07/14/2022

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F 000	INITIAL COMMENTS An unannounced {Medicare/Medicaid} revisit to the abbreviated survey conducted 5/16/22 through 5/19/22 , was conducted 7/13/22 through 7/14/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. One complaint was investigated during the survey (VA00055581 unsubstantiated with unrelated deficiency). The census in this 132 certified bed facility was 118 at the time of the survey. The survey sample consisted of 9 current Resident reviews (Residents 101 through 109).	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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	F 657		8/6/22

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

Electronically Signed | 08/05/2022

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F 657	Continued From page 1 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 Resident interview, staff interview, and clinical record review, the facility staff failed to review and revise the residents comprehensive care plan (CCP) in regards to transfers for 1 of 9 residents, Resident #101. The facility staff failed to update the residents CCP to include a sliding board transfer. The findings included: Resident #101's CCP included the following diagnoses muscle weakness, difficulty in walking, unsteadiness on feet, and need for assistance with personal care. Section C (cognitive patterns) of Resident #101's quarterly minimum data set assessment (MDS) with an assessment reference date (ARD) of 05/23/22 included a brief interview for mental status summary score (BIMS) of 15 out of a possible 15 points. Indicating the resident was alert and orientated. Section G (functional status) was coded to indicate the resident required extensive assistance of 2 people for bed mobility and transfers (3/3). The MDS was coded to indicate the resident had no impairment in the upper or lower extremities and used a wheelchair for mobility. Resident #101's CCP included the focus area's activities of daily living (ADL) self-care	F 657	F Tag 657 Care Plan Timing and Revision This Plan of Correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we agree with them. It is an affirmation that corrections to the areas cited have been made and the facility is following participation requirements. 1. Resident #101s care plan was updated to reflect the residents current transfer status. 2. All residents have the potential to be affected. An audit of current resident care plans was completed by the unit managers and care plans were updated to reflect current transfer status for residents. Current residents Kardex were audited to ensure that the correct transfer status was present. 3. DON/Designee has educated therapy staff to provide communication to the unit managers when a resident's transfer status changes. DON/Designee has educated the nurse leadership/nurse management team on the care plan process and updating care plans to reflect resident current individualized needs and including them on the resident Kardex.	

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F 657	Continued From page 2 performance deficit, impaired visual function, and at risk for falls. Interventions included transfers with hoyer lift. The facility nursing staff provided the surveyor with a copy of a kardex report as of 07/13/22. This report read as follows for Resident #101 transfers with hoyer lift. 07/13/22 4:20 p.m., Resident #101 was observed resting on bed and stated 2 female staff persons had assisted him to bed and no lift was utilized. The surveyor observed a sliding board laying in the resident's wheelchair. 07/13/22 4:25 p.m., Licensed Practical Nurse #1 stated the CCP needed to be updated and the resident did not use the hoyer lift for transfers. 07/13/22 4:35 p.m., Certified Nursing Assistant (CNA) #2 stated they were agency staff and the resident was not transferred using the lift. CNA #2 stated CNA #1 worked with this resident frequently and they knew how they transferred. 07/13/22 4:40 p.m., CNA #1 stated the therapy had told them how to transfer this resident. 07/13/22 5:10 p.m., Rehab Director stated Resident #101 used a sliding board for transfers and they were not sure why it was not on the CCP. The Rehab Director stated Resident #101 could still use the hoyer lift and it was their preference which one they used. 07/13/22, Rehab Director provided the surveyor with copies of therapy notes and a signed statement from the licensed physical therapist assistant this signed statement read in part,	F 657	4. The DON/Designee will audit therapy minutes 3x a week for 4 weeks then monthly x 2 months to ensure care plans have been updated with changes in transfer status and substantial compliance is achieved. Any issues identified with be addressed immediately. The DON/Designee will identify any trends and/or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly to review compliance. 5. Date of Compliance: 8/6/22	

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F 657	Continued From page 3 "...educated Resident #101 multi times with safe procedure using sliding board...educated multi CNA's on different occasions on using sliding board to transfer Resident #101..discussed with CNA's to use own judgment, leaving transfer to CNA's discretion if they feel comfortable and pt (patient) status that day." A review of the therapy notes revealed the therapy department were providing skilled services to Resident #101 that included using the sliding board. 07/13/22 5:30 p.m., during a meeting with the Administrator, Director of Nursing, and Regional Nurse the Regional Nurse stated the CCP included the highest level of transfer used by this resident. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: 2. For Resident #106, facility staff failed to obtain vital signs weekly as ordered.	F 684	F Tag 684 Quality of Care	8/6/22

