STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495156	A. BUILDING _____ B. WING _____	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT ROANOKE	324 KING GEORGE AVE SW ROANOKE, VA 24016

(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 7/17/2022 through 7/19/2022. The facility was 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 recertification survey was conducted 7/17/22 through 7/19/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 109 certified bed facility was 63 at the time of the survey. The survey sample consisted of 19 current resident reviews and 3 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 inappropriate. §483.10(g)(12) The facility must comply with the	F 578	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) 1. Resident #39' clinical record documentation regarding code status corrected on order, care plan, scanned documentation removed, and progress note written. 2. An audit of all resident records to assure code status accuracy. 3. Director of nursing or designee will educate MDS coordinator, Social Worker and Nursing regarding policy and procedure for Medical Documentation. 4. MDS coordinator or designee will audit twice weekly for six weeks code status clinical record documentation. Audits and audit findings will be reported to the facility QAPI Committee to review the need for	08/07/2022

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

			amendment of the plan. 5. Allegation of compliance set for 08/07/2022	

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

Morgan Sills | Administrator | 08/01/2022

leficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ving 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

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F 578	Continued From page 1 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 and clinical record review, the facility staff failed to ensure the code status for 1 of 19 residents in the survey sample, Resident #39. For Resident #39, the clinical record contained conflicting documentation regarding the resident's code status. The findings included:	F 578		

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING _____ B. WING _____	COMPLETED
	495156		07/19/2022

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F 578	Continued From page 2	F 578		

Resident #39's diagnosis list indicated diagnoses, which included, but not limited to Acute and Chronic Respiratory Failure with Hypoxia, Congestive Heart Failure, Chronic Peripheral Venous Insufficiency, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease Stage 3, Dysphagia, Gastro-esophageal Reflux Disease, Cerebral Infarction, Major Depressive Disorder, and Muscle Wasting and Atrophy.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 6/07/22 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact.

Resident #39's current physician's orders included an advanced directive order dated 5/26/21 for full code. The resident's clinical record included a completed Virginia Department of Health Durable Do Not Resuscitate (DDNR) Order dated 9/17/17 signed by the resident. The resident's clinical record also included an Advance Care Planning Tracking Form" completed by the Social Services Director dated 12/08/20 indicating the resident's advance directive was "Full Code". Surveyor attempted to speak with the Social Services Director, however, they were no longer employed by the facility.

Resident #39's current comprehensive plan of care included a focus area initiated on 1/24/18 stating the resident had elected full code status. Care plan interventions dated 1/24/18 stated in part "(Resident #39) has requested that CPR not be initiated in the event that his heart stops" and

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F 578	Continued From page 3 "(Resident #39) is a DNR status". On 7/18/22 at 5:16 pm, the survey team met with the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager, and the Regional Director of Clinical Services and discussed the concern of the discrepancies in the clinical record regarding Resident #39's code status. On 7/19/22 at 11:29 am, the Nurse Educator stated staff have talked with Resident #39 and he wants to be a full code. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/19/22.	F 578		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) 1. FRI on resident #59 properly reported. In-service Administrator/Director of Nursing on Reporting abuse to State Agencies and Other Entities/ Individuals policy and Abuse Investigation policy. 2. Audit all residents with incidents, accidents, and allegations of abuse have the potential to be affected by deficient practice. 3. Corporate Clinical Consultant in-serviced Administrator/ Director of Nursing on Virginia Department of Health Reporting of Incidences and facility policy on Abuse Prohibition. 4. Administrator/ or designee will 5. Will complete an audit tracking tool	08/07/2022

			with compliance date reporting/sending Final FRIs 3 times weekly for 6 weeks then monthly times 2 months. Allegation of compliance 8/7/22	

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F 609	Continued From page 4 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and facility document review, the facility staff failed to report the investigation results of an alleged episode of neglect to the appropriate agencies within 5 working days of the incident for one (1) of 19 sampled current residents, Resident #59. The facility staff self-reported an allegation of neglect involving Resident #59 to the state survey agency (SA); the facility staff failed to report the investigation results to the SA. The findings include: Resident #59's minimum data set (MDS)	F 609		

	assessment, with an assessment reference date (ARD) of 7/5/22, was signed as completed on 7/7/22. Resident #59 was assessed as able to make self understood and as able to understand others. Resident #59's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact or borderline cognition. Resident #59 was assessed as requiring assistance with bed mobility, transfers, dressing, and personal hygiene. Resident #59's diagnoses included, but were not limited to: anemia, high blood pressure, diabetes, anxiety, depression, and dementia.			

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F 609	Continued From page 5 A Facility Reported Incident (FRI), involving Resident #59, was reported to the SA on 5/18/22. This FRI alleged neglect involving Resident #59's activities of daily living (ADL) care. This FRI indicated the investigation was "Ongoing" and was not included in this FRI report. No evidence was found to indicate the investigation results were reported to the SA. On 7/19/22 at 2:15 p.m., the aforementioned FRI report was reviewed with the facility's Regional Director of Clinical Services (RDCS). The RDCS was unable to find evidence of the results of an investigation of this FRI being reported to the required agencies. The RDCS stated they would check with the local ombudsman and adult protective services (APS) to see if the investigation results were reported to them. The facility's documents related to this event included an "IN SERVICE SIGN-IN" form which addressed job expectations for a facility staff member involved in Resident #59's care and the events alleged in the FRI in question. The following information was found in a facility	F 609		

policy titled "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation" (with a reviewed/revised date of 10/22/20):
- "It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property [sic] are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes."
- "Neglect: Failure of the facility, its employees or service providers to provide goods and services

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F 609	Continued From page 6 to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." - "The Administrator should follow up with government agencies, during business hours, to confirm the report was received and to report the results of the investigation when final as required by state agencies." On 7/19/22 at 4:05 p.m., the Regional Director of Operations (an interim administrator) reported they were unable to find evidence of reporting the aforementioned FRI's investigation conclusions to the required agencies. The Regional Director of Operations stated they wasn't sure if the events reported in this FRI needed to be reported as a FRI.	F 609		
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	F 625	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) 1. Resident #13's emergency contact offered bed hold and declined. Bed hold notice completed and mailed to emergency contact. Progress note written and Bed Hold Notice scanned into the medical record.	08/07/2022

	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		2. Full facility audit of discharges since 7/20/22 to ensure bed hold has been offered. 3. BOM and Administrator reeducated on Bed Hold Policies. All licensed nursing staff reeducated regarding Bed Hold Policies by Director of Nursing or Designee. 4. BOM or designee will complete an audit 3 times weekly for six weeks then monthly for 2 months unexpected discharged residents, also residents going on leave of absence to ensure bed hold police is place and scanned into residents' charts Audits and audit findings will be reported to the facility QAPI Committee to review the need for continued intervention or amendment of the plan. 5. Allegation of compliance set for 08/07/2022	

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F 625	Continued From page 7 (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	F 625		

described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:

Based on interviews, clinical record review, and facility document review, the facility staff failed to provide bed hold policy information to a resident or resident's representative for one (1) of 19 sampled current residents, Resident #13. Resident #13 had been admitted to a local hospital.

The findings include:

Resident #13's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 4/25/22, was signed as completed on 5/5/22. Resident #13 was assessed as sometimes able to make self understood and as sometimes able to understand others. Resident #13's Brief Interview for Mental Status (BIMS) summary score was documented as zero (0) out of 15; this indicated severe cognitive impairment. Resident #13 was assessed as being dependent on others for bed mobility, transfers, eating, toilet use, and personal hygiene. Resident #13's diagnoses included: anemia, high blood pressure, diabetes, dementia, and respiratory failure.

Resident #13's clinical documentation was

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F 625	Continued From page 8	F 625		

reviewed on 7/19/22. It was noted the resident had been discharged from the facility to a hospital for greater than 72 hours. No evidence was found to indicate the resident and/or the resident's emergency contact person(s) had been provided 'bed hold' information related to Resident #13's recent hospitalization.

The following information was found in a facility

policy titled "Bed Hold Notice Upon Transfer" (with a reviewed/revised date of 10/22/20):
- "At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed."
- "In the event of an emergency transfers [sic] of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies, as stipulated in the State's plan."

On 7/19/22 at 1:05 p.m., the Regional Director of Operation (an interim administrator) reported a bed hold notice, for the aforementioned hospital transfer, had not been provided to the resident or the resident's representative. On 7/19/22 at 1:30 p.m., the Regional Director of Operations reported the bed hold notification should have been provided within 24 hours of the resident's discharge/transfer.

