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	495326	A. BUILDING _____ B. WING _____	C 07/21/2022

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MONROE HEALTH & REHAB CENTER	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(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 Medicare/Medicaid standard survey was conducted 07/19/2022 through 07/21/2022. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/19/2022 through 07/21/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. Complaint VA00055521 with two allegations was substantiated with deficient practice cited. Complaint VA00054639 with three allegations was unsubstantiated. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 123 at the time of the survey. The survey sample consisted of twenty-four (24) current resident reviews and three (3) closed record reviews.	F 000		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable,	F 559		8/1/22

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

Electronically Signed | 07/27/2022

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

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F 559	Continued From page 1 when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy review and clinical record review, the facility staff failed to provide advance notice of a room/roommate change for one of twenty-seven residents in the survey sample. Resident #75 was moved to a new room with a new roommate without prior notification to the resident's representative. The findings include: Resident #75 was admitted to the facility with diagnoses that included Alzheimer's dementia, insomnia, hypertension, history of COVID-19, major depressive disorder, COPD (chronic obstructive pulmonary disease), cerebral infarction, hemiplegia, aphasia and dysphagia. The minimum data set (MDS) dated 6/18/22 assessed Resident #75 with severely impaired cognitive skills. Resident #75's clinical record documented the resident was moved to a new room with a roommate on 7/5/22. A nursing note dated 7/5/22 at 6:38 p.m. documented, "Residents family present to see the resident...daughter came back to the nurses station asking why her mother was moved to another room, this nurse stated that several resident [s] had room changes that were in the rooms alone and placed together..." (Sic) The clinical record documented the resident had	F 559	Completion of this plan of correction is per regulations to maintain compliance with state and federal guidelines. It does not validate the facility's agreement with or admission to the alleged deficient practices listed. 1. Family notified of room change for patient # 75 on 7/5/22 2. All residents have the potential to be affected by this deficient practice. Audit of past 30 days of room changes that all residents and family were notified of room changes prior to room change 3. Director of Nursing educated nurse managers, social services and admissions that all room changes must have RP/Resident notification and approval prior to room change unless medically or safety necessity and review of policy of room change on 7/25/22 4. Social services will audit all room changes to ensure room change policy is followed weekly times three months and report to QAPI monthly	

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been in her previous room since 9/19/21.

Resident #75's clinical record documented a room change notice listing the resident was moved to a new room on 7/5/22. The reason for the room change was listed as "n/a" (not applicable). There was no documentation on this form or in the clinical record of any advanced notification to the resident's representative about the room/roommate change. There was no written notification to the resident's family about the room/roommate change of 7/5/22 or reasons for the change.

On 7/20/22 at 1:10 p.m., the facility's social worker (other staff #4) was interviewed about any advance and/or written notice to Resident #75's family prior to the room change on 7/5/22. The social worker stated she was not involved with the room change on 7/5/22 and did not provide any notification to the resident's family about the change. The social worker stated the 7/5/22 room change was initiated by nursing. The social worker stated room and roommate changes were usually discussed by the interdisciplinary team with notice and permission from the resident and/or family prior to the changes. The social worker stated residents were not typically moved to a new room without the resident's and/or resident representative's approval. The social worker stated she did not know why Resident #75 was moved to a new room and no reason was listed on the room change form.

On 7/20/22 at 1:24 p.m., the licensed practical nurse unit manager (LPN #3) was interviewed about any advance notice to Resident #75's representative prior to the room change on 7/5/22. LPN #3 stated Resident #75 had

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F 559	Continued From page 3 experienced a recent decline and was moved to a new room so she would have a roommate. LPN #3 stated she called the resident's daughter on 7/5/22 about the room change but got no answer or return call. The facility's policy titled Room and Roommate Change Policy (revised 8/13/20) documented, "The Facility will notify the resident/resident representative prior to a room or roommate change including the reason for the change. The facility will not relocate a resident solely for the convenience of staff...The facility will document that notification was completed with reason for change..." This finding was reviewed with the administrator, director of nursing and corporate consultant during a meeting on 7/20/22 at 4:20 p.m.	F 559		
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	F 656		8/1/22

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F 656	Continued From page 4 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 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 and clinical record review, the facility staff failed to develop a CCP (comprehensive care plan) for one of 25 residents in the survey sample. Resident #10 did not have a care plan for smoking. Findings include: Diagnoses for Resident #10 included: Chronic obstructive pulmonary disease, cirrhosis of the liver, obesity, and chronic pain. The most current MDS (minimum data set) was a significant	F 656	1. Care plan updated on resident # 10 on 7/20/22 2. All residents have the potential to be affected by this deficient practice. Care plan audit completed for all smokers to ensure care plan reflects smoking status 3. Director of Nursing educated MDS nurses and social services on development of care plan on new problems or risks on 7/25/2022	