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F 684	Continued From page 4 Resident #106 was admitted to the facility with diagnoses including myocardial infarction, heart failure, respiratory failure, acute kidney failure, traumatic brain injury, atherosclerotic heart disease, dysphagia, and difficulty walking. On the minimum data set assessment with assessment reference date 6/6/2022, the resident scored 15/15 on the brief interview for mental assessment and was assessed as without signs of delirium or psychosis. The resident exhibited verbal and other behaviors that affected care on 1-3 of the 7 days prior to the assessment date. During clinical record review on 7/13/22 (of entries after 6/30/22), the surveyor noted a physician order dated 6/7/22 for vital signs day shift every Thursday. The vital sign page in the electronic record recorded vital signs on 7/1/22. No later vital signs were documented. Vital signs for Thursday 7/7/22 were not documented. The surveyor was unable to locate vital signs documented during the period of review in progress notes or assessment notes. The failure to assess and record vital signs per order was reported to the Unit C manager on 7/13/22 while discussing resident records. Based on resident interview, staff interview, and clinical record review the facility staff failed ensure the highest practicable well-being for 2 of 7 residents, Resident #101 and #106. 1. For Resident #101, the nursing staff failed to apply the provider ordered treatment Triad Hydrophilic Wound Dress Paste. 2. For Resident #106, the facility staff failed to obtain Vital Signs as ordered by the provider.	F 684	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we agree with them. It is an affirmation that corrections to the area cited have been made and the facility is following participation requirements. 1. Residents #101 was assessed by nursing staff and vital signs obtained. MD was notified of missed vital signs on 7/7/22. Resident #106 was assessed by nursing staff and MD was notified of the missed treatments. An order was obtained to keep triad cream at bedside per residents wishes. A self-administration assessment was completed for resident #106. No adverse effects were noted for both residents. 2. All residents have the potential to be affected. An audit of all current residents with vital sign orders was conducted to ensure that vital signs were obtained per MD order. An audit of all treatment orders for the last 30 days was conducted to ensure all treatments were provided per order. The MD was notified immediately for any missed treatments. 3. All Licensed nurses were educated on providing care per MD orders. The education included the importance of obtaining vital signs per MD order, completing resident treatments per MD order and notifying the MD if they are unable to administer a treatment order. 4. DON or designee will audit treatment administration records 3x a week for 4 weeks to ensure all treatments have been	

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F 684	Continued From page 5 The findings included: 1. Resident #101 diagnoses included, but were not limited to, diabetes, chronic kidney disease, macular degeneration, and hypertension. Section C (cognitive patterns) of Resident #101's quarterly minimum data set assessment (MDS) with an assessment reference date (ARD) of 05/23/22 included a brief interview for mental status summary (BIMS) score of 15 out of a possible 15 points. Indicating the resident was alert and orientated. The Residents comprehensive care plan included the focus area activities of daily living (ADL) self-care performance stage 2 pressure ulcer to sacral area. Interventions included, but were not limited to, administer treatments as ordered. Resident #101's clinical record included an order for "Triad Hydrophilic Wound Dress Paste" every shift for denuded skin. The order date was documented as 02/28/22. A review of Resident #101's treatment sheets revealed that the facility nursing staff had not documented for the application of the paste on June 2, 9, 23, and 24 on the 7 a.m. to 7 p.m. shift. 07/13/22 1:30 p.m., Resident #101 stated that there were times when the nursing staff did not apply the cream. 07/13/22 3:30 p.m., Licensed Practical Nurse (LPN) #1 reviewed Resident #101's clinical record and stated a hole in an administration record indicated a medication error had occurred. 07/13/22 5:30 p.m., during a meeting with the	F 684	completed per MD order. DON/Designee will review vital sign orders 3x week for 4 weeks and monthly x 2 to ensure vital signs are obtained per MD order. Any issues identified with be addressed immediately. The DON/Designee will identify any trends and/or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly to review compliance. 5. Date of Compliance: 8/6/22	

