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LAKE MANASSAS HEALTH & REHABILITATION CENTER	14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155

(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 07/12/2022 through 07/14/2022. The facility was found to be in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/12/2022 through 7/14/2022. Six complaints were investigated during the survey (VA00055405- substantiated with deficiency, VA00054997- unsubstantiated without deficiency, VA00054965- unsubstantiated without deficiency, VA00053297- substantiated without deficiency, VA00052964- unsubstantiated without deficiency, VA00050568- substantiated with deficiency) . 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 120 certified bed facility was 118 at the time of the survey. The survey sample consisted of 36 current residents and 11 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or	F 578		8/22/22

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

Electronically Signed | 08/04/2022

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F 578	Continued From page 1 inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to evidence if a resident had or did not have an advance directive, or had a discussion with the resident and/or responsible party related to the resident's advance directive for two of 47 residents in the	F 578	The statements made in the following plan of correction are not an admission to the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of	

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F 578	Continued From page 2 survey sample, Residents #14 and #29. The findings include: 1. The facility staff failed to evidence documentation that advance directive was discussed with Resident #14, the presence of an advance directive, or if the resident wished information regarding formulating an advance directive. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/13/2022, Resident #14 (R14) scored a "12" on the BIMS (brief interview for mental status) score, indicating the resident is moderately cognitively impaired for making daily decisions. Part of the admission paperwork dated 5/20/2019, documented in part, "(Initial of corporation) Policies Covering the Implementation of Self-Determination Rights." documented in part, "Advanced Directive Acknowledgement: I HAVE executed the following portions of an Advance Medical Directive: Living Will, Optional Appointment of Agent to Make Healthcare Decisions. And Appointment of Agent for Making Anatomical Gift. I HAVE provided the Health & Rehabilitation Center with original directive(s). Yes or No. I HAVE provided the Health & Rehabilitation Center with a copy verified by the Health &Rehabilitation Center. Yes or No. The original is located (blank on form). I HAVE NOT executed Advance Medical Directive(s): (Please check one of the below) I DO WANT MORE INFORMATION regarding advance directives. I DO NOT WANT MORE INFORMATION regarding advance directives." Nothing on the form was checked off	F 578	correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F578 1. Resident #14□s representative was informed of information regarding formulation of an advance directive. The documentation was signed on July 19, 2022. Resident #29 is no longer a resident in the center. 2. A review of current residents in the centers was completed to ensure there is documentation is in the medical record regarding the offering of information regarding Advance Directives and/or a copy of the completed Advance Directive is in the medical record. 3. The Admissions Department will be educated by the Director of Nursing/designee on offering and documenting information regarding Advance Directives and requesting a copy of Advance Directives if the resident has Advance Directives. 4. The Director of Social Services/designee and Director of Nursing/designee will review new admissions/readmissions daily in clinical meeting 5x weekly for Advance Directives to ensure that the resident was offered information if desired and that a copy is easily available in the medical record.	

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F 578	Continued From page 3 for either having or not having an advance directive and the were no check marks next to wanting or not wanting information regarding an advance directive. The physician order dated, 11/17/2020, documented in part, "DNR (do not resuscitate)." The comprehensive care plan dated as revised on 3/11/2022, documented in part, "Focus: CODE STATUS (R14) has a DNR code status." The "Interventions" documented, "Coordinate all care and services to maintain DNR CODE STATUS. DNR will be observed during patient appropriate change in condition. Maintain staff, MD (medical doctor) and family notified of DNR CODE STATUS and of any change noted." The "Care Plan Meeting" notes dated, 5/23/2019, documented in part, "In attendance:...Nursing to follow up and will provide updated Med (medication) list and care plan goals. Therapist were unavailable at time of care plan meeting to give report. Discharge planner contacted daughter and gave her updates." The "Care Plan Meeting" notes dated, 11/17/2020, documented in part, "Care plan held today with daughter via phone cell and patient. Staff in attendance...Care plan reviewed and all questions answered. Copy of med and CP (care plan) provided to patient. IDT (interdisciplinary team) will continue to follow and provide." The "Care Plan Meeting" notes dated, 2/17/2021, documented in part, "Care plan meeting held today with patient, patient's daughter via phone....Care plan reviewed and all questions answered. IDT will continue to follow and to provide support." The "Care Plan Meeting" notes dated, 5/18/2021,	F 578	5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 8/22/2022	

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documented in part, "Care plan meeting held with daughter via phone. Staff in attendance....Care plan reviewed and all questions answered. IDT will continue to follow and provide support."
The "Care Plan Meeting" notes dated, 8/24/2021, documented in part, "Spoke to daughter for Care plan meeting that was held with patient's in room. Staff in attendance...IDT will continue to follow and provide support."
The "Care Plan Meeting" notes dated, 11/23/2021, documented in part, "Care plan was assisted by DCP (discharge planning) and Nurse. All questions were kindly answered. DCP will continue to follow and provide support."
The "Care Plan Meeting" notes dated, 2/22/2022, documented in part, "Care plan Meeting was held today with patient and patient's daughter via phone. Attendance to meeting....All questions were asked, and all addressed. IDT will continue to follow and provide support."
The "Care Plan Meeting" notes dated, 4/26/2022, documented in part, "Care plan held with patient and patient's daughter via phone. Attendance...All questions were addressed and answered."

An interview was conducted with OSM (other staff member) #4, the admissions director, on 7/14/2022 at 8:27 a.m. When asked the process for obtaining the advance directive acknowledgment, OSM #4 stated they go into the resident's room and go over the contract. When they get to the page regarding the advance directive, "We ask if they are their own responsible party, do they have a power of attorney and if they have an advance directive." OSM #4 stated the resident and/or responsible party fill out the page. If the resident has an advance directive they ask for the documents to

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put in the resident's chart. When asked if before you sign this document under the resident or responsible party's signature, wouldn't you ensure the document is filled in, OSM #4 stated that this document was before she was hired and she would not sign the document unless reviews it to make sure it is filled in.

An interview was conducted with OSM #8, the discharge planning director, on 7/14/2022 at 8:38 a.m. OSM #8 was asked to review the page of the admission contract, "Advanced Directive Acknowledgement." After OSM #8 read the document she stated, "There is nothing there." When asked if she periodically reviewed with the resident and/or responsible party if the resident has or would like information on creating an advance directive, OSM #8 stated, "I will be honest. In April I did an audit of who needs them and who has them. I went through the chart and didn't read that is didn't have anything checked. Something should be documented." When asked if she discusses with the resident and/or responsible party in the care plan meeting, OSM #8 stated, "At times, but we need to be more thorough with that."

The facility policy, "Admission Documents: Patient Self Determination Act." Documented in part, "Admissions Director must ask the patient at the time of admission if he/she has an advanced directive and must also inform the patient at the time of admission about their rights under Virginia law to make decisions about their medical care....3. The Admissions Director must ask the patient and/or responsible party if he/she has ever executed and advance directive prior to being admitted to the Health and Rehabilitation Center. If the patient has already executed and

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Advance Directive prior to admission, and he/she has it present, the Admissions Director must make a duplicate of the Advance Directive (Living Will, Medical Power of Attorney and/or Appointment of Anatomical Gift) and verify that it is an exact copy of the original....4. If the patient indicates that he/she has an Advance Directive, but does not have it present, the patient must be informed of the urgency to deliver the Advance Directive to the Admissions Director so that a verified copy can be placed in the patient's chart.....6. If the patient has not executed an Advance Directive the patient may wish more information or may wish to execute an Advance Directive. IF the patient requests additional information or requests to execute a Living Will or Durable Power of Attorney or an appointment of an Anatomical Gift, the Admissions Director will need to immediately contact the Director of Nursing and the Director of Social Services so that clinical and psychosocial consultation can be available to the patient. Any and all discussion related to the execution of Advance Directives, and any and all action taken must be documented in the medication record by Nursing and Social Services. Any and all executed documents must be immediately placed in the patient's medical record....12. The Admissions Director must present for signing to the patient and/or responsible parties the Advance Directive Notification/Acknowledgment included in the Admission Agreement."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical services, and ASM #5, the regional director of clinical services, were made aware of the above findings on 7/13/2022 at 5:30 p.m.

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No further information was obtained prior to exit.

2. The facility staff failed to evidence documentation that advance directive was discussed with Resident #29 (R29), the presence of an advance directive, or if the resident wished information regarding formulating an advance directive.

On the most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 6/23/2022, the resident scored a "4" on the BIMS (brief interview for mental status) score, indicating the resident is severely cognitively impaired for making daily decisions.

Part of the admission paperwork dated 11/5/2021, documented in part, "(Initial of corporation) Policies Covering the Implementation of Self-Determination Rights." documented in part, "Advanced Directive Acknowledgement: I HAVE executed the following portions of an Advance Medical Directive: Living Will, Optional Appointment of Agent to Make Healthcare Decisions. And Appointment of Agent for Making Anatomical Gift. I HAVE provided the Health & Rehabilitation Center with original directive(s). Yes or No. I HAVE provided the Health & Rehabilitation Center with a copy verified by the Health &Rehabilitation Center. Yes or No. The original is located (blank on form). I HAVE NOT executed Advance Medical Directive(s): (Please check one of the below) I DO WANT MORE INFORMATION regarding advance directives. I DO NOT WANT MORE INFORMATION regarding advance directives." Nothing on the form was checked off for either having or not

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having an advance directive and there were no check marks next to wanting or not wanting information regarding an advance directive.

The Face sheet of the clinical record documented in part, "Full Code."

The "Care Plan Meeting" notes dated, 11/3/2021, documented in part, "Care plan meeting held today with Patient, Patient's on...
Care plan reviewed and all questions answered. IDT will continue to follow and provide support."
The "Care Plan Meeting" notes dated, 12/14/2021, documented in part, "Care plan meeting held today with Patient, Patient's son in room....Care plan reviewed and all questions addressed. DCP will continue to follow and provide support."
The "Care Plan Meeting" notes dated, 3/22/2022, documented in part, "Care plan meeting held today with patient and daughter. Daughter would like to reschedule CPM (care plan meeting)...Care plan reviewed and all questions answered. IDT will continue to follow and provide support."
The "Care Plan Meeting" notes dated, 5/17/2022, documented in part, "Care plan meeting was held with patient and patient's nephew via phone...All questions were address and answered. IDT will continue to follow and provide support."