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F 656	Continued From page 5 change assessment with an ARD (assessment reference date) of 4/19/22. Resident #10's cognitive score was a 13 indicating cognitively intact. On 7/19/22 at 11:44 AM during an interview with Resident #10, Resident #10 verbalized that he smokes but the the staff would not let him smoke. When asked why, Resident #10 verbalized he was unsure, stating "I don't know." On 7/19/22 Resident #10's smoking assessment dated 1/18/22 was reviewed and documented: "Resident chooses to smoke, proceed with assessment." The assessment also documented Resident #10 needed supervision while smoking based on inability to use a cigarette lighter correctly. On 7/20/22 at 10:15 AM license practical nurse (LPN #1, unit manager) was interviewed regarding tobacco use. LPN #1 voiced awareness of Resident #10's tobacco use and said Resident #10 usually does not get out of bed, but if Resident #10 wants to smoke he is allowed but just needs supervision. On 7/20/22 Review of Resident #10's CCP's did not evidence a care plan was developed for smoking. On 7/20/22 at 3:26 PM MDS coordinator (registered nurse, RN #1) was interviewed regarding a smoking care plan for Resident #10. RN #1 reviewed Resident #10's care plan and verbalized unawareness that Resident #10 smoked and said if a Resident smokes then a care plan should be in place.	F 656	4. Social Services to audit all residents care plans that choose to smoke 1 time per week times 3 months and report to QAPI monthly	

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F 656	Continued From page 6 On 7/20/22 at 4:41 PM the above information was provided to the director of nursing, administrator and nurse consultant. On 7/21/22 at 8:00 AM the DON verbalized a care pan had now been put in place (after being informed of the concern). No other information was provided prior to exit on 7/21/22.	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 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	F 657		8/1/22

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comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record review, the facility staff failed to review and revise a comprehensive care plan (CCP) for 1 of 27 in the survey sample. Resident #70's CCP was not reviewed and revised to reflect a wander guard device, which was discontinued.

The findings included:

Resident #70 was admitted to the facility with diagnoses that included hyperlipidemia, cerebral infarction, major depressive disorder, hypertension, Alzheimer's Disease, Dementia with behavioral disturbances, and repeated falls. The minimum data set (MDS) dated 06/13/2022 was a quarterly, and assessed Resident #70 as moderately impaired for daily decision making with a score of 8 out of 15. The MDS assessed Resident $70 as having fluctuating periods of inattention, disorganized thinking and wandering for 1-3 days. Under Section P - Restraints, the MDS assessed Resident #70 has having a wander guard for elopement risk.

Resident #70 was interviewed on 07/19/2022 at 2:30 p.m. while in laying in bed. Resident #70 was asked about the type of care he received at the facility. Resident #70 smiled and laughed, while looking up at the ceiling mumbling non-sequential/non-conversational phrases. Resident #70's upper and lower extremities (arms and legs) were observed as not having without a wander guard.

Resident #70's clinical record was reviewed. The

1. Care plan updated on resident #70 on 7/21/22.

2. Care plan audit completed for discontinued orders for the last 30 days.

3. Director of Nursing educated MDS nurses on updating care plan on revision of care plan with order in Clinical Morning meeting on 7/25/22.

4. Audit all discontinued orders 1 time per week times three months and report to QAPI monthly.

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care plan stated: "The resident is an elopement risk/wanderer AEB (as evidenced by) disoriented to place, impaired safety awareness dementia. d/c'd(discontinued) 5/27/21 reactivated 6/4/21." Goals Included: "The resident's safety will be maintained through the review date. The resident will not leave facility unattended through the review date..." Interventions Included: "...wander device as ordered..."

Resident #70's treatment administration record (TAR) documented the wander guard was discontinued effective 06/23/2022. A review of the physician orders recap report documented the wander guard was discontinued 06/23/2022 for "no episodes of elopement greater than 90 days." An elopement assessment completed on 06/23/2022 assessed Resident #70 as a low risk for elopement with a score of 2.0.

On 07/20/2022 at 10:16 a.m. the unit manager (LPN #3) where Resident #70 resided was interviewed regarding Resident #70's risk/need for the wander guard. LPN #3 stated that the wander guard had been discontinued because Resident #70 was no longer an elopement risk.

On 07/21/2022 at 9:10 a.m., the MDS coordinator (RN #1) who was responsible for the care plans was interviewed. RN #1 reviewed Resident #70's clinical record and stated at the time of the 06/13/2022 quarterly MDS the care plan was accurate. RN #1 was advised the order for the wander guard was discontinued on 06/23/2022. RN #1 stated the changed orders were reviewed daily and she was not made aware that this order had been discontinued. RN #1 was asked if the care plan should have been reviewed and revised. RN #1 stated, "Yes, I will update the

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F 657	Continued From page 9 care plan to resolve the wander guard." On 07/21/2022 at 10:00 a.m., the above findings were shared during a meeting with the Administrator, DON, and Corporate Consultant. No additional information was provided to the facility prior to exit on 07/21/2022 at 10:30 a.m.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review, the facility staff failed to meet professional standards of practice for one of 27 residents in the survey sample, (Resident #95); the facility staff documented Resident #95 received chemotherapy medication when the medication was not available for administration. Findings include: Diagnoses for Resident #95 included, but were not limited to: high blood pressure, DM (diabetes mellitus), hemiplegia, major depressive disorder, history of pulmonary embolism, and rectal cancer. Resident #95's most recent MDS (minimum data set) was an admission assessment dated 06/28/22. This MDS assessed the resident with a cognitive score of 13, indicating the resident was	F 658	1. Medication for resident #95 received in facility on 7/15/2022, new order to extend medication for four doses on 7/20/2022, no harm to resident this was a specialty medication. 2. All residents have the potential to be affected by this deficient practice. 100% Audit of MAR to cart completed to ensure all medication is available. 3. Director of Nursing educated all nurses on medication availability and orders started when medication is due for delivery. Nurses educated to review medication of start time on MD and NP entered orders prior to confirmation on 7/25/2022. 4. Unit managers/designee to audit report	8/1/22