On 7/19/22 at 4:21 p.m., the failure of the facility staff to provide Resident #13 and/or the resident's representative 'bed hold' information within 24 hours of the recent discharge/transfer was discussed with the facility's Regional Director of Operations, Clinical Nurse Educator, Director of

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F 625	Continued From page 9 Nursing, Regional Director of Clinical Services, and a Medical Records employee. The Regional Director of Operations reported facility staff members will call Resident #13's emergency contact individual and mail the 'bed hold' information to the emergency contact individual.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641	Accuracy of Assessments CFR(s): 483.20 (g) 1. Resident #42 section C could not be	08/07/2022

	§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 the facility staff failed to ensure the accuracy of MDS (minimum data set) assessments for 1 of 19 residents, Resident #42. For Resident #42, the facility staff failed to ensure the BIMS (brief interview for mental status) was completed The findings included: Resident #42's face sheet listed diagnoses which included but not limited to traumatic subdural hemorrhage with loss of consciousness, dysphagia, depression, convulsions, and cognitive communication deficit. Resident #42's most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 06/12/22 failed to assign the resident a brief interview for mental status (BIMS) score in section C, cognitive patterns. The quarterly MDS with an ARD of 03/12/22 assigned the resident a BIMS score of 4 out of 15 in		corrected to reflect the MDS, BIMs score corrected in PCC. MDS Coordinator, received education on accurately coding section C resident BIMs score within coding timeframe. 2. An audit of all current residents BIMs Score will be conducted to assure that their most recent MDS reflects their appropriate Cognitive Pattern. In servicing by the Director of Nursing or Designee to the MDS Coordinator on correct coding of section C on the MDS 3. The MDS Coordinator educated on the facility policy on resident assessment and cognitive patterns. 4. Audits will be conducted by the MDS coordinator or Designee on Section C of the MDS for accuracy twice weekly times 6 weeks then monthly times two months. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan. 5. Allegation of compliance 08/07/22	

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F 641	Continued From page 10 section C. This indicates that the resident is severely cognitively impaired. Surveyor spoke with the MDS staff on 07/19/22 at 9:00 am. Surveyor asked MDS staff why the resident's BIMS score had not been assessed and MDS staff stated, "I have no idea". MDS staff also stated that the facility social worker is responsible is for completing section C. Facility	F 641		

	social worker was unavailable for interview. The concern of the facility staff not completing the BIMS assessment on the MDS was discussed with the administrative staff (administrator, director of nursing, clinical nurse educator, medical records, regional director of clinical services) on 07/19/22 at 4:20 pm			
F 645 SS=D	No further information was provided prior to exit. PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F 645	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) 1. Resident #55 PASARR completed. 2. Full facility audit to ensure PASARR Screening completed for MD & ID if deemed necessary. 3. Social worker reeducated to assure PASARR Screening for MD & ID is obtained on admission and/or completed if deemed necessary. 4. Social Worker or designee will audit three times weekly for six weeks then monthly for two months to assure PASARR Screening for MD & ID are completed if deemed necessary. Social worker will also audit all new admissions to assure PAASAR is complete twice weekly for six weeks then monthly for 2 months 5. Audits and audit findings will be reported to the facility QAPI Committee to review the need for continued intervention or amendment of the plan. 6. Allegation of compliance set for 08/07/2022	08/07/2022

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F 645	Continued From page 11 (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i) The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.	F 645		

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F 645	Continued From page 12 §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to conduct a level 1 PASARR (pre-admission screening and resident review) for 1 of 19 residents in the survey sample (Resident #55). Resident #55 was admitted to the facility with diagnoses including bipolar disorder, psychotic disorder, major depression, respiratory failure, coronary artery disease, heart failure, hypertension, malnutrition, hypertension, and anemia. On the minimum data set assessment with assessment reference date 7/6/2022, the resident scored 3/15 on the Brief Interview for Mental Status and was assessed as without delirium, psychosis, or behavior affecting care. On 7/18/22, the surveyor was unable to locate a PASARR in the resident's clinical record. The surveyor was offered a demographic form which did include the questions asked on a level 1 PASARR. The social worker stated to surveyors that the form was all the facility received from transferring facilities in North Carolina. There was also a brief discussion concerning the waiver of the requirement that the level 1 PASARR be conducted prior to admission. The waiver allows	F 645		

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F 645	Continued From page 13 facility staff to conduct the assessment within 30 days of admission. Resident #55 was admitted to the facility in 2017, before the waiver was issued. The surveyor reported the concern during a summary meeting on 7/19/2022 to the current acting administrator (as of 7/18/22), the prior acting administrator, the director of nursing, assistant director of nursing, and medical records coordinator.	F 645		
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 Resident interview, staff interview, clinical record review and facility document review the facility staff failed to follow professional standards of practice for the documentation of medications for 1 of 19 Residents, Resident #47. For Resident #47 the facility staff initialed a nebulizer treatment as being administered as ordered, when the resident was not receiving the treatment. The findings included: Resident #47's face sheet listed diagnoses which included but not limited to myocardial infarction (heart attack), chronic obstructive pulmonary disease, and congestive heart failure.	F 658	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) 1. Resident #47 medication not received was discontinued by provider. 2. Full facility audit of medications received as ordered. 3. Facility nursing staff that inaccurately documented, educated on policy and procedure for Medical Documentation. All facility nursing staff educated on policy and procedure for Medical Documentation 4. DON or designee will audit twice weekly for six weeks then monthly for two months to assure MAR/Medical documentation is completed accurately. Audits and audit findings will be reported to the facility QAPI Committee to review the need for continued intervention or amendment of the plan.	08/07/2022

			5. Allegation of compliance set for 08/07/2022	
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Resident #47's most recent quarterly minimum data set with an assessment reference date of 06/17/22 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.

Resident #47's comprehensive care plan was reviewed and contained a care plan which read in part, " ...is at nutrition and/or hydration risk aeb (as evidenced by) dx (diagnosis) COPD (chronic obstructive pulmonary disease), severe PCM (protein calorie malnutrition), alcohol/psychoactive substance abuse, CHF (congestive heart failure), anemia, homelessness, therapeutic diet". Interventions for this care plan included "Administer medications as ordered".

Resident #47's clinical record was reviewed and contained a physician's order summary for the month of July 2022, which read in part "Pulmicort suspension 0.5 mg/2 ml 0,5mg inhale orally two times a day for respiratory therapy **rinse mouth after each use to avoid oral thrush**". This order had a start date of 01/11/22.

Resident #47's electronic medication administration record for the month of July was reviewed and contained an entry, which read in part "part "Pulmicort suspension 0.5 mg/2 ml 0,5mg inhale orally two times a day for respiratory therapy **rinse mouth after each use to avoid oral thrush**". This entry was initialed as being administered as ordered on all dates/times, with the exception of 07/09/22 at 9:00 am and 07/17/22 at 9:00 pm.

	Surveyor spoke with Resident #47 on 07/18/22 at			

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F 658	Continued From page 15 3:00pm. Surveyor observed a nebulizer machine/mask on a table in resident's room. The nebulizer mask was not bagged/covered. Surveyor asked Resident #47 if the nebulizer mask was ever placed in a bag or covered and resident stated that they did not know the mask should be covered, but they rarely used it anyway. Surveyor asked resident if they use it twice a day, and resident stated that they do not. Resident stated that they have an inhaler that they use. Surveyor asked resident again for clarification if they used the nebulizer twice a day, and resident again stated that they do not. Resident stated they have not used it in approximately 2 weeks. Surveyor spoke with LPN (licensed practical nurse) #3 on 07/18/22 at 3:10 pm regarding Resident #47's Pulmicort. LPN #3 stated that resident's Pulmicort is administered via nebulizer. Surveyor observed the Pulmicort in the medication cart. The cart contained one opened 30-count box of Pulmicort vials, with a dispensed date of 07/04/22. The box contained 27 unopened vials. Surveyor spoke with the director of nursing (DON) on 07/18/22 at 4:05 pm regarding Resident #47's Pulmicort. DON stated that the resident usually uses an inhaler instead of nebulizer. Surveyor asked the DON why the nebulizer treatment had not been discontinued if the resident is not using it and DON stated, "It's probably just an oversight". DON also stated that the resident has not used the nebulizer "since I have been a nurse here". Surveyor asked the DON how long that has been and DON stated, "Since April".	F 658		