Review of the comprehensive care plan dated, 5/20/2022, failed to evidence documentation related to the resident's advance directive.

An interview was conducted with OSM (other staff member) #4, the admissions director, on 7/14/2022 at 8:27 a.m. When asked the process for obtaining the advance directive

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acknowledgment, OSM #4 stated they go into the resident's room and go over the contract. When they get to the page regarding the advance directive, "We ask if they are their own responsible party, do they have a power of attorney and if they have an advance directive." OSM #4 stated the resident and/or responsible party fill out the page. If the resident has an advance directive they ask for the documents to put in the resident's chart. When asked if before you sign this document under the resident or responsible party's signature, wouldn't you ensure the document is filled in, OSM #4 stated that this document was before she was hired and she would not sign the document unless reviews it to make sure it is filled in.

An interview was conducted with OSM #8, the discharge planning director, on 7/14/2022 at 8:38 a.m. OSM #8 was asked to review the page of the admission contract, "Advanced Directive Acknowledgement." After OSM #8 read the document she stated, "There is nothing there." When asked if she periodically reviewed with the resident and/or responsible party if the resident has or would like information on creating an advance directive, OSM #8 stated, "I will be honest. In April I did an audit of who needs them and who has them. I went through the chart and didn't read that is didn't have anything checked. Something should be documented." When asked if she discusses with the resident and/or responsible party in the care plan meeting, OSM #8 stated, "At times, but we need to be more thorough with that."

A request was made for documentation related to the advance directive for R29 on 7/14/2022 at 10:10 a.m. A copy of the "Advance Directives

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F 578	Continued From page 10 Acknowledgment" form dated 7/14/2022 was presented with check marks documenting the resident has an "Appointment of Agent to Make Healthcare Decisions." An interview was conducted with OSM #9, the assistant director of discharge planning, on 7/14/2022 at 12:49 p.m. When asked where the above document dated, 7/14/2022, OSM #9 stated she had contacted the resident's family today to get the form filled out. ASM #1, the administrator, was made aware of the above concern on 7/14/2022 at 2:01 p.m. No further information was obtained prior to exit.	F 578		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available	F 585		8/22/22

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to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to

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F 585	Continued From page 12 prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to resolve a grievance for 1 of 47 residents in the survey sample, Resident #57.	F 585	F585 1. Resident #47 was reimbursed for missing clothing on August 4, 2022. 2. Current residents have the potential to	

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	495424	A. BUILDING _____ B. WING _____	C 07/14/2022

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F 585	Continued From page 13 Resident #57 (R57) and/or the resident's family reported missing clothes to the facility staff in June 2022. The facility staff failed to resolve this grievance. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/29/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. On 7/12/22 at 1:19 p.m., an interview was conducted with R57. R57 stated it was hard finding personal belongings when the resident returns from the hospital. R57 stated approximately one month ago, it was difficult locating personal belongings upon the resident's readmission from the hospital. R57 stated the resident returned to a different room and some belongings including new shirts and pants were missing. R57 stated the family talked to someone in the maintenance and housekeeping departments but the resident was only provided clothes from the laundry department that did not belong to the resident. On 7/13/22 at 1:26 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (R57's unit manager) and OSM (other staff member) #8 (the discharge planning director). LPN #1 and OSM #8 were not aware of R57's missing clothes. On 7/13/22 at 2:33 p.m., another interview was conducted with LPN #1 and OSM #8. OSM #8	F 585	be affected. 3. Facility staff will be educated by the Staff Development Coordinator/designee on reporting resident grievances to the Administrator via email, written service concern, or verbally. 4. The Administrator/designee will complete the Grievance Form and track resolution of the grievance on a weekly basis. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 8/22/2022	

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stated R57's grievance regarding missing clothes was brought up at a care plan meeting on 6/7/22 but there was no specific documentation regarding the grievance. OSM #8 stated the discharge planning assistant spoke to the former housekeeping director and there was a manhunt to find the clothes but the clothes were never found. OSM #8 stated no one else was aware that the former housekeeping director could not locate R57's missing clothes so no further action was taken. In regards to the facility process for resolving grievances, OSM #8 stated the grievance should be addressed with the appropriate department via email, a service concern form or verbally. OSM #8 stated that if missing clothes cannot be found, the facility staff should follow up with the residents' family, have them purchase new clothes and bring in a receipt; then the facility will reimburse the family for the new clothes. OSM #8 stated the facility staff typically try to resolve grievances within a few days. LPN #1 stated that after the above interview on 7/13/22 at 1:26 p.m., she spoke with someone from the housekeeping department and another search for R57's missing clothes was completed. LPN #1 stated staff was unable to find the clothes so she had contacted R57's family, asked them to replace the clothes and bring in a receipt for reimbursement.

The former housekeeping director and discharge planning assistant were not available for interview.

A review of R57's clinical record failed to reveal documentation regarding missing clothes. A review of June 2022 grievances failed to reveal documentation regarding R57's missing clothes.

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F 585	Continued From page 15 On 7/14/22 at 8:35 a.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, "Grievances" documented, "1. Patient grievances/complaints filed with the Administrator will be processed and tracked via the (name of company) Grievance Form. The Administrator will make every reasonable effort to resolve grievances/complaints regarding the rights of the patient as promptly as possible. The review process by the Administrator is anticipated to be complete no later than five (5) business days from the Administrator receiving the filed grievance." No further information was presented prior to exit.	F 585		
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; (D) The health of individuals in the facility would	F 622		8/22/22

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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)(i) of this section.

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F 622	Continued From page 17 (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 and clinical record review, it was determined that the facility staff failed to provide the required documentation to the receiving facility at the time of a transfer for one of 47 residents in the survey sample, Resident #69 (R69). The findings include:	F 622	F622 1. No action taken for Resident #69 due to the time frame had already passed. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator/designee will educate the Licensed Nurses on the requirement for providing the required documentation with	

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F 622	Continued From page 18 The facility staff failed to evidence required documentation was provided for (R69) to the receiving facility for a facility-initiated transfer on 03/31/2022. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 05/24/2022, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. The facility's progress noted for (R69) dated 03/31/2022 documented, "Resident is alert and very confused with hallucinations. Sent out to ER (emergency room) for low H&H (hemoglobin (1) and hematocrit (2)) and AMS (altered mental status) ..." On 7/13/2022 at 2:39 p.m., an interview was conducted with LPN (licensed practical nurse) #1, unit manager. LPN #1 stated that they completed a change in condition assessment and transfer form in the computer and sent these documents with the resident to the hospital. LPN #1 stated that these documents included information regarding the resident and a summary of the current situation. Review of the clinical record and the EHR (electronic health record) failed to evidence documentation of required information provided to the hospital on 03/31/2022 for (R69). On 07/14/2022 at approximately 2:00 p.m., ASM (administrative staff member) # 2, director of nursing, stated that the change in condition assessment was not sent to the hospital at the	F 622	the resident when discharged to a receiving facility with documentation in the medical record. 4. The Unit Managers/designee will review 5x weekly in clinical meeting of facility-initiated transfers to ensure that required documentation was sent to the receiving facility with supporting documentation in the medical record that the information was sent. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 8/22/2022	

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F 622	Continued From page 19 time of (R69's) transfer on 03/31/2022. On 07/13/2022 at approximately 5:35 p.m., ASM # 1, administrator, and ASM # 2, and ASM # 4, regional director of clinical services and ASM # 5 , regional director of operations, were made aware of the above findings. No further information was provided prior to exit	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623		8/22/22

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be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance

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F 623	Continued From page 21 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide written notification to the resident and the resident's representative of a facility initiated transfer for 2 of 47 residents in the survey sample, Residents #69 (R69) and #138 (R138), and failed to notify the ombudsman of a facility-initiated transfer for 1 of 47 residents in the survey sample, Resident #138 (R138).	F 623	F623 1. No action was taken for Resident #69, due to the time frame has already passed. Resident #138 is no longer a resident in the facility. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator/designee will educate the Discharge Planners on notifying resident	

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F 623	Continued From page 22 The findings included: 1. The facility staff failed to evidence written notification was provided for (R69) and (R69's) responsible party for a facility-initiated transfer on 03/31/2022. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 05/24/2022, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. The facility's progress noted for (R69) dated 03/31/2022 documented, "Resident is alert and very confused with hallucinations. Sent out to ER (emergency room) for low H&H (hemoglobin (1) and hematocrit (2)) and AMS (altered mental status) ..." Review of the clinical record and the EHR (electronic health record) for (R69) failed to evidence written notification of discharge was provided to (R69) and (R69's) representative for the facility-initiated transfer on 03/31/2022. On 7/13/2022 at 3:17 p.m., an interview was conducted with OSM (other staff member) #8, discharge planner. OSM #8 stated that they were responsible for sending the written notification of transfer to the responsible party. OSM #8 stated that they send the notice to the responsible party when the resident has been out of the facility for 24 hours. OSM #8 stated that after 24 hours they filled out the written notification of transfer form, scanned a copy into the computer system, wrote	F 623	representatives of facility-initiated transfers and documenting the notification. The Staff Development Coordinator/designee will also educate the Discharge Planners on documentation of written notification to the ombudsman of resident transfers. 4. The Administrator/designee will complete a weekly review of transfers out of the facility to ensure that there is written documentation of representative and ombudsman notification of resident transfers. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 8/22/2022	

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a note in the medical record and mailed the notice to the responsible party.

On 07/14/2022 at approximately 2:00 p.m., ASM (administrative staff member) #2, director of nursing, stated that written notification was not provided to (R69's) and (R69's) representative regarding the transfer on 03/31/2022.

The facility's policy "Discharging Documentation" documented in part, "Provide proper advance written notification of the transfer/discharge to the patient and family member/ legal representative utilizing the MFA Notice of Transfer/Discharge form."

On 07/13/2022 at approximately 5:35 p.m., ASM #1, administrator, and ASM #2, and ASM #4, regional director of clinical services and ASM #5 , regional director of operations, were made aware of the above findings.

No further information was provided prior to exit

References:
1. A protein in red blood cells that carries oxygen. This information was obtained from the website: https://medlineplus.gov/ency/article/003645.htm.