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F 658	Continued From page 10 intact for daily decision making skills. On 07/20/22 Resident #95's clinical records were reviewed. The resident had a current physician's order for the chemotherapy medication, "Capecitabine Tablet 500 MG (milligrams) Give 2 tablet by mouth two times a day every Mon, Tue, Wed, Thu, Fri for chemotherapy until 07/22/2022 11:59 PM. This medication was ordered on 07/13/22 and the start date was entered for 07/13/22 at 5:00 PM. The resident's July 2022 MARs (medication administration records) were reviewed. The MAR documented that the resident received the above medication on 07/13/22 at 5:00 PM. The MAR was further reviewed and documented that the next scheduled dose, for the following morning (07/14/22) at 7:00 AM, was not administered to the resident. The resident's nursing notes were then reviewed. A nursing note dated 07/14/2022 and timed 7:53 AM documented, "...Capecitabine Tablet 500 MG Give 2 tablet by mouth two times a day every Mon, Tue, Wed, Thu, Fri for chemotherapy until 07/22/2022 awaiting delivery -pharmacy called spoke to (name of pharmacy person), ordered to be stated (sic) out...signature of LPN #2." The MAR further revealed that the next scheduled dose (07/14/22) the 5:00 PM was documented as administered to the resident (per documentation by LPN #6). The next scheduled dose for the following day (07/15/22) at 7:00 AM was again documented as not administered A nursing note dated 07/15/2022 and timed 6:05 AM documented, "...Capecitabine Tablet 500 MG	F 658	in PCC in Clinical Morning meeting Monday through Friday to ensure all medications are received and medications are not documented as not available times 3 months.	

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Give 2 tablet by mouth two times a day every Mon, Tue, Wed, Thu, Fri for chemotherapy until 07/22/2022... Awaiting delivery.

On 07/20/22 at approximately 4:00 PM, LPN #2 was interviewed regarding the above information. The LPN stated that he was the one who confirmed the order for the chemotherapy medication on 07/13/22. The LPN stated that it was documented by him that the medication was administered on 07/13/22 at 5:00 PM, but stated that the medication was not administered because the medication was not in the building to be administered. The LPN stated that he called the pharmacy and they had told him it would be at the facility on the midnight run (07/13/22), but further stated that he worked the following day and the medication had not arrived yet and that is when he made a note about it. The LPN stated that the documentation on 07/13/22 at 5:00 PM was in error and that the next dose he documented correctly. The LPN stated that he did not know why the nurse documented the medication was administered on 07/14/22 at 5:00 PM if the medication was not here. The UM (unit manager) LPN #5 was made aware of concerns that it didn't appear that this medication was available to be administered to Resident #95, but staff had documented as administered on several occasions. The UM was asked for the consulting pharmacist phone number for clarification.

On 07/20/22 at 4:10 PM a phone interview was conducted with the pharmacy supervisor (OS #2) regarding the above and was asked when this particular medication was delivered for Resident #95. OS #2 stated that this is an expensive medication and is not a medication that they keep

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in a stat box or omni cell and that this medication has to be ordered. OS #2 stated that the medication was ordered and was delivered to the facility (signed as received by a nurse) on 07/15/22 at 4:35 PM.

On 07/20/22 at 4:32 PM The DON (director of nursing), administrator, corporate nurse and ADON (assistant director of nursing) were made aware that staff nurses were signing off that a chemotherapy medication had been administered, when the medication was not available to administer. A policy was requested at this time on accurate medication administration and documentation.

On 07/21/22 at approximately 8:00 AM, the DON stated that they (the facility) do not have a specific policy on documenting medications that weren't given. The DON stated that we (facility) have the medication policy. The medication administration policy documented, "...Facility staff should verify that the medication name and dose are correct when compared to the medication order on the medication administration record...The pharmacy should be contacted to provide the correct dose...prior to administration of medication...should verify...each time a medication is administered that it is the correct medication....correct dose...route...rate...time, for the correct resident...confirm that the MAR reflects the most recent order...Observe the resident's consumption of the medication(s)...After administration...document necessary medication administration/treatment information...when medications are given...if medications are refused..."

The DON presented two statements. One

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statement was from LPN #2 which documented, "...On July 13th there was an order put in by PACE (Program of all inclusive care for elderly) NP (nurse practitioner) at 11:33 AM...I confirmed it on July 13th at approximately 4:30 PM. I clicked it off on the MAR but the medication was not in the building. I then called the pharmacy on July 14th at approximately 9:00 [AM]. I spoke...pharmacy...medication will be sent later...wrote a note in the resident's chart...signature LPN #2."

The other statement was from LPN #6 which documented, "...On July 14th, 2022...I accidentally clicked the wrong medication at 5:00 PM for [Name of Resident #95). I forgot to go back and correct it in the MAR...signature of LPN #6."

The Lippincott Manual of Nursing Practice 11th edition on page 15 includes in a list of common departures from standards of nursing care, "...Failure to administer medications properly and in a timely fashion or to report and administer omitted doses appropriately...Failure to make prompt, accurate entries in a patient's medical record..." (1)

No further information and/or documentation was presented prior to the exit conference on 07/21/22.

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2019.