	Surveyor spoke with the clinical nurse educator			
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F 658	Continued From page 16 (CNE) on 07/19/22 at 11:00 am regarding Resident #47's Pulmicort. CNE stated that if the medication was ordered, it should be administered as ordered, and if the resident refuses the medication, that should be documented in the clinical record. Surveyor asked the CNE if the medication should be initialed as administered if the resident is not receiving the medication, and CNE stated that it should not be. Surveyor asked the CNE what standard of practice the facility uses for documentation of medications, and CNE stated, "I'm sure we have a policy". Surveyor requested and was provided a facility policy entitled "Administering Medication", which read in part "Policy Statement-Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 3. Medications must be administered in accordance with the orders, including any required time frame. 18. If a drug is withheld, refused, or given at a time other that the scheduled time, the individual administering the medication shall initial and circle the MAR (medication administration record) space provided for that drug and dose." The concern of not following professional standards of practice for the administration of medications was discussed with the administrative staff (administrator, director of nursing, clinical nurse educator, medical records, regional director of clinical services) on 07/19/22 at 4:20 pm No further information was provided prior to exit.	F 658		

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F 684	Continued From page 17 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 resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure care and services were provided to address the needs for 5 of 19 residents in the survey sample, Residents #3, #16, #39, #47, and #164. For Residents #3 and #16, the facility staff failed to obtain weekly weights as ordered by the physician. For Resident #39, the facility staff failed to obtain a dermatology consult, gastroenterology consult, a chest CT (computed tomography) scan, and an upper GI (gastrointestinal) x-ray as ordered by the	F 684	Quality of Care CFR(s): 483.25 1. Residents # 3, #16 and # 164 weight obtained and documented. Resident #39 declined to attend consults and documentation has been completed. MD and Resident updated. Resident #47 medication was discontinued as ordered. 2. Full facility audit to ensure weights are completed as ordered. Full facility audit to ensure consults are ordered, scheduled, attended, and documented. Full facility audit to assure medication is administered as ordered. 3. All licensed nursing staff reeducated regarding weight monitoring, medication administration and medical documentation policy by Director of Nursing or designee. Medical Records Coordinator reeducated on medical documentation policy.	

	physician. For Resident #47, the facility staff failed to administer the medication Pulmicort as ordered by the physician. Pulmicort is an inhaled steroid used in the treatment of chronic obstructive pulmonary disease. For Resident #164, the facility staff failed to obtain a weight ordered by the dietician.		4. Director of Nursing or designee will audit weekly x 6 weeks that weights are obtained and documented as ordered. Director of Nursing/ or designee will audit twice weekly for six weeks the administration four randomly selected resident's medications to ensure proper administration and documentation of resident medications. Medical Records or designee will audit twice weekly x 6 weeks then monthly x 2 months that consult orders are received, appointments scheduled, appointments attended, appointment documentation is completed, and any follow up orders completed. Audits and audit findings will be reported to the facility QAPI Committee to review the need for continued intervention or amendment of the plan. 5. Allegation of compliance set for 08/07/2022	

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F 684	Continued From page 18 The findings included: 1. Resident #3's diagnosis list indicated diagnoses, which included, but not limited to Demyelinating Disease of Central Nervous System, Epilepsy, Dysphagia, Bipolar Disorder, Generalized Anxiety Disorder, Essential Hypertension, and Pseudobulbar Affect. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 4/20/22 assigned the resident a brief interview	F 684		

for mental (BIMS) summary score of 0 out of 15 indicating the resident was severely cognitively impaired. Resident #3 was coded for the presence of a feeding tube in which they received 51% or more of total calories and 501 cc/day or more of average fluid intake.

Resident #3's current physician's orders included an order dated 12/13/21 for weekly weights. A review of the resident's Weight Summary located in the clinical record included a weight of 138.7 obtained on 7/15/22 and a previous weight of 136.8 obtained on 6/06/22. Surveyor was unable to locate any documented weights obtained between 6/06/22 and 7/15/22.

On 7/18/22 at 9:53 am, surveyor notified the assistant director of nursing (ADON) of being unable to locate documentation of weekly weights for Resident #3.

On 7/19/22 at 1:01 pm, surveyor spoke with the director of nursing (DON) who stated they were unable to find where weekly weights were done for Resident #3 and education needed to be done.

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On 7/19/22 at 4:22 pm, the survey team met with the Administrator, DON, Nurse Educator, Regional Director of Clinical Services, and the Medical Records Director and discussed the concern of Resident #3's weights not being obtained weekly as ordered.

No further information regarding this concern was presented to the survey team prior to the exit conference on 7/19/22.

2. Resident #16's diagnosis list indicated

diagnoses, which included, but not limited to Pulmonary Embolism, Acute Embolism and Thrombosis of Unspecified Deep Veins of Left Lower Extremity, Type 2 Diabetes Mellitus, Morbid Obesity, Muscle Wasting and Atrophy, Thrombocytopenia, Essential Hypertension, and Carpal Tunnel Syndrome.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 5/04/22 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact.

Resident #16's current physician's orders included an order dated 4/13/22 to obtain a weight weekly. According to Resident #16's July 2022 treatment administration record (TAR), the resident was to be weighed on 7/06/22, however, no weight was documented and the order was not signed by a nurse as being completed. Surveyor reviewed Resident #16's clinical record and was unable to locate a weight for 7/06/22, the only documented weight for the month of July 2022 was obtained on 7/13/22.

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On 7/18/22 at 9:53 am, surveyor notified the assistant director of nursing (ADON) of being unable to locate documentation of weekly weights for Resident #16.

On 7/19/22 at 1:01 pm, surveyor spoke with the director of nursing (DON) who stated they could not find a 7/06/22 weight documented for Resident #16.

On 7/19/22 at 4:22 pm, the survey team met with the Administrator, DON, Nurse Educator,

Regional Director of Clinical Services, and the Medical Records Director and discussed the concern of Resident #16 not being weighed weekly on 7/06/22 as ordered.

No further information regarding this concern was presented to the survey team prior to the exit conference on 7/19/22.

3. Resident #39's diagnosis list indicated diagnoses, which included, but not limited to Acute and Chronic Respiratory Failure with Hypoxia, Congestive Heart Failure, Chronic Peripheral Venous Insufficiency, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease Stage 3, Dysphagia, Gastro-esophageal Reflux Disease, Cerebral Infarction, Major Depressive Disorder, and Muscle Wasting and Atrophy.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 6/07/22 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact.

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On 7/17/22 at approximately 3:00 pm, surveyor spoke with Resident #39 and noted a discolored scabbed-like area adjacent to their right ear. The resident stated the area had been there for about two years. Surveyor reviewed the resident's clinical record and a written physician's order dated 1/05/22 stated "Please schedule Dermatology consult to evaluate lesion right pre-auricular area. Concern neoplasm/skin cancer". A nursing progress note dated 1/05/22 at 2:49 pm stated "MD (name omitted) ordered Dermatology consult to evaluate lesion right

per-auricular [sp] area. Concern of skin cancer. (Name omitted) in medical is aware of order and will schedule".

Resident #39 was seen by the physician on 3/08/22, the progress note stated in part "The skin in the right preauricular area is inflamed. There is a crusted area that appears almost as if he has been picking it. I do not appreciate any heaped up margins ..." A physician's order dated 3/11/22 at 10:56 am stated "Dermatology Consult (re: lesion to right cheek)".

Resident #39 was seen by the family nurse practitioner (FNP) on 3/25/22, the progress note stated in part "Upon exam dried/scabbed lesion noted to right check, near his right ear. No open areas or drainage noted. Denies complaints of pain. It is noted that pt (patient) was referred to dermatology on 3/11 for this lesion ...Staff to ensure dermatology appt (appointment) followed through as ordered ..." A physician's order dated 3/25/22 stated in part "ensure pt went to dermatologist for eval (evaluation)".

Resident #39 was again seen by the FNP on 4/22/22 for the area to the right cheek. The

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progress note stated in part " ...will continue application of antibiotic more [sp] ointment but due to the discomfort and difficulty of getting a dressing to remain intact to the area will leave open to the air. Follow-up with Dermatology pending..."

Surveyor reviewed Resident #39's clinical record and was unable to locate documentation of the resident being seen by a dermatologist following the original 1/05/22 order.

On 7/18/22 at 2:30 pm, surveyor spoke with Resident #39 who stated that he had not been to a dermatologist but would like to go because the area was "painful and sore".

On 7/18/22 at 5:16 pm, the survey team met with the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager, and the Regional Director of Clinical Services and discussed the concern of Resident #39 not being seen by a dermatologist as ordered.