2. A blood test that measures how much of a person's blood is made up of red blood cells. This measurement depends on the number of and size of the red blood cells. This information was obtained from the website: https://medlineplus.gov/ency/article/003646.htm.
2. The facility staff failed to evidence written notification of transfer to the responsible party and ombudsman notification for facility initiated transfers of Resident #138 (R138) on 5/28/2022

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and 5/30/2022.

R138's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 6/29/2022, the resident scored 9 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is moderately impaired for making daily decisions.

The progress notes for R138 documented in part,
- "5/28/2022 10:08 (10:08 a.m.) Note Text: Patient noted with right side nose bleeding, checked V/S (vital signs)163/107 (blood pressure), 82% (oxygen saturation), 2 liters O2 (oxygen) via NC (nasal cannula), 69 (pulse), 97.7 (temperature), BS (blood sugar) 123, noted wheezing upon auscultation, having difficulties breathing and sweating. O2 Sat went up 87% via 4 liters NC. called and notified to NP (nurse practitioner) [Name of NP] by [Name of staff] regarding patient change of conditions, ordered received to send patient out to via 911 to [Name of hospital] ER (emergency room) for further evaluations..."
- "5/30/2022 09:01 (9:01 a.m.) ... Pt (patient) with OT (occupational therapy) seen coughing up sputum with blood. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Send pt to ER..."

The clinical record failed to evidence documentation of written notification provided to the responsible party for the transfers on 5/28/2022 and 5/30/2022 or notification of the ombudsman of the transfers.

On 7/13/2022 at approximately 11:41 a.m., a request was made by written list to ASM

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(administrative staff member) #1, the administrator for evidence of written notification provided to the responsible party and ombudsman notification for the transfers on 5/28/2022 and 5/30/2022.

On 7/13/2022 at 2:39 p.m., an interview was conducted with LPN (licensed practical nurse) #1, unit manager. LPN #1 stated that they completed a change in condition assessment and transfer form in the computer and sent these documents with the resident to the hospital. LPN #1 stated that these documents included information regarding the resident and a summary of the current situation. LPN #1 stated that nursing did not provide any type of bed hold notice or any written notification of transfer to the resident or responsible party.

On 7/13/2022 at 3:17 p.m., an interview was conducted with OSM (other staff member) #8, the discharge planning director. OSM #8 stated that they were responsible for sending the written notification of transfer to the responsible party. OSM #8 stated that they send the notice to the responsible party when the resident has been out of the facility for 24 hours. OSM #8 stated that after 24 hours they filled out the written notification of transfer form, scanned a copy into the computer system, wrote a note in the medical record and mailed the notice to the responsible party. OSM #8 stated that at the end of each month they sent a list of discharges to the ombudsman.

On 7/14/2022 at 12:37 p.m., ASM #2, the director of nursing stated that they did not have an ombudsman notification for R138's transfers on 5/28/2022 and 5/30/2022. ASM #2 stated that

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F 623	Continued From page 26 they do not send ombudsman notification unless the resident was admitted to the hospital. On 7/14/2022 at 2:15 p.m., ASM #1, the administrator was made aware of the findings. No further information was provided prior to exit.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625		8/22/22

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F 625	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide a bed hold policy to the resident or the resident's representative upon a transfer to the hospital for 2 of 47 residents in the survey sample, Residents # 69 (R69) and #127 (R127). The findings included: 1. For (R69), facility staff failed to provide a copy of the bed hold policy to the resident or resident representative at the time of transfer on 03/31/2022. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 05/24/2022, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. The facility's progress noted for (R69) dated 03/31/2022 documented, "Resident is alert and very confused with hallucinations. Sent out to ER (emergency room) for low H&H (hemoglobin (1) and hematocrit (2)) and AMS (altered mental status) ..." Review of the clinical record and the EHR (electronic health record) for (R69) failed to evidence documentation that the bed hold policy was provided to (R69) or (R69's) responsible party in regard to the transfer to the hospital on 03/31/2022.	F 625	F625 1. No action was taken for Resident #69, due to the time frame had already passed. Resident #127 is no longer a resident in the center. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator/designee will educate the Admission Department on provision and documentation of the bed hold policy at time of a transfer to the hospital. 4. The Unit Managers/designee will complete a review of discharges weekly to ensure documentation of providing the bed hold policy for residents who were transferred to the hospital. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 8/22/2022	

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On 7/13/2022 at 3:30 p.m., an interview was conducted with OSM #4, the admissions director. OSM #4 stated that they were responsible for bed holds. OSM #4 stated that bed hold policies and procedures were reviewed on admission with all residents. OSM #4 stated that when a resident was admitted to the hospital they made a phone call to discuss bed hold with the responsible party but did not provide a hard copy except on admission.

On 07/13/2022 at approximately 5:35 p.m., ASM # 1, administrator, and ASM # 2, and ASM # 4, regional director of clinical services and ASM # 5 , regional director of operations, were made aware of the above findings.

No further information was provided prior to exit.

References:
1. A protein in red blood cells that carries oxygen. This information was obtained from the website: https://medlineplus.gov/ency/article/003645.htm.

2. A blood test that measures how much of a person's blood is made up of red blood cells. This measurement depends on the number of and size of the red blood cells. This information was obtained from the website: https://medlineplus.gov/ency/article/003646.htm.
2. The facility staff failed to provide written bed hold notice for a facility initiated transfer on 7/1/2022 for Resident #127 (R127).

On the most recent MDS (minimum data set), a five-day assessment with an ARD (assessment reference date) of 6/25/2022, the resident scored 4 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is

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severely impaired for making daily decisions.

The progress notes for R127 documented in part,
-"7/1/2022 14:33 (2:33 p.m.) ...Patient sent out to [Name of hospital] because patient noted with hypoxia (low oxygen level) and bradycardia (low heart rate). NP (nurse practitioner) notified as per NP orders called 911 EMS (emergency medical services) took patient to [Name of hospital]. Patient wife was present in patient room..."
-"7/4/2022 15:33 (3:33 p.m.) ...Patient discharged to hospital with transport on 7/1..."

The clinical record failed to evidence documentation of a written bed hold notice being provided to R127's responsible party for the admission to the hospital on 7/1/2022.

On 7/13/2022 at 2:39 p.m., an interview was conducted with LPN (licensed practical nurse) #1, unit manager. LPN #1 stated that they completed a change in condition assessment and transfer form in the computer and sent these documents with the resident to the hospital. LPN #1 stated that these documents included information regarding the resident and a summary of the current situation. LPN #1 stated that nursing did not provide any type of bed hold notice to the resident or responsible party.

On 7/13/2022 at 3:30 p.m., an interview was conducted with OSM (other staff member) #4, the admissions director. OSM #4 stated that they were responsible for bed holds. OSM #4 stated that bed hold policies and procedures were reviewed on admission with all residents. OSM #4 stated that when a resident was admitted to the hospital they made a phone call to discuss bed hold with the responsible party but did not

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F 625	Continued From page 30 provide a hard copy except on admission. On 7/14/2022 at approximately 11:28 a.m., ASM #5, the regional director of clinical services, stated that they did not have evidence of a bed hold notice to provide for R127 for the facility initiated transfer on 7/1/2022. On 7/14/2022 at approximately 2:15 p.m., ASM #1, the administrator was made aware of the findings. No further information was provided prior to exit.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to correctly code an admission MDS (minimum data set) assessment for one of 47 residents in the survey sample, Resident #113 (R113). The findings include: Section N of the admission MDS with the ARD (assessment reference date) of 6/22/2022 coded R113 as receiving insulin injections during the assessment look back period, however there was no evidence of R113 receiving insulin. On the most recent MDS, an admission assessment with an ARD of 6/22/2022, the	F 641	F641 1. Resident #113□s MDS has been modified to reflect accurate coding of insulin administration. 2. A review of MDS(s) completed in the last 30 days was conducted to ensure section N-item N0350A was coded correctly. 3. The MDS Coordinators will be educated by the Regional Director of MDS/designee on accurate coding of Section N-item N0350A on admission MDS assessments. 4. The Regional Director of MDS/designee will complete a random review of Section N-item N0350A on MDS assessments completed for the week to	8/22/22

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F 641	Continued From page 31 resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. The physician orders for R113 failed to evidence an order for insulin. The eMAR (electronic medication administration record) for R113 dated 6/1/2022-6/30/2022 failed to evidence insulin administration. On 7/13/2022 at 3:40 p.m., an interview was conducted with RN (registered nurse) #2, MDS coordinator. RN #2 stated that Section N of the MDS had a seven day look back period. RN #2 stated that they reviewed the clinical record to obtain the information they used to code Section N including the physician orders and eMAR. RN #2 stated that they were not sure why insulin was coded on R113's admission MDS with the ARD of 6/22/2022 and they would investigate it. On 7/13/2022 at 3:52 p.m., an interview was conducted with RN #3, MDS coordinator. RN #3 stated that they used the RAI manual when completing the MDS. RN #3 reviewed R113's admission MDS with the ARD of 6/22/2022 and stated that they would have to investigate to see why they had coded it for insulin. RN #3 stated that they were not sure if it was due to the Ozempic (injectable antihyperglycemic medication) that R113 was receiving or not and they would have to check to see if this was supposed to be coded as insulin or not. On 7/13/2022 at 4:16 p.m., RN #3 stated that they had reviewed the admission assessment for R113 with the ARD of 6/22/2022 and had coded it	F 641	ensure accuracy of coding. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 8/22/2022	

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F 641	Continued From page 32 for insulin due to the administration of the medication Ozempic. RN #3 stated that they should not have coded this medication as insulin and needed to correct the MDS. According to the RAI Manual, Version 1.16, dated October 2018, section N0350: Insulin documented in part, "...Coding Instructions for N0350A, Enter in Item N0350A, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received..." On 7/13/2022 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical services and ASM #5, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.	F 641		
F 655 SS=E	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		8/22/22

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F 655	Continued From page 33 (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 resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to develop a baseline care plan and/or provide a written summary of the baseline care plan for 4 of 47 residents in the survey sample, Residents #115, #138, #113 and #247. The findings include:	F 655	F655 1. Resident #115□s care plan has been revised to reflect the pressure ulcers. Resident #138 and Resident # 247 are no longer in the facility. Resident #113 provided a written summary of the baseline care plan. 2. Current residents have the potential to be affected.	