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F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on a medication pass and pour observation, clinical record review, staff interview, facility document review, and during the course of a complaint investigation the facility staff failed to follow physician's order for two of 27 resident's in the survey sample (Resident #26 and Resident #95) and failed to obtain transportation to appointments for two of 27 residents (Resident #11 and #39) and failed to accurately assess skin impairments for one of 27 residents (Resident #24). 1. The facility staff failed to follow physician's orders during a medication pass and pour observation for Resident #26. 2. The facility staff failed to follow physician's orders for the administration of a chemotherapy medication for Resident #95. 3. The facility staff failed to ensure transportation for outside rehabilitation appointments for Resident #11. 4. The facility staff failed to ensure transportation	F 684	1. Resident # 26 received omitted medication on 7/20/2022 during medication administration. Medication for resident # 95 received in facility on 7/15/2022, new order to extend medication or four doses on 7/20/2022, no harm to resident, this was a specialty medication. Transportation for resident #11 was rescheduled for 8/11/2022. Resident no longer in facility and is aware of this appointment. Transportation for # 39 has been scheduled for 10/17/2022 Accurate wound assessment completed on 7/6/2022 for resident #24 2. All residents have the potential to be affected by this deficient practice. MAR to cart audit completed to ensure all medication is available. Audit of residents with wound assessments completed to ensure accuracy. Audit of past 30 days of residents that require transportation to medical appointments to ensure resident	8/1/22

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F 684	Continued From page 15 to an endocrinologist appointment for #39. 5. Resident #24 had conflicting and inaccurate assessments of skin tears. Findings include: 1. On 07/20/22 at 8:30 AM, a medication pass and pour observation was completed with LPN (Licensed Practical Nurse) #2. LPN #2 prepared medications for Resident #26. LPN #2 pulled the following tablets/pills for Resident #26: Sertraline 50 mg (one and a half tablets), one multivitamin, two sodium bicarbonate tablets (650 mg), one Vitamin C (500 mg), one Loratidine (10 mg), and one metoprolol succinate (50 mg). The LPN pulled a total of 8 tablets to administer to the resident. At 9:00 AM, a medication reconciliation was completed for Resident #26. The resident's current physician's orders included an order for "Ferrous Sulfate Tablet 325 (65 Fe) MG (milligrams) Give 1 tablet by mouth one time a day every Mon, Wed, Fri for Cardiac..." LPN #1 did not pull or administer the Ferrous Sulfate Tablet 325 (65 Fe) MG to Resident #26 during the medication administration pass and pour observation. At 9:10 AM, LPN #2 was interviewed regarding the resident's medications, specifically the Ferrous Sulfate 325 mg that was not administered to Resident #26. The LPN stated that he could not remember pulling that medication for the resident and must have signed it off when signing off the other medications. A policy was requested at that time on medication administration.	F 684	was transported. 3. Director of Nursing educated all nurses on following MD orders, accuracy of completion of skin assessments. Educate all charge nurses, nurses, nurse managers and transportation scheduler that if any medical appointments are missed due to transportation issues, then the MD is notified and clinic is called immediately to schedule next appointment and resident is notified of the transportation issue on 7/25/2022. 4. Unit manager/designee to complete medication pass per unit weekly times three months. NHA/DON/Designee will audit all transportation schedules on a weekly basis to ensure all residents are transported to scheduled medical appointments times three months and report to QAPI monthly. Unit manager/designee will audit wound assessments for accuracy weekly times three months and report to QAPI monthly.	

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On 07/20/22 at 9:34 AM, the medication administration policy was presented by the DON (director of nursing). The policy titled, "General Dose Preparation and Medication Administration" documented, "...Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in facility's medication administration schedule...facility should verify that the medication name and dose are correct when compared to the medication order on the medication administration record..."

On 07/20/22 at 4:32 PM, the DON, administrator and corporate nurse were made aware of the above information.

No further information and/or documentation was presented prior to the exit conference on 07/21/22.

2. The facility staff failed to follow physician's orders for medication administration of a chemotherapy agent for Resident #95.

Diagnoses for Resident #95 included, but were not limited to: high blood pressure, DM (diabetes mellitus), hemiplegia, major depressive disorder, history of pulmonary embolism, and rectal cancer.

Resident #95's most recent MDS (minimum data set) was an admission assessment dated 06/28/22. This MDS assessed the resident with a cognitive score of 13, indicating the resident was intact for daily decision making skills.

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On 07/20/22 Resident #95's clinical records were reviewed. The resident had a current physician's order for the medication, "Capecitabine Tablet 500 MG (milligrams) Give 2 tablet by mouth two times a day every Mon, Tue, Wed, Thu, Fri for chemotherapy until 07/22/2022 11:59 PM. This medication was ordered on 07/13/22 and was to start date on 07/13/22 at 5:00 PM.

The resident's July 2022 MARs (medication administration records) were reviewed. The MAR documented that the resident received the above medication on 07/13/22 at 5:00 PM. The MAR was further reviewed and documented that the next scheduled dose, for the following morning (07/14/22) at 7:00 AM, was not administered to the resident.

The resident's nursing notes were then reviewed. A nursing note dated 07/14/2022 and timed 7:53 AM documented, "...Capecitabine Tablet 500 MG Give 2 tablet by mouth two times a day every Mon, Tue, Wed, Thu, Fri for chemotherapy until 07/22/2022 awaiting delivery -pharmacy called spoke to (name of pharmacy person), ordered to be stated (sic) out...signature of LPN #2."

The MAR further revealed that the next scheduled dose (07/14/22) the 5:00 PM was documented as administered to the resident (per documentation by LPN #6). The next scheduled dose for the following day (07/15/22) at 7:00 AM was again documented as not administered

A nursing note dated 07/15/2022 and timed 6:05 AM documented, "...Capecitabine Tablet 500 MG Give 2 tablet by mouth two times a day every Mon, Tue, Wed, Thu, Fri for chemotherapy until 07/22/2022... Awaiting delivery.