On 7/19/22 at 9:45 am, surveyor spoke with the physician (MD) regarding Resident #39's dermatology consult, MD stated consults have been ordered on a couple occasions and the resident will refuse to go and maybe this was the same kind of issue. MD further stated he would "see what I can find and let you know", however, the MD did not return to the surveyor prior to the end of the survey.

On 7/19/22 at 11:21 am, surveyor met with the Medical Records Director (MRD) who also schedules outside appointments, regarding Resident #39's dermatology consult. The MRD stated the referral for the dermatology consult

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was sent to (name omitted) Dermatology on 3/11/22 and she contacted the office this morning and was told Resident #39 was "in the cue" to be scheduled and now an appointment has been made for 1/04/23 which was the earliest available appointment. Surveyor spoke with the MRD again at 12:45 pm who stated Resident #39 did not want to go to a dermatology appointment when first ordered back in January but then it got more severe. Surveyor was unable to locate documentation or physician notification related to the resident declining the dermatology consult in

January 2022.

On 7/19/22 at 11:34 am, surveyor spoke with the scheduler with (name omitted) Dermatology who stated the referral for an appointment for Resident #39 was loaded in the system on 3/29/22 and the referral was triaged on 4/06/22 for an appointment within eight (8) weeks if possible. Scheduler stated they were unsure why the appointment was not scheduled until 1/04/23.

Surveyor reviewed Resident #39's clinical record and was unable to locate documentation of any follow-up action regarding a dermatology consult or provider notification prior to being questioned by the surveyor on 7/18/22.

Resident #39's physician's orders included an order dated 2/25/22 for a GI (gastroenterologist) referral for an EGD (esophagogastoduodenoscopy). Resident #39 was seen by the MD on 3/08/22 at the request of the DON related to odynophagia (painful swallowing) and weight loss. The progress note stated in part "There are 3 probably distinct and separate new conditions that need to be addressed and looked into. Lung nodule: I

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CHOICE HEALTHCARE AT ROANOKE	324 KING GEORGE AVE SW ROANOKE, VA 24016

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talked with him about the abnormal chest x-ray finding. I told him that this could be worrisome ...He tells me he would like to know if there is something going on of concern. I will schedule a chest CT (computed tomography). Abnormal weight loss ...There was a dramatic drop of weight in a matter of 2 weeks. That preceded his decreased p.o. (oral) intake. We must consider that this is a real weight loss. Particularly in the face of a lung nodule as well as his odynophagia and abdominal pain. I am going to order a CMP (comprehensive metabolic panel), CBC

(complete blood count), and a TSH (thyroid stimulating hormone) ...Odynophagia ...We have already requested a GI consultation. There are no new patient GI appointments for a number of months. I am reluctant to let this wait. Certainly he does not need an ER visit for this. I have chosen to order the chest CT above but also order a traditional upper GI x-ray/traditional barium swallow ..."

Resident #39's clinical record included a physician's order dated 3/16/22 for an Upper GI x-ray with traditional barium swallow r/t (related to) odynophagia. A 3/22/22 physician's order stated "Chest CT with contrast for monitoring r/t (related to) lung nodule. May obtain serum creatinine clearance prior to CT".

Surveyor reviewed the resident's clinical record and was unable to locate evidence of a GI consult, upper GI x-ray, chest CT, CMP, CBC, or TSH as discussed in the 3/08/22 MD progress note.

On 7/19/22 at 9:45 am, surveyor spoke with the physician (MD) regarding Resident #39's GI consult, upper GI x-ray, chest CT, and lab tests,

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MD stated consults have been ordered on a couple occasions and the resident will refuse to go and maybe this was the same kind of issue. MD further stated he would "see what I can find and let you know", however, the MD did not return to the surveyor prior to the end of the survey.

On 7/19/22 at 11:21, surveyor spoke with the MRD who stated they sent the referral for the CT scan to (name omitted) Imaging in March and the order was authorized on 3/25/22. She stated she spoke with the resident on 3/21/22 and he wanted

	to go to the GI doctor before having the CT scan and an appointment was made with Dr. (name omitted) for 5/17/22 who would order the EGD. MRD stated when transport arrived on 5/17/22 to take the resident to the GI consult, he refused to go because he was feeling better. The MRD stated they could not find documentation of the MD being notified of the resident's refusal and the CT scan has not been rescheduled or discussed since he refused to go to the GI consult. Surveyor was unable to locate documentation regarding the resident's decision to wait for the CT scan or refusal to go to the GI consult on 5/17/22. Surveyor requested and received the facility policy entitled "Residents' Rights Regarding Treatment and Advance Directives" which read in part "11. Should the resident refuse treatment of any kind, the facility will document the following in the resident's chart: a. What the resident refused. b. The reason for the refusal. c. The advice given to the resident about the consequences of refusing. d. The offering of alternative treatments. e. The continuation of providing all other services".			

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F 684	Continued From page 26 Surveyor requested and received the facility policy entitled "Radiology and Other Diagnostic Services and Reporting" which read in part "1. The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents". Surveyor requested and received the facility policy entitled "Laboratory Services and Reporting" which read in part "1. The facility must provide or obtain laboratory services to meet the	F 684		

needs of its residents".

On 7/19/22 at 4:22 pm, the survey team met with the administrator, nurse educator, DON, ADON, and the MRD and discussed the concern of Resident #39 not having a dermatology consult, GI consult, chest CT, and upper GI x-ray as ordered by the physician.

No further information regarding this concern was presented to the survey team prior to the exit conference on 7/19/22.

4. Resident #47's face sheet listed diagnoses which included but not limited to myocardial infarction (heart attack), chronic obstructive pulmonary disease, and congestive heart failure.

Resident #47's most recent quarterly minimum data set with an assessment reference date of 06/17/22 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.

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Resident #47's comprehensive care plan was reviewed and contained a care plan which read in part, " ...is at nutrition and/or hydration risk aeb (as evidenced by) dx (diagnosis) COPD (chronic obstructive pulmonary disease), severe PCM (protein calorie malnutrition), alcohol/psychoactive substance abuse, CHF (congestive heart failure), anemia, homelessness, therapeutic diet". Interventions for this care plan included "Administer medications as ordered".

Resident #47's clinical record was reviewed and contained a physician's order summary for the month of July 2022, which read in part "Pulmicort suspension 0.5 mg/2 ml 0,5mg inhale orally two times a day for respiratory therapy **rinse mouth after each use to avoid oral thrush**". This order had a start date of 01/11/22.

Resident #47's electronic medication administration record for the month of July was reviewed and contained an entry, which read in part "part "Pulmicort suspension 0.5 mg/2 ml 0,5mg inhale orally two times a day for respiratory therapy **rinse mouth after each use to avoid oral thrush**". This entry was initialed as being administered as ordered on all dates/times, with the exception of 07/09/22 at 9:00 am and 07/17/22 at 9:00 pm.

Surveyor spoke with Resident #47 on 07/18/22 at 3:00pm. Surveyor observed a nebulizer machine/mask on a table in resident's room. The nebulizer mask was not bagged/covered. Surveyor asked Resident #47 if the nebulizer mask was ever placed in a bag or covered and resident stated that they did not know the mask should be covered, but they rarely used it anyway.

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Surveyor asked resident if they use it twice a day, and resident stated that they do not. Resident stated that they have an inhaler that they use. Surveyor asked resident again for clarification if they used the nebulizer twice a day, and resident again stated that they do not. Resident stated they have not used it in approximately 2 weeks.

Surveyor spoke with the director of nursing (DON) on 07/18/22 at 4:05 pm regarding Resident #47's Pulmicort. DON stated that the resident usually uses an inhaler instead of

nebulizer. Surveyor asked the DON why the nebulizer treatment had not been discontinued if the resident is not using it and DON stated, "It's probably just an oversight". DON also stated that the resident has not used the nebulizer "since I have been a nurse here". Surveyor asked the DON how long that has been and DON stated, "Since April".
Surveyor spoke with the clinical nurse educator (CNE) on 07/19/22 at 11:00 am regarding Resident #47's Pulmicort. CNE stated that if the medication was ordered, it should be administered as ordered, and if the resident refuses the medication, that should be documented in the clinical record.

Surveyor requested and was provided a facility policy entitled "Administering Medication", which read in part "Policy Statement-Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 3. Medications must be administered in accordance with the orders, including any required time frame.