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F 655	Continued From page 34 1. The facility staff failed to develop a baseline care plan for Resident #115 (R115) for pressure ulcers that were present on admission to the facility. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/23/2022 the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is cognitively intact for making daily decisions. Section M documented R115 having one Stage 3 pressure ulcer present upon admission to the facility and one unstageable-deep tissue injury present on admission to the facility. On 7/12/2022 at 2:30 p.m., an interview was conducted with R115 in their room. R115 stated that they had been in the facility for about a month. R115 stated that they had come to the facility for therapy and had several wounds that the nurses provided treatments to several times a day. The "Admission/Readmission Nursing Collection Tool" for R115 dated 6/17/2022 documented in part, "...Skin observations: Sacrum, Pressure, Length 5.2, Width 7.0, Stage III...Right heel, Pressure, Suspected deep tissue injury...Pt was noted with pressure ulcer at the sacrum, bruises at the abdomen, redness at both heels, right sided weakness..." The baseline care plan for R115 documented in part, "Skin: [Name of R115] has potential for skin impairment r/t (related to) anticoagulant use and limited mobility. Created on 06/17/2022." The	F 655	3. The Regional Director of MDS/designee will educate the IDT team on development of a baseline care plan and providing a baseline care plan summary to the resident and/or their responsible party. 4. The Regional Director of MDS/designee will review 5 admissions weekly to ensure baseline care plans are completed with documentation in the medical record of providing a summary of the baseline care plans to the resident and/or responsible party. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 8/22/2022	

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baseline care plan failed to address the pressure ulcers that were observed on admission to the facility on 6/17/2022.

On 7/14/2022 at 7:50 a.m., an interview was conducted with RN (registered nurse) #1, the assistant director of nursing. RN #1 stated that the baseline care plan was completed by the admission nurse. RN #1 stated that the baseline care plan should include the ADL's (activities of daily living), fall risk, pain, skin risk, isolation if applicable and any intravenous therapy. RN #1 stated that the purpose of the care plan was to be a guideline of how to care for the resident and provide resident care. RN #1 stated that staff should be able to go in the care plan and see what the resident needs and how to care for them. RN #1 reviewed the care plan for R115 and stated that there was no care plan addressing the pressure ulcers. RN #1 stated that if R115 had the pressure ulcers on admission they should have been addressed on the baseline care plan and there should be a comprehensive care plan addressing them.

The facility policy "Resident Assessment & Care Planning" dated 11/1/2019 documented in part, "Policy: A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient. Procedure: 1. The computerized baseline Care Plan is initiated and activated within 48 hours. The Center will provide the patient and representative(s) with a summary of the baseline care plan that includes, but is not

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limited to: The initial goals of the patient, A summary of the patient's medications list, The patient's dietary instructions, Any services and treatments to be administered by the Center and personnel acting on behalf of the Center, Any updated information based on the details of the comprehensive care plan..."

On 7/14/2022 at 10:52 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical services, ASM #5, the regional director of clinical services and ASM #6, the vice president of operations were made aware of the findings.

No further information was provided prior to exit.

2. The facility staff failed to evidence that a written summary of the baseline care plan was provided to Resident #138 (R138) or their responsible party.

R138's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 6/29/2022, the resident scored 9 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is moderately impaired for making daily decisions.

A baseline care plan for R138 was completed on 5/22/2022. The clinical record failed to evidence that a written summary of the baseline care plan was provided to the resident and/or the responsible party.

On 7/14/2022 at 7:50 a.m., an interview was conducted with RN (registered nurse) #1, the

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assistant director of nursing. RN #1 stated that the baseline care plan was completed by the admission nurse. RN #1 stated that the baseline care plan should include the ADL's (activities of daily living), fall risk, pain, skin risk, isolation if applicable and any intravenous therapy. RN #1 stated that the next day the interdisciplinary team had a "jump start" meeting where they all went in and introduced themselves to the resident and provided a copy of the baseline care plan and medication list to the resident. RN #1 stated that the unit manager should document this in a progress note. RN #1 stated that within a few days the unit manager completed the comprehensive care plan and included any other care areas that needed to be included. RN #1 stated that the unit manager or the MDS (minimum data set) staff would review and revise the care plan as needed. RN #1 stated that the purpose of the care plan was to be a guideline of how to care for the resident and provide resident care. RN #1 stated that staff should be able to go in the care plan and see what the resident needs and how to care for them.

Review of the progress notes for R138 failed to evidence documentation of a written summary of the baseline care plan being provided to the resident and/or the responsible party.

On 7/14/2022 at 10:10 a.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of a written summary of the baseline care plan being provided to the resident and/or the responsible party for R138.

On 7/14/2022 at 12:37 p.m., ASM #2, the director of nursing, stated that they did not have any documentation to provide that a written summary

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of the baseline care plan was provided to R138 or and/or the responsible party.

On 7/14/2022 at 10:52 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical services, ASM #5, the regional director of clinical services and ASM #6, the vice president of operations were made aware of the findings.

No further information was provided prior to exit.

3. The facility staff failed to evidence that a written summary of the baseline care plan was provided to Resident #113 (R113) and/or their responsible party.

On the most recent MDS, an admission assessment with an ARD of 6/22/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions.

On 7/12/2022 at 2:14 p.m., an interview was conducted with R113 in their room. When asked if the facility staff provided them with a written copy of their care plan, R113 stated that staff had been in and asked them questions but did not remember receiving any papers.

A baseline care plan for R113 was completed on 6/16/2022. The clinical record failed to evidence that a written summary of the baseline care plan was provided to the resident and/or the responsible party.

On 7/14/2022 at 7:50 a.m., an interview was

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conducted with RN (registered nurse) #1, the assistant director of nursing. RN #1 stated that the baseline care plan was completed by the admission nurse. RN #1 stated that the baseline care plan should include the ADL's (activities of daily living), fall risk, pain, skin risk, isolation if applicable and any intravenous therapy. RN #1 stated that the next day the interdisciplinary team had a "jump start" meeting where they all went in and introduced themselves to the resident and provided a copy of the baseline care plan and medication list to the resident. RN #1 stated that the unit manager should document this in a progress note. RN #1 stated that within a few days the unit manager completed the comprehensive care plan and included any other care areas that needed to be included. RN #1 stated that the unit manager or the MDS (minimum data set) staff would review and revise the care plan as needed. RN #1 stated that the purpose of the care plan was to be a guideline of how to care for the resident and provide resident care. RN #1 stated that staff should be able to go in the care plan and see what the resident needs and how to care for them.

Review of the progress notes for R113 failed to evidence documentation of a written summary of the baseline care plan being provided to the resident and/or the responsible party.

On 7/14/2022 at 10:10 a.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of a written summary of the baseline care plan being provided to the resident and/or the responsible party for R113.

On 7/14/2022 at 12:37 p.m., ASM #2, the director of nursing, stated that they did not have any

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documentation to provide that a written summary of the baseline care plan was provided to R113 or and/or the responsible party.

On 7/14/2022 at 10:52 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical services, ASM #5, the regional director of clinical services and ASM #6, the vice president of operations were made aware of the findings.

No further information was provided prior to exit.
4. The facility's baseline care plan for (R247) dated 07/14/2022 failed to evidence documentation for the use of a wound vac. (R247) was admitted to the facility with a diagnoses that included by not limited to: type 2 (two) diabetes mellitus (1).

The most recent MDS (minimum data set), an admission assessment was not due at the time of the survey.

The admission assessment for (R247) dated 07/10/2022 documented in part, "Cognitively intact."

The facility's "Skilled Daily Documentation" note for (R247) dated 07/11/2022 documented in part, "16. Skilled Nursing Focus: Resident alert and orientated. Wound vac applied by wound nurse."

The physician's order for (R247) documented in part, "Change wound vac to right thigh (rear) @ 120 mmgh (millimeters of mercury) continuous suction every day shift every MON, Wed, Fri. Order Date 7/11/2022."

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On 7/14/2022 at 7:50 a.m., an interview was conducted with RN (registered nurse) #1, the assistant director of nursing. RN #1 stated that the baseline care plan was completed by the admission nurse. RN #1 stated that the baseline care plan should include the ADL's (activities of daily living), fall risk, pain, skin risk, isolation if applicable and any intravenous therapy. RN #1 stated that the next day the interdisciplinary team had a "jump start" meeting where they all went in and introduced themselves to the resident and provided a copy of the baseline care plan and medication list to the resident. RN #1 stated that the unit manager should document this in a progress note. RN #1 stated that within a few days the unit manager completed the comprehensive care plan and included any other care areas that needed to be included. RN #1 stated that the unit manager or the MDS (minimum data set) staff would review and revise the care plan as needed. RN #1 stated that the purpose of the care plan was to be a guideline of how to care for the resident and provide resident care. RN #1 stated that staff should be able to go in the care plan and see what the resident needs and how to care for them.

On 07/14/2022 at approximately 8:15 a.m., an interview was conducted with RN # 1. After reviewing the baseline care plan for (R247) ADON stated that the care plan did not address (R247's) use of wound vac.

On 07/14/2022 at approximately 11:00 a.m., ASM (administrative staff member)# 1, administrator, ASM # 2, director of nursing, ASM # 3, were made aware of the findings.

No further information was provided prior to exit.