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On 07/20/22 at approximately 4:00 PM, LPN #2 was interviewed regarding the above information. The LPN stated that he was the one who confirmed the order for the chemotherapy medication on 07/13/22. The LPN stated that it was documented by him that the medication was administered on 07/13/22 at 5:00 PM, but stated that the medication was not administered because the medication was not in the building to be administered. The LPN stated that he called the pharmacy and they had told him it would be at the facility on the midnight run (07/13/22), but further stated that he worked the following day and the medication had not arrived yet and that is when he made a note about it. The LPN stated that the documentation on 07/13/22 at 5:00 PM was in error and that the next dose he documented correctly. The LPN stated that he did not know why the nurse documented the medication was administered on 07/14/22 at 5:00 PM if the medication was not here. The UM (unit manager) LPN #5 was made aware of concerns that it didn't appear that this medication was available to be administered to Resident #95, but staff had documented as administered on several occasions. The UM was asked for the consulting pharmacist phone number for clarification.

On 07/20/22 at 4:10 PM a phone interview was conducted with the pharmacy supervisor (OS #2) regarding the above and was asked when this particular medication was delivered for Resident #95. OS #2 stated that this is an expensive medication and is not a medication that they keep in a stat box or omni cell and that this medication has to be ordered. OS #2 stated that the medication was ordered and was delivered to the

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facility (signed as received by a nurse) on 07/15/22 at 4:35 PM.

On 07/20/22 at 4:32 PM The DON (director of nursing), administrator, corporate nurse and ADON (assistant director of nursing) were made aware that staff nurse had signed off that the physician ordered chemotherapy medication had been administered, when in fact it had not and that according to documentation the resident had missed four doses of this medication.

A policy was requested at this time on administering medication per physician's order.

On 07/21/22 at approximately 8:00 AM, the DON presented the policy on medication administration. The policy documented, "...Facility staff should verify that the medication name and dose are correct when compared to the medication order on the medication administration record...prior to administration of medication...should verify...each time a medication is administered that it is the correct medication....correct dose...route...rate...time, for the correct resident...confirm that the MAR reflects the most recent order...Observe the resident's consumption of the medication(s)...After administration...document necessary medication administration/treatment information...when medications are given...if medications are refused..."

The DON presented two statements. One statement was from LPN #2 which documented, "...On July 13th there was an order put in by...NP (nurse practitioner) at 11:33 AM...I confirmed it on July 13th at approximately 4:30 PM. I clicked it off on the MAR but the medication was not in the

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building. I then called the pharmacy on July 14th at approximately 9:00 [AM]. I spoke...pharmacy...medication will be sent later...wrote a note in the resident's chart...signature LPN #2."

The other statement was from LPN #6 which documented, "...On July 14th, 2022...I accidentally clicked the wrong medication at 5:00 PM for [Name of Resident #95). I forgot to go back and correct it in the MAR...signature of LPN #6."

No further information and/or documentation was presented prior to the exit conference on 07/21/22.

3. Resident # 39 in the survey sample was admitted with diagnoses that included type II diabetes mellitus, atrial fibrillation, hypertension gastroesophageal reflux disease, hyperlipidemia, anxiety disorder, bipolar disorder, schizoaffective disorder, nausea, borderline personality disorder, gender identity disorder, and insomnia. According to an Annual Minimum Data Set with an Assessment Reference Date of 5/20/2022, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

At 9:30 a.m. on 7/20/2022, Resident # 39 was interviewed regarding transportation to medical appointments. "Transportation is terrible," the resident said. "I have missed an appointment with my endocrinologist and other doctors. The transport just didn't show up."

Review of the Progress Notes in the resident's

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Electronic Health Record revealed the following entry:

4/12/2022 - Nursing Note - "Late entry resident was scheduled for an endocrine clinic follow up appointment April 11th (sic) 2022. Transportation was set up by transportation coordinator. VA (Virginia) Premier could not provide transportation for resident, the provider did not have any drivers available and sent trip back to Va Premier. Appointment has been rescheduled for Oct 17th (sic) 2022 @ 8:30 am. MD and RP notified."

At approximately 3:00 p.m. on 7/20/2022, CNA # 3 (Certified Nursing Assistant), the facility's Transportation Coordinator, was interviewed. CNA # 3 confirmed that transportation is a problem, that a number of medical transports are either late, or the transports do not show up at all.

CNA # 3 went on to say that the hospital made the appointment for Resident # 39, and also arranged transportation. "The resident has always gone to the hospital for his endocrine appointments," CNA # 3 said. CNA # 3 went on to say she calls the insurance provider's Care Coordinator to ensure transportation arrangements are made for medical transports.

The finding was discussed during an end of day meeting at 4:00 p.m. on 7/20/2022 that included the Administrator, Director of Nursing, Assistant Director of Nursing, and the survey team.

This is a Complaint Deficiency

4. Resident # 11 in the survey sample was admitted with diagnoses that included neurogenic bladder, hypotension, insomnia,

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gastroesophageal reflux disease, gastrostomy status, anxiety disorder, anemia, hypertension, depressive disorder, acute necrotizing hemorrhagic encephalopathy, urogenital implants, paraplegia, and injury at level C4 of cervical spinal cord. According to a Quarterly Minimum Data Set with an Assessment Reference Date of 4/19/2022, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

During the interview at 3:00 p.m. on 7/20/2022, CNA # 3 said that on 5/11/2022, Resident # 11 had an appointment at 12:20 p.m. with a physical medicine/rehabilitation provider in Charlottesville. "The transport was an hour late. At about five minutes out (from the facility), the transport called to say they were on the way. By that time, the resident was tired of waiting and decided not to keep the appointment."