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F 684	Continued From page 6 Administrator, Director of Nursing, and Regional Nurse the Regional Nurse stated Resident #101 was out of the building on June 9 for a medical appointment. The treatment sheets did not list a specific time for the paste to be used and just listed the administration times as day shift and night shift. No further formation regarding this issue was provided to the survey team prior to the exit conference.	F 684		
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 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 and clinical record	F 692	F Tag 692 Nutrition/Hydration Status	8/6/22

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F 692	Continued From page 7	F 692		

review, facility failed to address the registered dietician recommendations in response to resident weight loss for 1 of 3 residents in the survey sample reviewed for weight loss (Resident #105).

Resident #105 was admitted with diagnoses including chronic kidney disease, respiratory failure, heart failure, hypertension, basal cell carcinoma, atherosclerosis and embolism or thrombosis of right leg. On the minimum data set assessment with assessment date 6/28/2022, the resident scored 7/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The resident was assessed with >5% weight loss over 1 month and >10% over 90 days.

During clinical record review on 7/13/22 of dietary orders, the surveyor noted weight record:

Date	Value
7/12/2022 12:26	123.2 Lbs
7/5/2022 12:48	122.0 Lbs
6/29/2022 11:24	123.4 Lbs
6/21/2022 14:58	122.4 Lbs
6/14/2022 17:57	124.4 Lbs
6/7/2022 16:37	121.6 Lbs
5/31/2022 14:47	123.4 Lbs
5/24/2022 15:15	123.0 Lbs
5/17/2022 13:05	123.8 Lbs
5/11/2022 15:54	127.2 Lbs
5/3/2022 15:23	124.4 Lbs
4/26/2022 15:09	125.0 Lbs
4/19/2022 16:44	124.0 Lbs
4/12/2022 17:59	125.4 Lbs

Maintenance

This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we agree with them. It is an affirmation that corrections to the area cited have been made and the facility is following participation requirements.

1. Resident #105 dietary recommendations were reviewed with the MD and orders were entered for changes to her diet and supplements per RD recommendations.
2. All residents with dietary recommendations have the potential to be affected. All dietary recommendations for the past 30 days were reviewed by the unit managers and addressed with the MD. New orders were entered in the medical record.
3. DON/Designee will educate the RD and nurse managers on the facilities process for reviewing and implementing RD orders. The RD will give a copy of the recommendations to the DON and unit managers for MD notification and implementation.
4. DON/Designee will audit all dietary recommendations weekly x 4 weeks and monthly x 2 to ensure the MD has been notified and all recommendations have been addressed. Any issues identified with be addressed immediately. The DON/Designee will identify any trends and/or patterns and additional education will be provided on an ongoing basis.

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F 692	Continued From page 8 4/7/2022 15:07 128.4 Lbs 3/24/2022 00:46 134.0 Lbs 3/16/2022 15:14 136.2 Lbs 3/15/2022 14:43 135.8 Lbs 3/8/2022 16:11 140.6 Lbs A Weight Change progress note dated 6/18/22 stated, in part, "...Weight loss of 13.5% x 90 days. Weight stable x 30 days. Diet is NAS mech soft and PO intake is variable (0-100%).Supplements: magic cup with meals and Ensure with meals. Multiple comorbidities and advanced age (100). Order for meals out of bed - patient tends to refuse. Will recommend to provide Ensure BETWEEN the meals; continue weekly wts". A second Weight Change progress note dated 6/18/22 "Will also recommend to change diet to regular mech soft". The active dietary order during clinical record review on 7/13/22 and dated 5/31: NAS (No Added Salt) diet Mechanical Soft texture, Regular/Thin consistency, NO TOMATO SOUP;PLEASE SEND MAGIC CUP ON EACH TRAY. A dietary supplement order dated 5/10/22 indicated Ensure with meals for supplement. On 7/13/22 at 3 PM, the surveyor asked the C wing manager (where the resident resides) about the 6/18 dietary orders. The manager stated dietary orders went to the D wing manager. The C wing manager stated the resident now seems to have little appetite and rarely eats a full meal. The surveyor replied that was likely why the dietician recommended liberalizing the diet and moving the Ensure supplements from meal time to between meals. The D wing manager indicated dietary orders went to the director of nursing and were forwarded to the unit managers.	F 692	Findings will be presented to QAPI monthly to review compliance. 5. Date of Completion: 8/6/22	