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F 655	Continued From page 42 References: (1)Vacuum-assisted closure of a wound is a type of therapy to help wounds heal. It's also known as wound VAC. During the treatment, a device decreases air pressure on the wound. This can help the wound heal more quickly. The gases in the air around us put pressure on the surface of our bodies. https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/vacuumassisted-closure-of-a-wound#:~:text=Vacuum%2Dassisted%20closure%20of%20a%20wound%20is%20a%20type%20of,the%20surface%20of%20our%20bodies.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		8/22/22

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F 656	Continued From page 43 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to develop a comprehensive care plan for one of 47 residents in the survey sample, Residents #115. The findings include: The facility staff failed to develop a comprehensive care plan for Resident #115 (R115) for pressure ulcers that were present on admission to the facility. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/23/2022 the resident scored 14 out of 15 on the BIMS (brief interview for	F 656	F656 1. Resident #115□s care plan has been revised to include the pressure ulcers. 2. Current residents have the potential to be affected. 3. The Regional Director of MDS/designee will educate IDT team on development of the comprehensive care plan to reflect resident□s current status. 4. Regional Director of MDS/designee will review 5 comprehensive care plans weekly to ensure the care plan reflects the resident□s current status including ensuring pressure areas (if any) are addressed in the plan of care. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the	

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F 656	Continued From page 44 mental status) assessment, indicating the resident is cognitively intact for making daily decisions. Section M documented R115 having one Stage 3 pressure ulcer present upon admission to the facility and one unstageable-deep tissue injury present on admission to the facility. On 7/12/2022 at 2:30 p.m., an interview was conducted with R115 in their room. R115 stated that they had been in the facility for about a month. R115 stated that they had come to the facility for therapy and had several wounds that the nurses provided treatments to several times a day. The "Admission/Readmission Nursing Collection Tool" for R115 dated 6/17/2022 documented in part, "...Skin observations: Sacrum, Pressure, Length 5.2, Width 7.0, Stage III...Right heel, Pressure, Suspected deep tissue injury...Pt was noted with pressure ulcer at the sacrum, bruises at the abdomen, redness at both heels, right sided weakness..." The baseline care plan for R115 documented in part, "Skin: [Name of R115] has potential for skin impairment r/t (related to) anticoagulant use and limited mobility. Created on 06/17/2022." The baseline care plan failed to address the pressure ulcers that were observed on admission to the facility on 6/17/2022. The comprehensive care plan documented the same as documented above baseline care plan. The physician orders for R115 documented in part, - "Order Date: 6/21/2022 15:10 (3:10 p.m.) Clean	F 656	problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 8/22/2022	

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pressure ulcer to sacrum with normal saline, pat dry and apply Honey Fiber and dry dressing every evening shift for wound care and as needed for incont. (incontinence) care apply barrier cream." - "Order Date: 6/20/2022 13:28 (1:28 p.m.) Cleanse right heel (DTI) (deep tissue injury) with NS (normal saline) pat dry and apply skin prep, every day and evening shift for wound care."

On 7/14/2022 at 7:50 a.m., an interview was conducted with RN (registered nurse) #1, the assistant director of nursing. RN #1 stated that the purpose of the care plan was to be a guideline of how to care for the resident and provide resident care. RN #1 stated that staff should be able to go in the care plan and see what the resident needs and how to care for them. RN #1 stated that within a few days after admission, the unit manager completed the comprehensive care plan and included any care areas that needed to be included that were not already in the baseline care plan. RN #1 stated that the unit manager or the MDS (minimum data set) staff would review and revise the care plan as needed. RN #1 reviewed the baseline and comprehensive care plan for R115 and stated that there was no care plan addressing the pressure ulcers. RN #1 stated that if R115 had the pressure ulcers on admission they should have been addressed on the baseline care plan and there should be a comprehensive care plan addressing them also.

The facility policy "Resident Assessment & Care Planning" dated 11/1/2019 documented in part, "Policy: A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care,

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F 656	Continued From page 46 and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient..." On 7/14/2022 at 10:52 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical services, ASM #5, the regional director of clinical services and ASM #6, the vice president of operations were made aware of the findings. No further information was provided prior to exit.	F 656		
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		8/22/22

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F 657	Continued From page 47 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, clinical record review, and facility document review, it was determined that the facility staff failed to review and/or revise the comprehensive care plan for 3 of 47 residents in the survey sample, Residents #113, #28 and #57. The findings include: 1. The facility staff failed to review and revise Resident #113's (R113) comprehensive care plan to include the use of a CPAP (continuous positive airway pressure machine) and incentive spirometer. On the most recent MDS, an admission assessment with an ARD of 6/22/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section O did not document R113 using a CPAP during the assessment period. On 7/12/2022 at 2:14 p.m., an interview was conducted with R113 in their room. A CPAP machine was observed on the nightstand to the right of the residents bed with a mask lying on top of the machine uncovered. When asked about the CPAP machine and mask, R113 stated that they wore the mask at night when sleeping for sleep apnea. An incentive spirometer was	F 657	F657 1. Resident #113□s care plan was revised to include use of the CPAP. The incentive spirometer was discontinued for Resident #113. Resident #28□s care plan was revised to include fall interventions. Resident # 57□s care plan was revised to include use of the CPAP. 2. Current residents have the potential to be affected. 3. The Regional Director of MDS/designee will educate IDT team on development a comprehensive care plan to reflect resident□s current status. 4. Regional Director of MDS/designee will review 5 comprehensive care plans weekly to ensure the care plan reflects the resident□s current status including ensuring CPAP(s) and incentive spirometer (if ordered) are addressed in the care plan. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 8/22/2022	

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observed on the nightstand in front the CPAP machine uncovered. When asked about the incentive spirometer, R113 stated that they were given the spirometer in the hospital and used it "a few times a day." When asked if the facility staff covered or cleaned the CPAP mask or incentive spirometer when not in use, R113 stated that they had never seen it done.

The comprehensive care plan for R113 documented in part, "Nursing Care Needs: [Name of R113] has nursing care needs r/t (related to) DM2 (diabetes mellitus type 2), OSA (obstructive sleep apnea), hypertension, hypothyroidism, right knee cellulitis, arthritis, right kneed wound. Created on: 06/17/2022." The care plan failed to evidence use of an incentive spirometer or a CPAP.

The progress notes for R113 documented in part, "6/16/2022 23:45 (11:45 p.m.) Patient is [Age and sex of R113] admitted to facility at 20:42 (8:42 p.m.) via stretcher and accompanied by paramedics...OSA on CPAP..."

The physician orders for R113 failed to evidence an order for the use of a CPAP or an incentive spirometer.

On 7/13/2022 at 3:01 p.m., an interview was conducted with RN (registered nurse) #1, the assistant director of nursing. RN #1 stated that stated that the purpose of the care plan was to be a guideline of how to care for the resident and provide resident care. RN #1 stated that staff should be able to go in the care plan and see what the resident needs and how to care for them. RN #1 stated that the unit manager or the MDS (minimum data set) staff would review and

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revise the care plan as needed. RN #1 stated that incentive spirometer use and CPAP use would be included in the residents nursing care plan. RN #1 stated that R113's care plan should reflect the use of the incentive spirometer and the CPAP.

The facility policy "Resident Assessment & Care Planning" dated 11/1/2019 documented in part, "Policy: A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient..."

On 7/14/2022 at 10:52 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical services, ASM #5, the regional director of clinical services and ASM #6, the vice president of operations were made aware of the findings.

No further information was provided prior to exit.
2. The facility staff failed to review and revise the care plan for falls for Resident #28 (R28).

R28 had diagnoses that included but were not limited to: absence of left foot, absence of toes on right leg, and peripheral vascular disease.

On the most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/7/2022, the resident scored a 10 out of 15 of the BIMS (brief interview for mental status) score, indicating

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the resident was moderately cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as extensive assistance of one person for moving in the bed, transfers, walking in the room, and toileting. In Section J - Health Conditions R28 was coded as having had two or more falls during the look back period.

The nurse's note dated, 5/4/2022 at 1:06 p.m. documented in part, "Resident had an unwitnessed fall in her room with hematoma noted to face and skin tear to RUE (right upper extremity - arm). Nursing staff observed resident in a posterior position beside her WC (wheelchair) during rounding. Resident unable to verbalize situation that led to fall, neuro (neurological) check initiated per facility protocol, all parties made aware of fall and resident is her own RP (responsible party), safety measures in place to prevent further fall."

The nurse's note dated, 5/5/2022 at 11:32 p.m. documented in part, "While making rounds pt (patient) observed sitting on the floor next to her bed, bed was in lowest position and all light was within reach. Pt stated, 'I was trying to transfer from the bed to the wheelchair and slid from the chair.' Head to toe assessment done, ROM (range of motion) done, no abnormalities noted, no injury observed, neuro checks initiated, NP (nurse practitioner) and RP (responsible party) made aware...transferred back to bed with 2 staff assistance, currently sleeping well with no distress observed."

The comprehensive care plan dated, 2/8/2022 and revised on 5/23/2022, documented in part, "Focus: (R28) sustained a fall and is at risk for

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further falls related to: muscle weakness, poor vision, psychoactive medications, requiring assistive devices to walk or transfer, unsteady gait, unaware of safety needs." The "Interventions" documented, "2/9/2022 - Ensure that (R28) is wearing appropriate footwear when ambulating or mobilizing in w/c (wheelchair). 2/9/2022 - Keep environment free of trip hazards. 2/9/2022 - Remind (R28) to use their call light to ask for assistance with ADLS (activities of daily living). 5/2/2022 - Assist as needed. 5/2/2022 - Bed to low position. 2/9/2022 - Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. 2/9/2022 - encourage resident to wear their glasses when out of bed. 2/9/2022 - Ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed. 4/8/2022 - Frequent rounds. 4/25/2022 - Incontinent care as needed. 2/9/2022 - non-skid socks while out of bed. 2/9/2022 - Place common items within reach of the resident. 2/9/2022 - PT (physical therapy) evaluate and treat as ordered or PRN (as needed). 2/9/2022 - Remind the resident to use their walker to perform ADLS. 2/9/2022 - Therapy referral."

Review of the "Post Fall Investigation" dated, 5/4/2022 at 12:50 p.m. failed to evidence documentation related to the care plan.
Review of the "Post Fall Investigation" dated, 5/5/2022 at 3:15 p.m. failed to evidence documentation related to the care plan.

An interview was conducted with RN (registered nurse) #1, the assistant director of nursing on 7/14/2022 at 1:06 p.m. When asked what the purpose of the care plan is, RN #1 stated it's a guideline to provide care for our patients, it tells

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you what to do for them. RN #1 was asked to review the care plan and fall investigations above. When asked does she see on the care plan where it was reviewed or revised in regards to the resident's falls on 5/4/2022 and 5/5/2022, RN #1 stated the resident has balance issues. When asked if there should be a new interventions for each fall, RN #1 stated, yes, for every fall. When asked if she saw an interventions for the above two falls, RN #1 stated, no.

ASM (administrative staff member) #1, the administrator, was made aware of the above concerns on 7/14/2022 at approximately 2:10 p.m.