The concern of not following physician's orders was discussed with the administrative staff

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(administrator, director of nursing, clinical nurse educator, medical records, regional director of clinical services) on 07/19/22 at 4:20 pm

No further information was provided prior to exit.

5. For Resident #164, facility staff failed to obtain a weight ordered by the dietician.

Resident #164 was admitted to the facility with

	diagnoses including dysphagia, gastroesophageal reflux disorder, diabetes mellitus, chronic respiratory failure with mechanical ventilator dependence, essential hypertension, urinary tract infection, pancreatitis, and depression. On the minimum data set assessment with assessment reference date 7/5/22, the resident scored 14/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The surveyor spoke with the resident on 7/17/2022. The resident expressed no concerns with care. Clinical record revealed a registered dietician (RD) progress note dated 6/17/2022, where the dietician ordered weekly weights times 1 month to monitor weight of a new admission. The note indicated the resident was obese and non-significant weight loss was desirable. The clinical record recorded weights. On 06/15/2022, the resident weighed 185.3 lbs. On 07/08/2022, the resident weighed 108.8 pounds which is a -41.28 % Loss. A RD note dated 7/11/2022 indicated the second weight (108.8 was likely inaccurate and requested a re-weight.			

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F 684	Continued From page 30 The concern was reported to the director of nursing (DON), assistant director of nursing (ADON), and unit manager at end of day meeting on 7/18/22. The DON discussed the issue with obtaining resident weights with surveyors on 7/18 and 7/19. If the resident was weighed prior to the end of the survey, the surveyor was not made aware.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	08/07/2022

	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and facility document review the facility staff failed to provide supervision to prevent potentially avoidable accidents for 1 of 19 residents. (Resident #5) For Resident #5 the facility staff failed to provide supervision while the resident was smoking. The findings were: Resident #5's admission record noted their diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease, delusional disorders, non-ST elevation myocardial infarction (heart attack), and		1. Resident #5 is now supervised smoking. Smoking Assessment and careplan updated. 2. Full facility audit to ensure accurate smoking assessments, careplans reflecting smoking status, staff assigned to smokers, designated smoking area utilized and Smoking items locked up when not in use. 3. All licensed nursing staff regarding re-educated by Director of Nursing/ or designee on smoking policy and procedure. 4. Director of Nursing/ or designee will audit smoking items locked up when not in use, residents smoking in designated smoking area, smoking assessments completed and accurate careplan reflecting smoking status and staff assigned to smokers twice weekly for six weeks then monthly x 2 months. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan. 5. Allegation of compliance set for 08/07/2022	

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F 689	Continued From page 31 difficulty in walking. Resident #5's quarterly	F 689		

minimum data set with an assessment reference date of 04/25/2022 coded the resident's brief interview for mental status at a 14 out of 15 in Section C (cognitive patterns). Section G (functional status) read in part, for surface-to-surface transfers the resident was not steady, but able to stabilize without staff assistance. For functional limitation in range of motion, Resident #5 was coded as having "no impairment" in upper or lower extremities.

During an interview with LPN#5 (licensed practical nurse) on 07/18/2022 at approximately 2:30 p.m., the LPN stated the facility did not currently have any resident who required smoking supervision.

A Safe Smoking Screening document dated 02/02/2022 triggered Resident #5 "must be at minimum a Supervised smoker" under the cognition and physical sections. The "D. Other" section at #3.b read, "Resident requires supervision while smoking." The resident's care plan included, but was not limited to, a focus area for: At risk for injury related to smoking with interventions that included (but not limited to) lighters and cigarettes will be kept in a locked box and labeled with their name on their pack, will have only one cigarette at a time, and will smoke only when there is an assigned staff member in the designated smoking area. Another focus area read the resident requires continuous oxygen support removed long enough to smoke supervised on the smoking block.

On 07/19/2022 at 10:00 a.m., the surveyor observed Resident #5 in a wheelchair, in the facility's outdoor courtyard smoking a cigarette.

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F 689	Continued From page 32 There were no other residents present and no	F 689		

staff present in the courtyard. The surveyor interviewed Resident #5 who reported he was allowed to smoke without supervision because he had a "LOA" (leave of absence). The resident said one of the CNAs (certified nursing assistants) usually helped him with the door to get out to the courtyard. He reported the smoking blanket "hindered" him too much and therefore he didn't wear one. Resident #5 was observed holding a whole pack of cigarettes and the resident stated he kept his own cigarettes and lighter with him. The resident's upper extremity mobility was not visibly impaired and Resident #5 was observed managing his cigarette(s) and cigarette butt without difficulty. Right after returning inside the facility from the courtyard, the surveyor looked back to the courtyard through a window in the door and observed Resident #5 smoking another cigarette.

The director of nursing (DON) provided the facility's policy titled "Resident Smoking" with an implementation date of 11/01/2020. The policy was reviewed and read in part, "10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan." At #13 the policy read, "Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff."

The nurse educator, regional director of clinical services, administrator, medical records director and DON was informed of the above described observation during a meeting with the survey

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F 689	Continued From page 33 team on 07/19/2022 at 4:22 p.m. The medical	F 689		

	records director reported Resident #5's reference to a leave of absence was referring to when the resident would leave the facility's property to smoke "down on the corner," not while the resident remained on the facility property which included the courtyard. The DON stated the resident probably did not understand the difference between having a LOA versus having to be supervised while smoking on the property. No further information was provided prior to the exit conference.			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced	F 692	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) 1. Resident #3 was assessed by nursing with no abnormal findings and MD was updated. Tube feeding was resumed as ordered and new order was received for BMP. 2. Full facility audit of all enteral feedings to ensure tube feeding is being administered as ordered. 3. All licensed nursing staff regarding re-educated by Director of Nursing/ or designee on administration of enteral orders. 4. Director of Nursing/ or designee will audit residents tubing feeding hanging appropriately with feeding infusing according to MD orders twice weekly x 6 weeks then monthly x 2 months. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan. 5. Allegation of compliance set for 08/07/2022	08/07/2022

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F 692	Continued From page 34	F 692		

by:
Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a resident who is fed by enteral means receives the provider ordered tube feeding nutrition and hydration and failed to address a significant weight loss for 2 of 19 residents in the survey sample, Residents #3 and #164.

For Resident #3, the facility staff failed to provide tube feeding formula and water as ordered on 7/18/22.

For Resident #164, facility staff failed to address a documented significant weight loss.

1. Resident #3's diagnosis list indicated diagnoses, which included, but not limited to Demyelinating Disease of Central Nervous System, Epilepsy, Dysphagia, Bipolar Disorder, Generalized Anxiety Disorder, Essential Hypertension, and Pseudobulbar Affect.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 4/20/22 assigned the resident a brief interview for mental (BIMS) summary score of 0 out of 15 indicating the resident was severely cognitively impaired. Resident #3 was coded for the presence of a feeding tube in which they received 51% or more of total calories and 501 cc/day or more of average fluid intake.

Resident #3's current physician's orders included an order dated 2/09/21 for Osmolite 1.5 per GT (g-tube) via pump at a rate of 60 ml per hour for 24 hours per day to provide 1980 calories per 24 hours. The resident also had a current order

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F 692	Continued From page 35 dated 2/16/22 for 100 ml of water every 4 hours. Resident #3's diet order stated nothing by mouth. On 7/18/22 at 8:26 am, surveyor observed Resident #3 in bed with the tube feeding pump turned off. Surveyor spoke with licensed practical nurse (LPN) #2 who stated the previous shift reported the tube feeding was turned off around 5:30 am because the resident was sick. Surveyor reviewed Resident #3's clinical record and was unable to locate any documentation related to the resident being ill or the tube feeding being turned off. Surveyor observed Resident #3 again at 9:38 am, 10:56 am and 1:26 pm and the tube feeding pump remained off. At 1:26 pm, surveyor again spoke with LPN #2 regarding the tube feeding pump being off and LPN #2 stated the resident's stomach was "full" this morning but the resident had not vomited. LPN #2 stated the resident's tube feeding had been turned off since their shift started that morning and it will be restarted when the resident was laid back down in bed. Surveyor observed a visitor pushing Resident #3 throughout the facility in their wheelchair. Surveyor observed Resident #3 sitting in a wheelchair beside their bed at 3:37 pm and laying in the bed at 5:15 pm and the tube feeding pump was off with each observation. On 7/18/22 at 5:16 pm, the survey team met with the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager, and the Regional Director of Clinical Services and discussed the concern of Resident #3 not receiving tube feeding as ordered.	F 692		