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F 692	Continued From page 9 The D wing manager did not receive a dietary recommendation on 6/18/22. The director of nursing at that time no longer works at the facility and could not be interviewed.	F 692		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		8/6/22

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F 842	Continued From page 10 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure a complete and accurate clinical record for 2 of 3 discharged residents in the survey sample, Resident #103, and #104.	F 842	F Tag 842 Resident Records- Identifiable Information This plan of correction is respectfully submitted as evidence of all alleged	

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F 842	Continued From page 11 For Resident #103 and #104, the facility staff failed to obtain the resident's and/or responsible party's signature at discharge when their personal belongings were released. The findings included: 1. Resident #103's diagnosis list indicated diagnoses, which included, but not limited to Fracture of Right Femur with Routine Healing, Type 2 Diabetes Mellitus, Acute Kidney Failure, Polyosteoarthritis, and Spinal Stenosis. The admission minimum data set (MDS) with an assessment reference date (ARD) of 6/21/22 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #103's clinical record included a nursing progress note dated 7/01/22 at 11:06 am stating in part "RSD (resident) D/C (discharged) facility via family car with a family member ...All residents personal belongings left with resident ..." Surveyor reviewed Resident #103's clinical record and was unable to locate a signed release for the resident's personal belongings. On 7/13/22 at 2:03 pm, surveyor requested the resident's signed release. At 3:18 pm, the administrator stated they did not have Resident #103's signed release for their personal belongings. Surveyor requested and received the facility policy entitled "Release of Resident's Personal Belongings" which read in part: 1. The personal belongings of a resident	F 842	compliance. The submission is not an admission that the deficiencies existed or that we agree with them. It is an affirmation that corrections to the area cited have been made and the facility is following participation requirements. 1. Residents #103 and #104 have notes entered in the medical record stating that all personal belongings were sent with them at discharge. A call was placed to resident #103 and #104 to ensure that they received all their belongings at discharge and were not missing any items. 2. All residents that are discharging from the facility have the potential to be affected. An audit of all residents discharged in the last 2 weeks was conducted to ensure the inventory sheets were signed at discharge. If the inventory sheets were not signed, a call was placed to the resident/resident representative to ensure all belongings were sent home with the resident and that there were no items missing. 3. DON/Designee will educate licensed nurses on the process for discharging a patient to include ensuring that the inventory sheets are signed at discharge and all belongings are sent with the resident. 4. DON/Designee will review discharge records 3x/week for 4 weeks to ensure all inventory sheets are signed at discharge. The DON/Designee will identify any trends and/or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly to review compliance.	

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	495333	A. BUILDING _____ B. WING _____	C 07/14/2022

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F 842	Continued From page 12 transferred or discharged from our facility will be released to the resident or authorized resident representative. 3. Individuals receiving the resident's personal belongings will be required to sign a release for such items. 5. Disposal or disposition of the resident's personal belongings will be filed in the resident's medical record. On 7/13/22 at 5:30 pm, the survey team met with the administrator, director of nursing, assistant director of nursing, and the regional nurse consultant and discussed the concern of Resident #103's clinical record not including a signed release as stated by the facility in their policy and plan of correction when the resident's personal belongings were released. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/13/22. 2. Resident #104's diagnosis list indicated diagnoses, which include, but not limited to Sepsis, Urinary Tract Infection, Atrial Fibrillation, Chronic Kidney Disease Stage 4, Type 2 Diabetes Mellitus, Essential Hypertension, and Diastolic Heart Failure. The admission minimum data set (MDS) with an assessment reference date (ARD) of 6/21/22 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #104's clinical record included a nursing progress note dated 7/01/22 at 11:01 am stating in part "RSD (resident) D/C (discharged) facility	F 842	5. Date of Completion: 8/6/22	

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F 842	Continued From page 13	F 842		

via family car with a family member ...All residents personal belongings left with resident ..."

Surveyor reviewed Resident #104's clinical record and was unable to locate a signed release for the resident's personal belongings. On 7/13/22 at 2:03 pm, surveyor requested the resident's signed release. At 3:18 pm, the administrator stated they did not have Resident #104's signed release for their personal belongings.