CNA # 3 went on to say she calls the insurance provider's Care Coordinator two to three weeks ahead of a resident's medical appointment to arrange transportation. "Before the appointment time, I call again to verify transport is coming," CNA # 3 said.

The finding was discussed during an end of day meeting at 4:00 p.m. on 7/20/2022 that included the Administrator, Director of Nursing, Assistant Director of Nursing, and the survey team.

This is a Complaint Deficiency

5. Resident #24 was admitted to the facility with diagnoses that included dementia with behaviors, gout, hypertension, anxiety, depressive disorder,

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history of hip fracture, diabetes and dysphagia. The minimum data set (MDS) dated 5/2/22 assessed Resident #24 with severely impaired cognitive skills.

Resident #24's clinical record documented the resident acquired a skin tear to the left elbow on 6/23/22. A nursing note dated 6/23/22 documented, "Wound type is a skin tear. Wound location left elbow." This note documented measurements for the skin tear were 1.6 x 2.2 x 0.1 (length by width by depth in centimeters) with small amount of serous drainage noted. A physician's order dated 6/24/22 documented, "Cleanse skin tear to left arm with wound cleanser, apply bacitracon [bacitracin] and cover with a 4.4 border gauze every day shift for skin tear..."

Nursing notes documented monitoring of the left elbow skin tear as follows.

6/24/22 - "IDT [interdisciplinary team] met resident with left arm with small amount of bleeding, were [where] the skin had peel back were [where] a discolored area previously was located..." (Sic)
6/28/22 - "...Wound type is a skin tear. Wound Location left elbow..."
7/4/22 - "...Wound type is a skin tear. Wound Location left elbow...resolved..."

Weekly wound assessments starting on 6/23/22 listed the status of the left elbow skin tear. Wound assessments documented the following.

6/23/22 - "...Resident with skin tear left elbow margins with previous ecchymosis. Denies discomfort..."

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6/28/22 - "...Skin Tear...left elbow...area improving..."
7/4/22 - "...Skin Tear...left elbow...resolved..."

A nursing note dated 7/5/22 documented the location of the left elbow skin tear was inaccurate. This 7/5/22 note documented, "Incident report from 6/23/22 documentation on the location of the residents skin tear was incorrectly entered, order was incorrect as well of the location of the skin tear. Residents skin tear located to the left upper arm, order has been clarified by the nurse...Unit manager was present and made aware by this nurse of the incorrect documentation and the location of the skin tear..."

There were no wound assessments and/or nursing notes documenting the location of a skin tear as the left upper arm. On 7/7/22 a nursing note documented, "This note is a follow up to...skin tear right lower arm...Dressing are currently ordered..." There was no assessment of a right lower arm skin tear listing the measurements, appearance or drainage presence until 7/11/22.

A wound assessment dated 7/11/22 documented the resident had a skin tear measuring 4.5 cm x 4.8 cm x 0.1 cm on the right upper arm with note stating, "Resident seen for assessment See new order for treatment..." This wound assessment documented the skin tear was first identified on 7/6/22. There was no nursing note or wound note on 7/6/22 about a skin tear. A wound assessment dated 7/18/22 documented the right upper arm skin tear was closed and nursing was to monitor the area.

On 7/20/22 at 10:22 a.m., with Resident #24's

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F 684	Continued From page 25	F 684		

permission, the resident's arms were observed. The resident had healed skin tears with scabs in place on the right forearm and an old skin tear on the right upper arm. There were no open areas and no scars or signs of an old skin tear on the left elbow.

On 7/20/22 at 1:28 p.m., the licensed practical nurse unit manager (LPN #3) was interviewed about the conflicting and inaccurate skin tear assessments. LPN #3 stated she understood the error was in the location of the skin tear. LPN #3 stated the nurse got the right and left mixed up and the skin tear that started on 6/23/22 was actually on the right arm. LPN #3 stated the wound nurse (LPN #4) documented weekly wound assessments for the skin tears.

On 7/20/22 at 3:25 p.m., the wound nurse (LPN #4) that performed weekly assessments of Resident #24's skin tears was interviewed about the conflicting/inaccurate assessments. LPN #4 stated the note and assessments dated 6/23/22 listed the skin tear was on the left elbow but the tear was actually on the right. LPN #4 stated the skin tear went from the upper arm to the elbow area and stated, "It is the same area." LPN #4 stated the documentation did not match the wound. LPN #4 reviewed the wound assessments and nursing notes about the left elbow skin tear and stated, "I see the confusion. I'm confused too." LPN #4 stated all the resident's skin tears were treated and all were healed or had scabs. LPN #4 stated the resident did not have a skin tear to the left arm and/or elbow. LPN #4 stated, "What skin tears I saw were on the right arm and not left." LPN #4 stated the right lower arm skin tear she assessed on 7/11/22 was not new and the documentation