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F 692	Continued From page 36 On 7/19/22, surveyor reviewed Resident #3's clinical record a nursing progress note dated 7/18/22 at 8:04 pm stated "resident did not receive tube feeding throughout the shift. Nursing staff stated to survivor [sp] resident had abdominal distension. During assessment no abdominal distention noted bowel sounds present. No vomiting noted throughout day shift of 7/18 md notified gave orders for a BMP (basic metabolic panel) and monitor throughout the shift". On 7/19/22 at 1:01 pm, surveyor spoke with the DON and asked if there was a reason why Resident #3's tube feeding was turned off on 7/18/22 and the DON stated "not to my knowledge". Surveyor requested and received the facility policy entitled "Enteral Nutrition" which read in part "Adequate nutritional support through enteral feeding will be provided to residents as ordered". No further information regarding this concern was presented to the survey team prior to the exit conference on 7/19/22. 2. For Resident #164, facility staff failed to address a documented significant weight loss. Resident #164 was admitted to the facility with diagnoses including dysphagia, gastroesophageal reflux disorder, diabetes mellitus, chronic respiratory failure with mechanical ventilator dependence, essential hypertension, urinary tract infection, pancreatitis, and depression. On the minimum data set assessment with assessment reference date 7/5/22, the resident scored 14/15 on the brief interview for mental status and was	F 692		

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F 692	Continued From page 37 assessed as without signs of delirium, psychosis, or behaviors affecting care. The surveyor spoke with the resident on 7/17/2022. The resident expressed no concerns with care. Clinical record revealed a registered dietician (RD) admission progress note dated 6/17/2022, where the dietician wrote: Calculated residents needs for weight maintenance / some weight loss using ABW (65 kg): 1614-1936 kcals/day (25-30 kcals/kg); 65-77g/pro/day (1-1.2 g/kg); 2461 mL/fluid/day (obesity); current PO intake of meals not adequate for meeting nutritional needs; Recommend: 1. If PO <50% of meals, offer alternate option; 2. Offer snacks TID between meals d/t poor PO noted / resident refusing meals; 3. Weekly weights x1 mo d/t new admit; RD to monitor & f/u PRN. A RD readmission note dated 7/11/2022 documented "Weight of 7/11 likely inaccurate/misrecorded due to severe change x 1month. PO intake concerningly low but may be due to pain associated with acute pancreatitis episode. Recommendation: 1) Reweigh patient. Wt: (7/11) 108.8# (6/15) 185.3# 2)Continue to monitor po intake." The clinical record recorded weights. On 06/15/2022, the resident weighed 185.3 lbs. On 07/08/2022, the resident weighed 108.8 pounds which is a -41.28 % Loss. No subsequent weights were recorded. The concern was reported to the director of nursing (DON), assistant director of nursing (ADON), and unit manager at end of day meeting on 7/18/22. The DON discussed the issue with obtaining resident weights with surveyors on 7/18	F 692		

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F 692	Continued From page 38 and 7/19. If the resident was weighed prior to the end of the survey, the surveyor was not made aware.	F 692		
F 695 SS=D	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 interview and facility document review the facility staff failed to maintain respiratory equipment for 1 of 19 residents, Resident #47. For Resident #47 the facility staff failed to store the resident's respiratory equipment to prevent contamination. The findings included: Resident #47's face sheet listed diagnoses which included but not limited to myocardial infarction (heart attack), chronic obstructive pulmonary disease, and congestive heart failure. Resident #47's most recent quarterly minimum data set with an assessment reference date of 06/17/22 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the	F 695	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) 1. Resident #47 routine respiratory treatment was discontinued by MD. 2. Full audit of all residents on nebulizer treatments to assure respiratory equipment is properly stored to prevent contamination. 3. All licensed nursing staff reeducated regarding storage of respiratory equipment by Director of Nursing/ or designee. 4. Director of Nursing/ or designee will audit twice weekly for six weeks then monthly x 2 months to assure resident's respiratory equipment is properly stored to prevent contamination. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan. 5. Allegation of compliance set for 08/07/2022	08/07/2022

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F 695	Continued From page 39 resident is cognitively intact. Resident #47's clinical record was reviewed and contained a physician's order summary for the month of July 2022, which read in part "Pulmicort suspension 0.5 mg/2 ml 0,5mg inhale orally two times a day for respiratory therapy **rinse mouth after each use to avoid oral thrush**". This order had a start date of 01/11/22. On 07/17/22 at 1:26 pm, surveyor observed a nebulizer machine with mask attached on a side table in Resident #47's room. The mask was not covered/bagged. Surveyor observed the uncovered mask again on 07/18/22 at 8:20 am and 10:20 am. Surveyor spoke with Resident #47 on 07/18/22 at 3:00pm. Surveyor observed the nebulizer machine/mask on a table in resident's room. The nebulizer mask was not bagged/covered. Surveyor asked Resident #47 if the nebulizer mask was ever placed in a bag or covered and resident stated that they did not know the mask should be covered, but they rarely used it anyway. Surveyor asked resident if the mask had ever been covered and resident stated that it had not. Surveyor requested and was provided with a facility policy entitled, "Administering Medications through a Small Volume (Handheld) Nebulizer" which read in part "Purpose-The purpose of this procedure is to safely and aseptically administer particles of medication into the resident's airway. 29. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it." The concern of not storing the resident's	F 695		

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F 695	Continued From page 40 nebulizer mask to prevent contamination was discussed with the administrative staff (administrator, director of nursing, clinical nurse educator, medical records, regional director of clinical services) on 07/19/22 at 4:20 pm. Regional Director of Clinical Services stated that the resident's nebulizer mask should have been bagged/covered. No further information was provided prior to exit.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) 1. Resident #25, #32, #3 medication availability for administration has been assured. 2. Full audit of all resident's medication availability for administration completed. 3. All licensed nursing staff reeducated regarding ordered of medications to assure medication availability for administration by Director of Nursing/ or designee. 4. Director of Nursing/ or designee will audit medications to assure medication availability for administration twice weekly for six weeks then monthly x 2 months to assure resident's medications are available for administration. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan. 5. Allegation of compliance set for 08/07/2022	08/07/2022

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F 755	Continued From page 41 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, clinical record reviews, facility document reviews, and during a medication pass and pour the facility staff failed to ensure medications were available for 3 of 19 residents. (Resident #25, Resident #32, and Resident #3) For Resident #25, facility staff failed to ensure Azelastine HCl Solution 0.05% eye drops (used to treat allergic eye inflammation) were available for administration. For Resident #32 the facility staff failed to ensure the medications Fentanyl and pantoprazole were available for administration. For Resident #3, the facility staff failed to ensure Clonazepam, a benzodiazepine used to control certain types of seizures and relieve panic attacks, was available for administration on seven (7) separate occasions. The findings were: 1. Resident #25's admission record contained a list of diagnoses which included but not limited to, Guillain-Barre Syndrome (immune system attacks the nerves), narcolepsy (chronic sleep disorder), asthma, encephalopathy (altered brain function), and anxiety disorder. The resident's annual minimum data set with an assessment reference	F 755		

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F 755	Continued From page 42	F 755		

date of 05/20/2022 coded the resident's brief interview for mental status at a 15 out of 15 in Section C (cognitive patterns).

During a medication administration observation of LPN #5 (licensed practical nurse) on 07/18/2022 at 8:23 a.m., Resident #25's Azelastine HCl Solution 0.05% eye drops were not available for administration. Resident #25 reported knowing the eye drops ran out after the dose the night before. LPN#5 identified the eye drops had been ordered on both 06/30/2022 and again on 07/11/2022 however, the eye drops were not present. LPN#5 stated she would keep checking throughout her shift to see if the medication was delivered.

Resident #25's order summary report listed the order for Azelastine HCl Solution 0.05% instill 1 drop in both eyes two times a day for allergies. The order started on 05/09/2022 with no end date. The medication administration record (MAR) indicated both doses of the medication had been administered the day before.

At approximately 2:30 p.m. on 07/18/2022, LPN#5 had not received the eye drops. The director of nursing (DON) provided their pharmacy's (located out of town) phone number. At 2:50 p.m., the pharmacy was contacted and reported that as of 06/22/2022, there had been an "insured preferred medication change" to an over-the-counter medication (Ketotifen) and therefore the medication would not be sent out from that pharmacy. The pharmacy employee reported that medication change had been signed by the nurse practitioner.