Surveyor requested and received the facility policy entitled "Release of Resident's Personal Belongings" which read in part:
1. The personal belongings of a resident transferred or discharged from our facility will be released to the resident or authorized resident representative.
3. Individuals receiving the resident's personal belongings will be required to sign a release for such items.
5. Disposal or disposition of the resident's personal belongings will be filed in the resident's medical record.

On 7/13/22 at 5:30 pm, the survey team met with the administrator, director of nursing, assistant director of nursing, and the regional nurse consultant and discussed the concern of Resident #104's clinical record not including a signed release as stated by the facility in their policy and plan of correction when the resident's personal belongings were released.

No further information regarding this concern was presented to the survey team prior to the exit conference on 7/13/22.

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Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure a complete and accurate clinical record for 2 of 3 discharged residents in the survey sample, Resident #103, and #104.

For Resident #103 and #104, the facility staff failed to obtain the resident's and/or responsible party's signature at discharge when their personal belongings were released.

The findings included:

1. Resident #103's diagnosis list indicated diagnoses, which included, but not limited to Fracture of Right Femur with Routine Healing, Type 2 Diabetes Mellitus, Acute Kidney Failure, Polyosteoarthritis, and Spinal Stenosis.

The admission minimum data set (MDS) with an assessment reference date (ARD) of 6/21/22 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact.

Resident #103's clinical record included a nursing progress note dated 7/01/22 at 11:06 am stating in part "RSD (resident) D/C (discharged) facility via family car with a family member ...All residents personal belongings left with resident ..."

Surveyor reviewed Resident #103's clinical record and was unable to locate a signed release for the resident's personal belongings. On 7/13/22 at 2:03 pm, surveyor requested the resident's signed release. At 3:18 pm, the administrator stated they did not have Resident #103's signed

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F 842	Continued From page 15	F 842		

release for their personal belongings.

Surveyor requested and received the facility policy entitled "Release of Resident's Personal Belongings" which read in part:
1. The personal belongings of a resident transferred or discharged from our facility will be released to the resident or authorized resident representative.
3. Individuals receiving the resident's personal belongings will be required to sign a release for such items.
5. Disposal or disposition of the resident's personal belongings will be filed in the resident's medical record.

On 7/13/22 at 5:30 pm, the survey team met with the administrator, director of nursing, assistant director of nursing, and the regional nurse consultant and discussed the concern of Resident #103's clinical record not including a signed release as stated by the facility in their policy and plan of correction when the resident's personal belongings were released.

No further information regarding this concern was presented to the survey team prior to the exit conference on 7/13/22.

2. Resident #104's diagnosis list indicated diagnoses, which include, but not limited to Sepsis, Urinary Tract Infection, Atrial Fibrillation, Chronic Kidney Disease Stage 4, Type 2 Diabetes Mellitus, Essential Hypertension, and Diastolic Heart Failure.

The admission minimum data set (MDS) with an assessment reference date (ARD) of 6/21/22 assigned the resident a brief interview for mental

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F 842	Continued From page 16	F 842		

status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact.

Resident #104's clinical record included a nursing progress note dated 7/01/22 at 11:01 am stating in part "RSD (resident) D/C (discharged) facility via family car with a family member ...All residents personal belongings left with resident ..."

Surveyor reviewed Resident #104's clinical record and was unable to locate a signed release for the resident's personal belongings. On 7/13/22 at 2:03 pm, surveyor requested the resident's signed release. At 3:18 pm, the administrator stated they did not have Resident #104's signed release for their personal belongings.

Surveyor requested and received the facility policy entitled "Release of Resident's Personal Belongings" which read in part:
1. The personal belongings of a resident transferred or discharged from our facility will be released to the resident or authorized resident representative.
3. Individuals receiving the resident's personal belongings will be required to sign a release for such items.
5. Disposal or disposition of the resident's personal belongings will be filed in the resident's medical record.

On 7/13/22 at 5:30 pm, the survey team met with the administrator, director of nursing, assistant director of nursing, and the regional nurse consultant and discussed the concern of Resident #104's clinical record not including a signed release as stated by the facility in their policy and plan of correction when the resident's

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F 842	Continued From page 17 personal belongings were released. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/13/22.	F 842		