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F 684	Continued From page 26 that the skin tear was first identified on 7/6/22 was inaccurate. On 7/21/22 at 8:22 a.m., the director of nursing (DON) was interviewed about the inaccurate and conflicting wound assessments. The DON stated there was a problem with documentation regarding left and right. The DON stated the resident acquired a skin tear on 6/23/22 and nursing notes and wound assessments listed the tear on the left when it was actually on the right. The DON stated the date of origin (7/6/22) listed on the assessment for the right lower arm skin tear was not accurate as the wound was acquired on 6/23/22. The DON stated the nursing note on 7/5/22 also included inaccurate documentation as the corrected location of the skin tear was listed as the left upper arm when it was actually on the right upper arm. The DON stated the resident never had a left upper arm skin tear and the wounds were on the right upper arm and right forearm. The DON stated the location and dates the wounds were acquired were not accurate. Resident #24's plan of care (revised 6/1/22) listed the resident had potential for skin impairments due to thin, fragile skin, pulling/scratching skin, swinging at staff during care, self-propelling in wheelchair and moving bed table about in the room. Interventions to maintain skin integrity included weekly body audits, skin/wound assessments as needed and treatments as ordered for skin impairments. This finding was reviewed with the administrator, director of nursing and corporate consultant during a meeting on 7/20/22 at 4:20 p.m.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision	F 685		8/1/22

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F 685	Continued From page 27 CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on complaint investigation, clinical record review, resident interview, and staff interview, the facility failed for one of 27 residents in the survey sample, Resident # 27, to ensure transportation for vision related medical appointments was provided. Resident # 27 missed three appointments for vision care between 5/5/2022 and 7/15/2022 due to transportation issues. The findings were: Resident # 27 in the survey was admitted with diagnoses that included acute respiratory failure with hypoxia, hypertension, gastroesophageal reflux disease, neurogenic bladder, diabetes mellitus, hyperlipidemia, thyroid disorder, cerebral palsy, paraplegia, morbid obesity, history of COVID-19, chronic renal insufficiency, chronic pain, sleep apnea, and generalized muscle weakness. According to an Annual Minimum Data Set with an Assessment Reference Date of 5/4/2022, the resident was assessed under	F 685	1. Transportation has been arranged for vision appointment for resident # 27 for 8/26/2022. Resident is aware of appointment and transportation has been scheduled with Lifecare. NHA/designee will call all transportation companies and insurance companies that participate in facility residents transportation to discuss contingency plan for ensuring residents are transported timely to medical appointments. 2. All residents have the potential to be affected by this deficient practice, audit of the past 30 days of scheduled medical appointments to ensure all residents were transported to scheduled medical appointments. If not, appointment rescheduled and resident made aware of change. 3. Director of Nursing educated all charge	

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F 685	Continued From page 28 Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. Under Section B (Hearing, Speech, and Vision), the resident was assessed as having adequate vision with the use of corrective lenses. Resident # 27's care plan included the following focus (problem): "Potential vision impairment requires eye glasses for corrective vision. Sees Dr. (name) at JPA Ophthalmology." The goals for the focus included, "Show no signs of infection in eyes through next review; Resident will have adequate vision ability with prescription glasses AEB (as evidenced by) no injuries and feeling safe and secure in environment through next review." Interventions to the stated problem included, "Eye appointments as ordered; Eye exams as per orders; Optometry/ophthalmology appointments as ordered; Ensure eyeglasses are clean, appropriate and being worn by resident; Adapt environment to resident's individual needs to ensure resident is able to recognize objects/own environment; and, Administer vitamin/mineral supplements as ordered." At 9:00 a.m. on 7/20/2022, Resident # 27 was interviewed regarding her vision care. "I had a cataract removed from one eye several years ago and my vision improved, but my vision has gotten worse the last few years," the resident said. When asked about missed eye appointments, the resident said she has missed at least three because of transportation. "This last appointment, I decided not to go."	F 685	nurses, nurse managers and transportation scheduler that if any medical appointments are missed due to transportation issues then the MD is notified, and clinic is called immediately to schedule next appointment and resident is notified of the transportation issue. 4. DON/NHA will audit all transportation schedules on a weekly basis to ensure all residents are transported to scheduled medical appointments times three months and report to QAPI monthly.	

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The resident went on to explain that because of her size, the transportation company wants to take her on a gurney instead of her wheelchair. "This last time, the gurney they used was too small. When I got on it, they could only get one siderail up. When they raised the gurney and rolled me down the ramp to the van (ambulance) I got scared. I was afraid I would fall off so I made them take me back inside."

The review of the Progress Notes in Resident # 27's Electronic Health Record revealed the following entries:

5/11/2022 - Nursing Note - "May 5th (sic) 2022 resident's transportation did not show up at scheduled time for an appointment with the eye clinic at 2:30 pm. This writer spoke with transportation coordinator regarding the missed appointment. TC (Transportation Coordinator - CNA # 3) explained that she did received (sic) a call from 6th Kingsley Medical Transportation explaining that they were waiting on another crew to help with transport due to the weight of the resident. May 5th (sic) 2022 Kingsley Medical transport called and explained they were not able to find help for the trip. Appointment rescheduled for the 6th of June 2022 @ 9:30 am. MD and RP aware."

6/6/2022 - Nursing Note - "Resident did not get picked up this morning for a 9:30 eye appointment. Transportation coordinator (TC - CNA # 3) received a call from Aetna Better Health of VA. Representative asked TC did resident get picked up this morning. TC let the representative know that no one had come to pick her up. Representative was not aware that dispatch had not secured a ride for the resident. TC asked if a

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supervisor would be able to call and explain why they could not secure a ride for resident. TC called eye clinic and let them know she would not be able to come to her appointment due to transportation issue. Eye clinic rescheduled for August 11th (sic) 2022 @ 9:30 am. MD and RP made aware."