The DON, assistant DON, unit manager and

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F 755	Continued From page 43 regional director of clinical services were informed of the concern regarding Resident #25's eye drops during an end of day meeting on 07/18/2022 at 5:24 p.m. The order for Azelastine HCl eye drops was discontinued on 07/18/2022 at 6:21 p.m. No further information was provided prior to the exit conference. 2. Resident #32's face sheet listed diagnoses which included but not limited to morbid obesity, respiratory failure, depression, bipolar disorder, and hypothyroidism. The most recent minimum data set with an assessment reference date of 06/02/22 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #32's comprehensive care plan was reviewed and contained care plans which read in part, " ... has GERD (gastroesophageal reflux disease)" and " ... is on pain medication therapy r/t (related to) S/P (status post) surgical ID (incision and drainage) rt (right) thigh abscess and stage e PU (pressure ulcer)". Interventions for these care plans include "give medication as ordered" and "administer analgesic medications as ordered by physician". Resident #32's clinical record was reviewed and contained a physician's order summary for the month of July 2022, which read in part "fentaNYL Patch 72 Hour 12 MCG/HR-Apply 1 patch	F 755		

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F 755	Continued From page 44	F 755		

transdermally one time a day every 3 day (s) for pain and remove per schedule" and "Pantoprazole Sodium Tablet Delayed Release 40 mg Give 1 tablet by mouth one time a day for abscess and cellulitis of gluteal region and Give 1 time only related to Gastroesophageal reflux disease without esophagitis". Resident #32's medication administration record for the months of June and July of 2022 were reviewed and contained entries as above. The entry for Fentanyl was coded with "9" on 06/29/22 and 07/02/22. The entry for Pantoprazole was coded "9" 06/22/22. Chart code "9" is the equivalent of "Other/See Nurse Notes".

Resident #32's nurse's progress notes were reviewed and contained notes which read in part, "6/21/2022 05:55:00 Pantoprazole Sodium Tablet Delayed Release 40 mg. Give 1 tablet by mouth one time a day for abscess and cellulitis of gluteal region. Meds unavailable", "6/29/2022 15:39 fentaNYL Patch 72 Hour 12 MCG/HR-Apply 1 patch transdermally one time a day every 3 day (s) for pain and remove per schedule on order from pharm, Md aware, new rx (prescription) needed" and "7/2/2022 13:15 fentaNYL Patch 72 Hour 12 MCG/HR-Apply 1 patch transdermally one time a day every 3 day (s) for pain and remove per schedule awaiting ne (sic) rx, MD aware"

Surveyor spoke with Resident #32 on 07/18/22 at 10:30 am. Surveyor asked Resident #32 if there was a time when their Fentanyl patch had not been available, and Resident #32 stated not that they were aware of. Surveyor asked Resident #32 about their pain, and Resident #32 stated their pain was controlled and that they received as needed pain medication in addition to the

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F 755	Continued From page 45 Fentanyl patch. Surveyor spoke with the clinical nurse educator (CNE) on 07/19/22 at 11:00 am regarding medications not being available for Resident #32. CNE stated if medications are not available in the medication cart, the nurse should check to see if the medication is available in the facility Cubex (supply of commonly used medications). If the medication is not available in the Cubex, then the nurse should call the physician to either get an order to hold the medication or obtain an alternative. Surveyor requested and was provided with a facility policy entitled "Unavailable Medications" which read in part, "4. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: a. Determine the reason for the unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. b. Notify physician of inability to obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold." The concern of the resident's medications not being available for administration was discussed with the administrative staff (administrator, director of nursing, clinical nurse educator, medical records, regional director of clinical services) on 07/19/22 at 4:20 pm No further information was provided prior to exit. .	F 755		

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F 755	Continued From page 46 3. Resident #3's diagnosis list indicated diagnoses, which included, but not limited to Demyelinating Disease of Central Nervous System, Epilepsy, Dysphagia, Bipolar Disorder, Generalized Anxiety Disorder, Essential Hypertension, and Pseudobulbar Affect. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 4/20/22 assigned the resident a brief interview for mental (BIMS) summary score of 0 out of 15 indicating the resident was severely cognitively impaired. Resident #3's current physician's orders included an order dated 5/19/21 for Clonazepam 1 mg via PEG-tube two times a day for generalized anxiety disorder. A review of the resident's June 2022 medication administration record (MAR) revealed Clonazepam 1 mg was not administered as ordered on 6/16/22, 6/18/22, 6/19/22, 6/20/22, and 6/21/22. According to the resident's progress notes, the medication was not administered for the following documented reasons: 6/16/22 9:00 pm - "awaiting arrival from pharmacy" 6/18/22 9:00 pm - "medication is on order, hold x 1 dose, MD aware" 6/19/22 9:00 am - "awaiting arrival from pharmacy" 6/19/22 9:00 pm - "hold x 1 dose, new script to be signed and faxed to pharmacy, MD aware" 6/20/22 9:00 pm - MAR blank and no corresponding documentation in progress notes 6/21/22 9:00 am - "new order per NP (nurse practitioner) (name omitted) to hold 0900 1 mg Clonazepam and administer 0.5 mg Clonazepam" 6/21/22 9:00 pm - "awaiting pharmacy to deliver".	F 755		

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F 755	Continued From page 47 On 7/18/22 at 2:55 pm, surveyor spoke with an employee with the facility's pharmacy provider regarding Resident #3's Clonazepam supply from 6/16/22 through 6/21/22. The pharmacy employee stated a 29 day supply of 58 tablets was delivered to the facility on 4/20/22 and facility should have ran out of the Clonazepam sooner than 6/16/22. Pharmacy employee stated the facility requested a refill on 6/09/22 but the order could not be filled due to the resident needing a new script from the physician. The new script was received by the pharmacy on 6/21/22 and the order was filled and sent out to the facility. Resident #3's current comprehensive care plan included a focus stating "(Resident #3) requires anti-anxiety medications r/t (related to) anxiety disorder: screaming, hollering, excessive body movements" with an intervention stating "Give anti-anxiety medications ordered by physician ..." On 7/18/22 at 5:16 pm, the survey team met with the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager, and the Regional Director of Clinical Services and discussed the concern of Resident #3 not receiving Clonazepam as ordered between 6/16/22 through 6/21/22. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/19/22.	F 755		
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	F 756	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) 1. Resident #59 has no pharmacy recommendations currently. MD updated on pharmacy recommendation from Jan.2022	08/07/2022

			and no new orders were received. 2. Full audit of all July pharmacy recommendations to assure completion and scanned into the residents' medical records. 3. All licensed nursing staff reeducated regarding addressing medication review recommendations by Director of Nursing/ or designee. Medical records coordinator educated regarding scanning all medication review recommendation into the residents' electronic medical record. 4. Director of Nursing/ or designee will audit monthly x 3 months pharmacy recommendations to assure completion and scanned into the residents' medical record. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan. 5. Allegation of compliance set for 08/07/2022	

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F 756	Continued From page 48 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	F 756		

irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the 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 interviews, facility document review, and clinical record review, it was determined the

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CHOICE HEALTHCARE AT ROANOKE	324 KING GEORGE AVE SW ROANOKE, VA 24016

(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 49 facility staff failed to ensure: (a) medical regimen reviews (MRRs) were completed and/or (b) medical regimen review (MRR) recommendations were addressed by a medical provider for three (3) of 19 sampled current residents, Resident #1, Resident #31, and Resident #59.	F 756		

The findings include:

1. The facility staff failed to ensure a medical provider addressed a MRR pharmacist recommendation for Resident #59.

Resident #59's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 7/5/22, was signed as completed on 7/7/22. Resident #59 was assessed as able to make self understood and as able to understand others. Resident #59's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact or borderline cognition. Resident #59 was assessed as requiring assistance with bed mobility, transfers, dressing, and personal hygiene. Resident #59's diagnoses included, but were not limited to: anemia, high blood pressure, diabetes, anxiety, depression, and dementia.

The following information was found in a facility policy titled "Addressing Medication Regimen Review Irregularities" (with a reviewed/revised date of 10/28/22):
- "It is the policy of this facility to provide a Medication Regimen Review (MRR) for each resident in order to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event."
- "The medication regimen of each resident must

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F 756	Continued From page 50	F 756		

be reviewed by a licensed pharmacist at least once a month (or more frequently, as indicated by the resident's condition)."
- "The pharmacist must report any irregularities to the attending physician, the facility's medical director and director of nursing, and the reports must be acted upon."