No further information was provided prior to exit.
3. The facility staff failed to review and revise Resident #57's (R57) comprehensive care plan for the use of a CPAP (continuous positive airway pressure) machine.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/29/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions.

A review of R57's clinical record revealed a physician's order to apply a CPAP every evening and night shift. R57's comprehensive care plan dated 5/17/22 failed to document information regarding a CPAP machine.

On 7/12/22 at 1:19 p.m. and 7/13/22 at 8:37 a.m., a CPAP machine was observed on R57's nightstand.

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F 657	Continued From page 53 On 7/14/22 at 8:01 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated a care plan is a guideline for how staff takes care of patients. RN #1 stated, "You should be able to go in there to see what the patient needs to take care of them." RN #1 stated a resident's care plan should be reviewed and revised to include the use of a CPAP machine. On 7/14/22 at 8:35 a.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 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to provide ADL (activities of daily living) care for one of 47 residents in the survey sample, Resident #300. The facility staff failed to offer and provide bathing/showers to Resident #300 (R300) on multiple dates in November 2021 and December 2021. The findings include:	F 677	F677 1. Resident #300 is no longer a resident in the center. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator/designee will educate Licensed Nurses/CNAs on providing and accurate documentation of showers. 4. The Unit Managers/designee will complete a review for 10 residents weekly to ensure ADL records reflect completion of showers. 5. The results of the review will be	8/22/22

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F 677	Continued From page 54 On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/28/21, the resident scored 10 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately cognitively impaired for making daily decisions. Section G coded R300 as being totally dependent on one staff with bathing. A review of R300's ADL records for the resident's stay from 11/22/21 through 12/22/21 only revealed documentation that the resident received bathing/shower on four days (11/30/21, 12/3/21, 12/10/21 and 12/17/21), per coding related to the legend on the ADL records (the legend coding documented): 1- Task Completed? 0 - Yes 1 - No 2 - Resident Not Available 3 - Resident Refused 4 - Not Applicable 2- BATHING: SELF PERFORMANCE - How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair) 0 -INDEPENDENT - No help provided 1 - SUPERVISION - Oversight help only 2 - Physical help limited to transfer only 3 - Physical help in part of bathing activity 4 - TOTAL DEPENDENCE 8 - Activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity 3- BATHING: SUPPORT PROVIDED - How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair) 0 - No setup or physical help from staff 1 - Setup help only 2 - One person physical assist 3 - Two+ persons physical assist 8 - ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time	F 677	discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 8/22/2022	

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4- Type of Skin Hygiene Sh- Shower Ba- Bath BB- Bed Bath).

There was coding on the ADL records for 11/23/21, 11/26/21, 12/7/21 and 12/14/21 but this coding did not correlate to the legend and did not indicate bathing/shower was provided.
The coding for 11/23/21, 11/26/21 and 12/7/21 documented: "-97, 8, 8, -97".
The coding for 12/14/21 documented: "-98, 8, 8, -98".

One of the CNAs (certified nursing assistants) who documented the inaccurate coding was not available for interview. On 7/13/22 at 2:41 p.m., an interview was conducted with CNA (certified nursing assistant) #3 (the other CNA who documented the inaccurate coding). CNA #3 stated residents are supposed to receive a shower twice a week according to a shower schedule and receive a partial or complete bed bad all other days. CNA #3 was shown R300's ADL records and stated she was not sure what her coding meant. CNA #3 stated she could not recall if R300 was provided bathing/shower on the days she inaccurately coded the records.

On 7/14/22 at 8:04 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated every resident is scheduled a shower two days a week and can receive additional showers as requested. RN #1 stated CNAs are supposed to evidence that bathing/showers are provided on the ADL records and CNAs are supposed to complete shower sheets but sometimes the shower sheets are not done. RN #1 was shown R300's ADL records and stated she did not understand the codes documented by CNA #3 and the other CNA. RN #1 stated the CNAs have

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F 677	Continued From page 56 to document the correct codes according to the legend on the ADL records and should complete the shower sheets. RN #1 stated the CNAs cannot evidence that bathing/shower was provided unless they do this. RN #1 was asked to provide shower sheets for R300. No shower sheets were provided. On 7/14/22 at 8:35 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. ASM #1 and ASM #2 were asked to provide shower sheets for R300. No shower sheets were provided. The facility policy titled, "Shift Responsibilities for CNA" documented, "4. Perform shift responsibilities/assignments that promote quality of care..." No further information was provided prior to exit. Complaint deficiency.	F 677		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 695	F695	8/22/22

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F 695	Continued From page 57 interview, facility document review and clinical record review, it was determined the facility staff failed to provide respiratory services for 4 of 47 residents in the survey sample, Residents #39, #8, #113 and #57. The findings include: 1. For Resident #39 (R39), the facility staff failed to administer oxygen at the physician prescribed rate and failed to store respiratory equipment in a sanitary manner. R39 has a diagnosis of chronic obstructive pulmonary disease (COPD). On the most recent MDS (minimum data set) assessment, the resident was coded as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen while a resident at the facility. Observation was made on 7/12/2022 at approximately 1:00 p.m. of R39 sitting up in their wheelchair. The resident had oxygen on via a nasal cannula (two prong sitting inside the nose). The oxygen concentrator was set at 3 LPM (liters per minute). R39 stated they were supposed to be on 2 LPM. A nebulizer mask was sitting on top of a paper towel uncovered. There was a portable oxygen tank behind the resident in a stand, and the oxygen tubing was wrapped around the top of the tank, not covered. A second observation was made of R39 on 7/13/2022 at 8:36 a.m. sitting up in their wheelchair eating breakfast. The nebulizer mask	F 695	1. Resident #39 is receiving oxygen at the ordered rate and equipment is being stored in a sanitary manner. Resident #8 is receiving oxygen at the ordered rate. Resident #113□s CPAP and incentive spirometer are stored in a sanitary manner and have current orders for use. Resident #57□s CPAP is stored in a sanitary manner. 2. Current residents in the center receiving respiratory therapy including oxygen, incentive spirometers, and CPAP(s) have the potential to be affected. 3. The Staff Development Coordinator/designee will educate current licensed Nurses on obtaining orders for use of incentive spirometer and CPAP, sanitary storage of incentive spirometers and CPAPs, and providing oxygen at the ordered rate. 4. The Unit Managers/designee will complete review of new admissions in the center weekly to ensure there are orders in place for any type of respiratory services (ex: O2, incentive spirometer and/or CPAP(s). In addition, Unit Managers/designee will via direct observation 3x weekly to verify residents O2 is at the order rate and that equipment is being stored in a sanitary manner. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction.	

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F 695	Continued From page 58 was sitting on the nightstand, uncovered, on a paper towel. The resident stated they had not used the nebulizer mask as she had refused her treatment as they were not feeling well. The oxygen was set between 2.5 and 3 LPM. Observation was made on 7/13/2022 at 3:19 p.m. accompanied by RN (registered nurse) #1, the assistant director of nursing. The oxygen level was still set at 3 LPM, the nebulizer mask was still sitting on the night stand, and the oxygen tubing remained wrapped around the oxygen tank. When asked how the nurses read the oxygen concentrator, RN #1 stated it's by the black lines. The ball is supposed to be in the middle. RN #1 was asked to clarify where the ball and line were to be. RN #1 stated the line is supposed to run through the middle of the ball. When asked if the oxygen was set correctly, RN #1 stated, no, not if she is supposed to be on 2 LPM. When asked how the nebulizer mask is to be stored, RN #1 stated after the treatment is given, the nurse is to rinse it and let it air dry. Then the nurse returns and puts it in a bag. When asked how the oxygen tubing should be stored, RN #1 stated it should be stored in a plastic bag. The physician order dated, 6/29/2022, documented, "Oxygen Therapy - Oxygen at (2) liters per minute via nasal cannula every shift." The nurse's note dated, 7/12/2022 at 10:22 p.m. documented in part, Pt (patient) continues O2 (oxygen) therapy @ (at) 2 LPM via nasal cannula." The comprehensive care plan dated, 6/29/2022, documented in part, "OXYGEN THERAPY: (R39) has oxygen therapy r/t (related to) CHF	F 695	6. Date of compliance: 8/22/2022	

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(congestive heart failure)." The "Interventions" documented in part, "OXYGEN SETTINGS: O2 via nasal cannula."

The facility policy, "Respiratory/Oxygen Equipment" documented in part, "Licensed staff will administer and maintain respiratory equipment, oxygen administration and oxygen equipment per physician's order and in accordance with standard of practice...Medicated Nebulizer Treatment...5. Rinse out nebulizer reservoir with tap water, dry, and place in a plastic gab when no tin use...Oxygen Therapy via Nasal Cannula, Simple Mask, Venturi Mask and Oximizer.....5. Store oxygen tubing/mask in plastic storage bag when not in use."

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment."

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, regional director of clinical services and

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ASM #5, regional director of clinical services were made aware of the above concern on 7/13/2022 at 5:30 p.m.

No further information was provided prior to exit.

2. For Resident #8 (R8), the facility staff failed to administer oxygen per the physician orders.

On the most recent MDS (minimum data set) assessment, quarterly assessment, with an assessment reference date of 4/10/2022, the resident was coded as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section O - Special Treatments, Procedures and Programs, coded the resident as receiving oxygen while a resident at the facility.

Observation was made of R8 on 7/12/2022 at approximately 1:05 p.m. R8 was in bed, with oxygen on via a nasal cannula. The oxygen concentrator was set at 1.5 LPM. The resident stated they were supposed to be on 3 LPM.

A second observation was made on 7/13/2022 accompanied by RN #1. When asked to look at the oxygen concentrator setting, RN #1 stated it looked like it was on 1.75, not on 2 but not on 1.5, the ball was between them. When asked how the nurses read the oxygen concentrator, RN #1 stated it's by the black lines. The ball is supposed to be in the middle. RN #1 was asked to clarify where the ball and line were to be. RN #1 stated the line is supposed to run through the middle of the ball. When asked if the oxygen was set correctly, RN #1 stated she would have to check the physician's orders.

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The physician order dated, 10/3/2020, documented, "Oxygen Therapy @ 2 L (liters per minute) via NC (nasal cannula) for comfort every shift for SOB (shortness of breath). Maintain saturation of 90% or higher."