7/15/2022 - Nursing Note - "Resident was scheduled for a 10:00 am at the eye clinic, transportation arrived @ 9:00 am. When transferring resident from wheelchair to the gurney, the side rails were unable to come up on the right side of the patient due to residents size. The gurney was not wide enough. Which made it unsafe to transport resident. Resident was nervous stated to staff 'I don't feel safe, I feel like I am going to fall out.' After resident voiced her concern we than transferred her back into her wheelchair. Transportation coordinator rescheduled appointment August 26th (sic) 2022 @ 1:15 pm. MD and RP notified."

At approximately 3:00 p.m. on 7/20/2022, CNA # 3 (Certified Nursing Assistant), the facility's Transportation Coordinator, was interviewed. CNA # 3 acknowledged that transportation to medical appointments has been a problem. According to CNA # 3, transportation is arranged through Aetna Better Health of VA. "I call Aetna two to three weeks ahead of the appointment date. Aetna then calls the transportation provider. I usually try to call back to verify transportation has been arranged." CNA # 3 went on to say there have been times when transportation was either late, or did not show up at all.

Regarding Resident # 27, CNA # 3 said because

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F 685	Continued From page 31 the resident's size, the transport provider wants the resident to use a gurney, and they want an extra transport crew for assistance. For Resident # 27, the transport vehicle is non-emergency ambulance. Speaking on the May 5, 2022 missed appointment, CNA # 3 said the transport provider was unable to find a second crew to assist with the transport. As to the missed appointment on 6/6/2022, CNA # 3 said Aetna called to verify the resident had been picked up, and was unaware the transport provider had not sent a transport vehicle. Speaking to the missed appointment on 7/15/2022, CNA # 3 said the gurney was not wide enough to accommodate the resident, and when on the gurney, Resident # 27 did not feel safe. CNA # 3 said Aetna Better Health of VA is called for transportation, but that is about all them facility can do. According to CNA # 3, Aetna Better Health of VA is the contracted transportation provider and the facility is limited as to what they can do.	F 685		
F 842 SS=D	This is a Complaint Deficiency 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.	F 842		8/1/22

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§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted 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

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F 842	Continued From page 33 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure a complete and accurate clinical record for one of 27 residents. Resident #121's ADL (activities of daily living) forms included documentation that care was provided while she was in the hospital. Findings were: Resident #121 was admitted to the facility with the following diagnoses including but not limited to: AFTT (adult failure to thrive) schizophrenia, autoimmune hepatitis, gastrointestinal hemorrhage, history of mental and behavior problems, coronary artery disease, and transient cerebral ischemic attacks. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/16/2021 (MDS most recent to the time frame of the complaint) assessed	F 842	1. Resident #121 has been discharged from facility, the staff member that did not complete accurate documentation is no longer assigned to this facility. Facility is no longer using paper ADL documentation and there was no harm to resident. 2. All residents have the potential to be affected by this deficient practice. Audit completed on all residents discharged from facility in the past 30 days to hospital to ensure they have not had ADL documentation completed while not in facility. 3. Director of Nursing educated nursing assistants on proper ADL documentation and not to document on patients that are not in facility on 7/25/2022. 4. Unit managers/designee will audit POC	

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F 842	Continued From page 34 Resident #121 as moderately impaired with a cognitive summary score of "12". A significant change MDS with an ARD of 01/18/2022 (Post hospitalization 01/11/2022-01/13/2022) assessed her as cognitively intact with a summary score of "14". Resident #121 was added to the survey sample as a closed record due to a complaint received from the local APS (adult protective services). Per the documentation provided, the "disposition" for APS services was listed as: "Need for Protective Services No Longer Exists" and "Substantiated Maltreatment: Neglect". Rationale for the disposition was based on facility documentation on ADL (activities of daily living) records. The clinical record was reviewed beginning at approximately 12:00 p.m. documentation reviewed included ADL records, nursing notes, care plans, physician orders, and hospice notes. Resident #121 was sent to a local hospital on 01/11/2022 at 5:33 p.m. and returned on 01/13/2022 at 5:40 p.m. Review of the ADL records included documentation that Resident #121 had been provided ADL care on the 11-7 shift the two nights that she was out of the facility. The DON (director of nursing) was interviewed on 07/20/2022 at approximately 10:00 a.m. regarding the ADL sheet documentation. She was asked if the CNA (certified nursing assistant) who had documented on Resident #121 while she was out of the facility was still employed at the facility. She pulled the schedule for the dates in question (01/11/2022-01/13/2022) and stated, "That was an agency CNA who is no longer here." She was asked why she thought the documentation had	F 842	ADL documentation daily Monday through Friday in Clinical meeting and report to QAPI monthly times three months.	

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been completed on Resident #121 while she was in the hospital. She stated, "It looks like they followed suit and just documented what was already there incorrectly."

On 07/21/2022 at approximately 9:00 a.m., a copy of the facility policy for ADL documentation was requested from the DON. The "ADL Documentation Policy", included the following: "... In facilities still using paper records, ADLS will be documented in the ADL Flow Record: On each shift the Nursing Assistant will complete each ADL in the appropriate box utilizing the legend on the form; It is a best practice to document the care as soon as possible after the care is provided, when feasible; ...The Nurse will review the ADL Flow Record...before the end of the shift to ensure completion before staff depart." The DON stated, "They are supposed to document the care provided, not follow suit on the form. We aren't using the paper forms anymore. Now all the documentation is in (Name of electronic health record).

The above information was discussed with the administrator and the DON during an end of survey meeting on 07/21/2022.

No further information was obtained prior to the exit conference on 07/21/2022.