The comprehensive care plan dated, 10/3/2020 and revised on 1/28/2022, documented in part, "Focus: OXYGEN THERAPY: (R8) has oxygen therapy r/t (related to) ineffective gas exchange." The "Interventions" documented in part, "OXYGEN THERAPY: O2 (oxygen) via nasal cannula."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, regional director of clinical services and ASM #5, regional director of clinical services were made aware of the above concern on 7/13/2022 at 5:30 p.m.

No further information was provided prior to exit.
3. The facility staff failed to store a CPAP (continuous positive airway pressure) mask and incentive spirometer in Resident #113's (R113) room in a sanitary manner and obtain an order for their use.

On the most recent MDS, an admission assessment with an ARD of 6/22/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section O did not document R113 using a CPAP during the assessment period.

On 7/12/2022 at 2:14 p.m., an interview was conducted with R113 in their room. A CPAP

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machine was observed on the nightstand to the right of the residents bed with a mask lying on top of the machine uncovered. When asked about the CPAP machine and mask, R113 stated that they wore the mask at night when sleeping for sleep apnea. An incentive spirometer was observed on the nightstand in front the CPAP machine uncovered. When asked about the incentive spirometer, R113 stated that they were given the spirometer in the hospital and used it "a few times a day." When asked if the facility staff covered or cleaned the CPAP mask or incentive spirometer when not in use, R113 stated that they had never seen it done.

The progress notes for R113 documented in part, "6/16/2022 23:45 (11:45 p.m.) Patient is [Age and sex of R113] admitted to facility at 20:42 (8:42 p.m.) via stretcher and accompanied by paramedics...OSA on CPAP..."

The physician orders for R113 failed to evidence an order for the use of a CPAP or an incentive spirometer.

The comprehensive care plan for R113 documented in part, "Nursing Care Needs: [Name of R113] has nursing care needs r/t (related to) DM2 (diabetes mellitus type 2), OSA (obstructive sleep apnea), hypertension, hypothyroidism, right knee cellulitis, arthritis, right kneed wound. Created on: 06/17/2022." The care plan failed to evidence use of an incentive spirometer or a CPAP.

On 7/13/2022 at 3:01 p.m., an interview was conducted with RN (registered nurse) #1, the assistant director of nursing. RN #1 stated that residents who used incentive spirometer normally

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came from the hospital with them. RN #1 stated that they normally would check with the resident to see if they were using the incentive spirometer and if they were they would get a physician order for it. RN #1 stated that the mouthpiece would be cleaned and it would be stored in a plastic bag when not in use to keep it clean. RN #1 stated that residents who used CPAP's also required a physicians order and the staff would clean the mask and store it in a bag when not in use to keep it clean. RN #1 stated that these processes were for infection control purposes. RN #1 observed the uncovered CPAP mask on the nightstand in R113's room and the uncovered incentive spirometer on the nightstand in R113's room and stated that they should be covered in a bag when not in use to keep them clean. RN #1 stated that there should be a physician's order for the use of the CPAP and incentive spirometer.

The facility policy "Respiratory/Oxygen Equipment" dated 11/01/2019 documented in part, "...CPAP/BIPAP Set-Up Adult...8. Mask and tubing are to be placed in a bag when not in use. 9. Wipe off mask daily with damp wash cloth. 10. Mask and tubing are to be changed according to manufacturer's recommendations..."

The facility policy "Incentive Spirometry" dated 4/1/2022 documented in part, "Incentive Spirometry is a method that involves using a device that encourages the patient's achievement of maximal inspriatory ventilation. The purpose is to enable patients with varying inspiratory capacities to receive reinforcement of inspiratory maneuvers to regain or maintain their maximum inspiratory volume ability. Procedure: ...3. Licensed nursing staff will be trained on appropriate procedure and documentation of

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incentive spirometry use. 4. Obtain physician's order for incentive spirometry including: a. Volume goal b. Number of repetitions c. Directions for use d. Encourage cough between repetitions...6. Wash the mouthpiece with soap and warm water, then dry. Place the mouthpiece in a plastic storage bag."

On 7/14/2022 at 10:52 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical services, ASM #5, the regional director of clinical services and ASM #6, the vice president of operations were made aware of the findings.

No further information was provided prior to exit.
4. The facility staff failed to store Resident #57's (R57) CPAP (continuous positive airway pressure) mask in a sanitary manner.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/29/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions.

A review of R57's clinical record revealed a physician's order to apply a CPAP every evening and night shift. R57's comprehensive care plan dated 5/17/22 failed to document information regarding a CPAP machine.

On 7/12/22 at 1:19 p.m., R57's CPAP mask was observed uncovered and directly sitting on a nightstand. R57 stated a bag or another item to keep the mask covered and clean had not been provided. R57 stated that a couple of months

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F 695	Continued From page 65 ago, one of the aides asked if the resident had been provided a cover and the resident told the aide a cover had not been provided. On 7/12/22 at 3:25 p.m. and 7/13/22 at 8:37 a.m., R57's CPAP mask remained uncovered and directly sitting on a nightstand. On 7/13/22 at 4:21 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated a CPAP mask should be placed in a cleaning machine or a bag when not in use to prevent infection. On 7/13/22 at 4:35 p.m., observation of R57's CPAP mask was conducted with LPN #3. The mask remained uncovered and directly sitting on a nightstand. LPN #3 stated the mask was not in a bag and should be. On 7/14/22 at 8:35 a.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 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and during a complaint investigation, it was determined the facility staff failed to ensure one of	F 698	F698 1. Resident #199 is no longer a resident in the center.	8/22/22

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F 698	Continued From page 66 47 residents in the survey sample received dialysis services per the plan of care, (Resident #199). The findings include: Resident #199 (R199) was admitted to the facility on 1/3/2020, with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis and depression. On the most recent MDS (minimum data set), around the time of the complaint, an annual assessment, with an assessment reference date of 1/5/2021, the resident was coded as scoring a 15 out of 15, indicating the resident was not cognitively impaired for making daily decisions. In Section D - Mood, the resident was coded as having little or no interest of doing things several days during the look back period and feeling down and depressed several days during the look back period. In Section O - Special Treatment, Procedures and Programs, R199 was coded as having dialysis while a resident at the facility. The clinical record was reviewed. The physician order dated, 7/13/2020 documented, "Patient is scheduled for (name of dialysis center and address) Q (every) Monday, Wednesday, and Fridays, every day shift every Mon, Wed, Fri for dialysis." The following was evidenced in the documentation: December 21, 2020 - the nurse's note documented the resident went to dialysis. December 23, 2020 - the nurse's note documented the resident went to dialysis. December 25, 2020 (holiday) - the nurse's notes	F 698	2. Current residents in the center who receive dialysis services have the potential to be affected. 3. The Staff Development Coordinator/designee will educate Licensed Nurses on ensuring that residents receive dialysis as ordered, physician notification of refusals or missed sessions, and documentation of dialysis. In addition, the Staff Development Coordinator/designee will also educate the Discharge Planners on arrangement of transportation for dialysis. 4. The Unit Managers/designees will complete a weekly review of residents with orders for dialysis to ensure that the dialysis is provided as ordered. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 8/22/2022	

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documented the resident went to dialysis on December 26, 2020.
December 28, 2020 - the nurse's note documented the resident went to dialysis.
December 30, 2020 - The nurse's note at 3:40 p.m., documented in part, "Pt (patient) dialysis is cancelled from dialysis center due to Covid 19 positive results and pt is going for dialysis tomorrow. Will continue to monitor."

January 1, 2021 - there is no documentation the resident went to dialysis.
January 4, 2021 - there is no documentation the resident went to dialysis.
January 5, 2021 - The nurse's note at 5:45 p.m. documented, "DCP (discharge planner) was unaware patient's dialysis location changed and times changed. Per nurse at dialysis they changed Medicaid transport, however transportation did not show up. DCP called Medicaid transportation who stated it was not dispatched correctly, however, transportation has been arrange for Thursday (1/7/2021) and Saturday (1/9/2021), and then reverted back to original schedule on Monday 1/11."
January 7, 2021 - The nurse's note at 5:42 p.m. documented, "Medicaid transport arrived today for patient's dialysis with a wheelchair instead of a stretcher that was ordered. DCP on hold with Medicaid transport now to attempt to resolve issue. "
January 7, 2021 - The nurse's note at 6:18 p.m. documented, "DCP spoke with NP (nurse practitioner) and per dialysis center it is too late to see patient. DCP will arrange for stretcher transport on Saturday for dialysis."
January 7.2021 - The nurse's note at 10:03 p.m. documented in part, "Pt was supposed to transport to dialysis appointment, transport

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service sent incorrect vehicle for patient, facility and NP notified. Pt has appointment rescheduled for Saturday 1/9/2021 in the evening. Will continue to monitor."
January 8, 2021 - The nurse's note at 8:57 a.m. documented, "DCP arranged new transportation as patient will be going back to original dialysis schedule, M-W-F at (location of dialysis center) chair time 11:30 a.m. Pickup by Medicaid transport at 10:30 a.m."

The nurse's note dated 1/8/2021 at 2:32 p.m. documented in part, "Pt alert and verbally responsive, pleasant and cooperative with care during shift."

The nurse's note dated 1/9/2021 at 11:15 a.m. documented in part, "Pt notes with nausea and weakness this morning. Was scheduled for dialysis, transport came to pick the pt at around 10:30 a.m. but pt refused to go to dialysis stating she is too weak for dialysis and does not wish to go. NP notified and order to send the pt out to the ER (emergency room). Pt agreed with the order."

The comprehensive care plan dated, 1/5/2020, documented in part, "Focus: (R199) needs hemodialysis r/t ESRD. Patient has a tendency to self-manage dialysis appointments by choosing when to attend dialysis sessions even after staff education. "

An interview was conducted with OSM (other staff member) #8, the discharge planning director, on 7/13/2022 at 10:45 a.m. When asked if R199 missed dialysis, OSM #8 stated most likely due to the Medicaid transportation, they are not reliable. OSM #8 stated the daughter expressed

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F 698	Continued From page 69 frustration about the transportation issues for dialysis, when she did, I would inform the NP and the director of nursing. An interview was conducted with RN (registered nurse) #6 on 7/13/2022 at 3:36 p.m. When asked if the resident missed dialysis, RN #6 stated, yes, he remembered when she was on the 400 unit, she refused to go. When asked if there was an issue with transportation, RN #6 stated he could not recall. When asked if he remembered a time when the resident did not get to dialysis for one week, RN #6 could not recall that. An interview was conducted with LPN (licensed practical nurse) #5 on 7/13/2022 at 3:52 p.m. When asked if he recalled if R199 ever missed dialysis, LPN #5 stated he didn't recall that. On 7/14/2022 at approximately 2:01 p.m. ASM #1, the administrator was informed of the findings. No further information was provided prior to exit.	F 698		
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,	F 756		8/22/22

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F 756	Continued From page 70 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 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 a pharmacy recommendation for one of 47 residents in the survey sample, Resident #75. The facility staff failed to act upon Resident #75's (R75) February 2022 pharmacy recommendation for thyroid and lipid levels. The findings include:	F 756	F756 1. Thyroid and lipid levels were obtained for resident #75 on August 4, 2022 as ordered by the Medical Provider. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator/designee will educate Licensed nurses on completion of consultant pharmacy recommendations. 4. The Unit Managers/designee will	

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F 756	Continued From page 71 On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/31/22, R75 scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. A review of a consultant pharmacist recommendation to physician with a medication regimen review date of 2/27/22 documented a recommendation to add thyroid and lipid levels to R75's routine labs due to R75's use of thyroid and cholesterol medications. The physician/prescriber's response section of the form was blank. Further review of R75's clinical record failed from February 2022 through July 2022 failed to reveal documentation that the facility staff acted upon the above recommendation. Also, the clinical record did not contain any physician's orders for thyroid and lipid levels and did not reveal any lab results for thyroid and lipid levels. On 7/14/22 at 9:19 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated she was not responsible for ensuring pharmacy recommendations were acted upon in February but there was a recent change in the process and she is now responsible. ASM #2 stated once a month, she prints out all pharmacy recommendations and separates them by nurse practitioner. ASM #2 stated she sits down with each nurse practitioner, reviews the recommendations, ensures the recommendations are addressed and scans the recommendations into each patient's chart.	F 756	complete review of consultant pharmacy recommendations monthly ensure that the recommendations were addressed. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 8/22/2022	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 72 On 7/14/22 at 10:53 a.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. The facility policy titled, "Medication Management/Medication" documented, "2. The consultant pharmacist will provide MRR (medication regimen review) reports addressed to the Medical Director, Director of Nursing, and attending physician within three (3) days of completion via secure email or hard copy. The attending physician is to review and sign the patient's individual MRR and document that he/she has reviewed the pharmacist's identified irregularities within 30 days of receipt." No further information was presented prior to exit.	F 756		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		8/22/22

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F 842	Continued From page 73 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 842		

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F 842	Continued From page 74 (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 and clinical record review, it was determined the facility staff failed to maintain a complete and accurate clinical record for one of 47 residents in the survey sample, Resident #28 (R28). The findings include: The facility staff failed to document in the clinical record fall interventions that were discussed in the at risk management meeting after two falls for R28. R28 had diagnoses that included but were not limited to: absence of left foot, absence of toes on right leg, and peripheral vascular disease. On the most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/7/2022, the resident scored a 10 out of 15 o the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as extensive assistance of one person for moving in the bed, transfers, walking in the room, and toileting. In Section J - Health Conditions R28 was coded as having had two or more falls during the look back period.	F 842	F842 1. Resident #28□s medical record includes accurate documentation of identified fall interventions. 2. Current residents with falls the potential to be affected. 3. The Staff Development Coordinator/designee will educate Licensed nurses on accuracy of documentation of newly identified fall interventions in the resident□s clinical record. 4. The Unit Managers/designees will complete a weekly review of documentation in high risk meeting of newly identified fall interventions to ensure accuracy of the clinical record. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 8/22/2022	

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F 842	Continued From page 75	F 842		

The nurse's note dated, 6/20/2022, documented in part, "Resident had an unwitnessed fall in her room, observed in a sitting position beside her bed during rounding by nursing staff, no injury notes, all parties notified of fall, neuro (neurological) checks initiated per facility protocol, call light placed within reach, resident educated to use for assistance to prevent further fall and verbalized understanding."

The comprehensive care plan dated, 2/8/2022 and revised on 5/23/2022, documented in part, "Focus: (R28) sustained a fall and is at risk for further falls related to: muscle weakness, poor vision, psychoactive medications, requiring assistive devices to walk or transfer, unsteady gait, unaware of safety needs." The "Interventions" documented, "2/9/2022 - Ensure that (R28) is wearing appropriate footwear when ambulating or mobilizing in w/c (wheelchair). 2/9/2022 - Keep environment free of trip hazards. 2/9/2022 - Remind (R28) to use their call light to ask for assistance with ADLS (activities of daily living). 5/2/2022 - Assist as needed. 5/2/2022 - Bed to low position. 2/9/2022 - Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. 2/9/2022 - encourage resident to wear their glasses when out of bed. 2/9/2022 - Ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed. 4/8/2022 - Frequent rounds. 4/25/2022 - Incontinent care as needed. 2/9/2022 - non-skid socks while out of bed. 2/9/2022 - Place common items within reach of the resident. 2/9/2022 - PT (physical therapy) evaluate and treat as ordered or PRN (as needed). 2/9/2022 - Remind the resident to use their walker to perform ADLS. 2/9/2022 -

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Therapy referral."

Review of the "Post Fall Investigation" dated, 5/4/2022 at 12:50 p.m. failed to evidence documentation related to the care plan.
Review of the "Post Fall Investigation" dated, 5/5/2022 at 3:15 p.m. failed to evidence documentation related to the care plan.

An interview was conducted with RN (registered nurse) #1, the assistant director of nursing on 7/14/2022 at 1:06 p.m. When asked what the purpose of the care plan is, RN #1 stated it's a guideline to provide care for our patients, it tells you what to do for them. RN #1 was asked to review the care plan and fall investigations above. When asked does she see on the care plan where it was reviewed or revised in regards to the resident's falls on 6/20/2022 and 6/28/2022, RN #1 stated the resident has balance issues and an appointment with a podiatrist was made to see if the resident can have some sort of prosthesis to help with her balance issues. When asked where the intervention of the podiatry consult was on the care plan, RN #1 stated, it's not.

An interview was conducted with ASM (administrative staff member) #1, the administrator, on 7/14/2022 at 2:01 p.m. When asked what a fall intervention is, ASM #1 stated it's something she has been working on with the team since she arrived. We did review the falls, we do put in new interventions. This is done at the risk meetings. When asked how the new interventions are communicated with the staff caring for the resident, ASM #1 stated it is expected to be communicated by the staff at the meeting to the nurses and CNAs (certified nursing assistants). ASM #1 presented

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F 842	Continued From page 77 documentation from the quality assurance notes of the risk meeting related to R28's fall on 6/20/2022, the notes documented in part, "Nursing staff to ensure bed is always in a low/safe height level. Nursing staff to round frequently to encourage hydration, promote regular urinary elimination patterns, and prevent unsafe transfers. On PT (physical therapy) caseload. Maintenance staff to assess pt's bed. Add toileting program." When asked why these interventions are not on the comprehensive care plan ASM #1 stated she was working on that. The risk meeting related to R28's fall on 6/28/2022, the notes documented in part, "Re-educate patient on use of call light for assistance. Staff to increase purposeful rounding to anticipate needs. Specialist for boots,? prosthesis." Another document, "Resident Appointment Form" documented in part, an appointment on 7/20/2022 at 9:00 a.m. for a podiatrist for possible toe prosthesis." ASM (administrative staff member) #1, the administrator, was made aware of the above concerns on 7/14/2022 at approximately 2:10 p.m. On 7/14/2022 at 2:52 p.m. ASM #1 stated the facility did not have a policy on maintaining a complete and accurate clinical record. No further information was provided prior to exit.	F 842		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop	F 883		8/22/22

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F 883	Continued From page 78 policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		

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F 883	Continued From page 79 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide education prior to administering the influenza immunization for one of 5 resident immunization reviews, Resident #55. The facility staff failed to provide education regarding the benefits and potential side effects of the influenza immunization prior to administering the immunization to Resident #55 (R55) on 11/19/21. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/27/22, 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. A review of R55's clinical record revealed a physician's order dated 11/19/21 for the influenza immunization. A review of R55's immunization record revealed the resident received the immunization on 11/19/21. Further review of	F 883	F883 1. Resident #55 has been educated on the risks and benefits of flu immunization. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator/designee will educate Licensed Nurses on resident education on risks and benefits of immunizations prior to administering the immunization. 4. The Unit Managers/designees will complete a random weekly review of immunizations to ensure that education of the risks and benefits was documented. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 8/22/2022	

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F 883	Continued From page 80	F 883		

R55's clinical record failed to reveal documentation that education regarding the benefits and potential side effects of the influenza immunization was provided to R55.

On 7/14/22 at 10:04 a.m., an interview was conducted with OSM (other staff member) #10 (the infection preventionist), regarding the process for the administration of the influenza immunization. OSM #10 stated the process is collaborative with herself, the staff development coordinator and the nurses. OSM #10 stated she looks at the Virginia Immunization Information System to see what vaccines the resident has already received. OSM #10 stated if a resident is eligible to receive the influenza immunization then the resident and/or representative is provided a vaccine information statement (a form that documents the benefits and potential side effects of the immunization), physical or verbal consent is obtained and staff documents that education was provided on the vaccine information statement form. OSM #10 stated she could not locate evidence that R55 was provided education regarding the influenza immunization or that consent was obtained.

On 7/14/22 at 10:53 a.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, "Influenza & Pneumococcal Vaccinations" documented, "g. Prior to administering the flu vaccine to patients, complete the following...2. Provide Vaccination Information Sheet (VIS) for influenza vaccine to patient and/or responsible party. Copy of VIS will be maintained with Patient Influenza Vaccine

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F 883	Continued From page 81 Tracking/Surveillance Log(s) and a copy will be placed in the patient's record as proof of education; include the date of the first page of the Vaccination Information Sheet (VIS)." No further information was presented prior to exit.	F 883		