- "Any irregularities noted by the pharmacist during this review must be documented on a separate, written report which may be in paper or electronic form."
- "The report will be sent to the attending physician, the facility's medical director and director of nursing and lists, at minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified."
- "The attending physician must document in the resident' [sic] 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."
- "If no irregularities were identified during the review, the pharmacist includes a signed and dated statement to that effect."

Resident #59's clinical record included notes indicating medication regime reviews were completed on the following dates: 1/27/22; 2/26/22; 3/29/22; 4/29/22; 5/25/22; and 6/29/22. The documentation did not indicate whether or not concerns or issues were identified as part of the aforementioned medication regime reviews.

On 7/19/22 at 8:20 a.m., a medical record employee (Staff Member (SM) #3) was interviewed about Resident #59's medication regime reviews. SM #3 reported the facility does

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not get a hard copy of the MRRs from the pharmacy. SM #3 reported the MRRs are accessed through the pharmacy website.

On 7/19/22 at 08:32 a.m., SM #3 and the facility's Director of Nursing (DON) were unable to find the MRRs on the pharmacy's website.

On 7/19/22 at 11:05 a.m., the facility's Clinical Nurse Educator (CNE) reported the outcomes of Resident #59 MRRs were not in the resident's clinical record. The CNE provided the survey team a copy of an email which indicated Resident #59's January 2022 MRR had a recommendation written for the medical provider; this email also indicated Resident #59's MRRs for February 2022, March 2022, April 2022, Mary 2022, and June 2022 had no medical provider recommendations.

Resident #59's MRR information for the 1/27/22 pharmacist review identified the following concern documented on a "Consultant Pharmacist Recommendation to Physician" form: "Resident currently has order for: - Metoprolol tartrate 50mg: 1t po QD (one (1) tablet by mouth every day) ... Metoprolol is available in two different formulations, tartrate and succinate. Metoprolol tartrate is typically dosed every 12 hours. Metoprolol succinate is typically dosed every 24 hours. Can you please clarify which formulation this resident should be taking? Thank you!" This form included a section for a medical provider to: (a) respond to the pharmacist recommendation, (b) sign the form, and (c) date the form. This form did not include: (a) a medical provider response, (b) medical provider signature, and/or (c) a date documented by the medical provider.

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F 756	Continued From page 52 On 7/19/22 at 11:28, the facility's CNE reported a medical provider had not addressed the 1/27/22 pharmacist recommendation. The CNE reported the results of Resident #59's MRRs for January 2022, February 2022, March 2022, April 2022, May 2022, and June 2022 were not contained in Resident #59's clinical record.	F 756		

The failure of the facility staff to ensure a medical provider addressed Resident #59's 1/27/22 MRR pharmacist recommendation was discussed with the facility's Regional Director of Operations, Clinical Nurse Educator, Director of Nursing, Regional Director of Clinical Services, and a Medical Records employee on 7/19/22 at 4:21 p.m.

2. For Resident #1, facility staff failed ensure that medical record reviews (MRR) were conducted and that facility staff acted upon recommendations.

Resident #1 was admitted to the facility with diagnoses including respiratory failure, anemia, deep vein thrombosis, heart failure, hypertension, diabetes mellitus, arthritis, and depression. On the minimum data set assessment with assessment reference date 4/13/22, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behavior affecting care.

While conducting the medication regimen review on 7/19/22, the surveyor found notes each calendar month from August 2021 through June 2022, except December 2021: "Pharmacy Review Note: MRR completed." No pharmacy review recommendations later than June 2021

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were found in the clinical record.

Surveyors asked the corporate regional clinical services consultant (regional consultant) on site whether there had been any recommendations from the reviews, how they were conveyed to the physician, and the process for physician response to those recommendations. Regional

consultant reported on 7/19/22 at 9:51 AM trying to locate the MRR content on the pharmacy data base. No reviews were provided to surveyors prior to exit.

The medication regimen review (MRR) policy was requested. The policy states that the pharmacist will provide a written report of any irregularities to the physician, medical director, and director of nursing. If no irregularities are discovered, the pharmacist is to provide a separate signed written statement to that effect.

Neither reports of irregularities nor statements that no irregularities were noted were provided to surveyors prior to exit.

The surveyor reported the concern during a summary meeting on 7/19/2022 to the current acting administrator (as of 7/18/22), the prior acting administrator, the director of nursing, assistant director of nursing, and medical records coordinator.

3. For Resident #31, facility staff failed ensure that medical record reviews (MRR) were conducted and that facility staff acted upon recommendations.

Resident #31 was admitted to the facility with diagnoses including acute and chronic respiratory

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failure with tracheostomy and ventilator dependence, gastrostomy with colostomy, deep vein thrombosis, and hypertension. On the minimum data set assessment with assessment reference date 5/30/22, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The resident received

antipsychotic medication, antianxiety medication, antidepressant medication, and anticoagulant medication 7 of the 7 days prior to the assessment.

While conducting the medication regimen review on 7/19/22, the surveyor found notes dated 5/25/2022 and 6/29/2022: "Pharmacy Review Note: MRR completed."

Surveyors asked the corporate regional clinical services consultant (regional consultant) on site whether there had been any recommendations from the reviews, how they were conveyed to the physician, and the process for physician response to those recommendations. Regional consultant reported on 7/19/22 at 9:51 AM trying to locate the MRR content on the pharmacy data base. No reviews were provided to surveyors prior to exit.

The medication regimen review (MRR) policy was requested. The policy states that the pharmacist will provide a written report of any irregularities to the physician, medical director, and director of nursing. If no irregularities are discovered, the pharmacist is to provide a separate signed written statement to that effect.

Neither reports of irregularities nor statements that no irregularities were noted were provided to

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F 756	Continued From page 55 surveyors prior to exit. The surveyor reported the concern during a summary meeting on 7/19/2022 to the current acting administrator (as of 7/18/22), the prior acting administrator, the director of nursing, assistant director of nursing, and medical records coordinator.	F 756		

F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) 1. Director of Nursing assured that all medications carts remain locked when not in use and no medications are noted on top the medication cart unsecured. Director of Nursing assured that double lock placed on medication room refrigerator. 2. Full audit of all medication carts and medication room refrigerator lock. 3. All licensed nursing staff reeducated on locking medication carts, assuring that medication is inside the cart is lock and that double lock is in place to medication room refrigerator by Director of Nursing/ or designee. 4. Director of Nursing/ or designee will audit medication carts and medication room refrigerator lock twice a week x 6 weeks then monthly x 2 months to assure that medication are secured properly. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan. 5. Allegation of compliance set for 08/07/2022	08/07/2022

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F 761	Continued From page 56 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to safely store medications on 1 of 3 units (unit 1) and failed to secure a narcotic in 1 of 1-medication rooms. 1. The facility nursing staff failed to lock their medication cart when out of view and failed to secure a bottle of 325 mg Tylenol. 2. The facility staff failed to store liquid oxycodone, a Schedule II drug, in a separate and locked compartment within one (1) of one (1) medication storage units. The findings included: 1. 07/18/22 1:18 p.m., the surveyor observed an unattended medication cart positioned between two rooms on unit 1. The surveyor observed this medication cart to be unlocked. The surveyor also observed an open bottle of 1000 tablet-325 mg Tylenol on top of this cart. The surveyor observed residents in the hallway, a unit manager walked by this cart and spoke with the surveyor, and other various staff were observed in the hallway. Licensed Practical Nurse (LPN) #2 stated they were in the middle of a medication pass and they were in a resident's room, across the hall, standing at the sink.	F 761		

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F 761	Continued From page 57 07/18/22, the facility staff provided the survey team with a policy titled, Administering Medications. This policy read in part, during administrations of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or other passing by. 07/18/22 5:15 p.m., during an end of the day meeting with the Director of Nursing (DON), Assistant Director of Nursing (ADON), unit manager, and Regional Director of Clinical Services the issue with the unlocked medication cart and unsecured medications was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. A surveyor, escorted by the director of nursing (DON), made observations in the facility's one (1) medication storage room on 07/19/2022 at 9:38 a.m. The medication storage room's door was locked. One of the mini-refrigerators inside the	F 761		

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F 761	Continued From page 58 room contained multiple residents' medications in the form of pills, intravenous antibiotics and liquid medications. Two (2) bottles of liquid oxycodone (a Schedule II narcotic) was present. The DON removed the two bottles and reported one bottle contained approximately 195cc and the second bottle contained approximately 240cc of liquid oxycodone. The mini-refrigerator had a lock applied to the door however that lock was unlocked. The DON acknowledged the liquid oxycodone was found amongst multiple medications within the unlocked mini-refrigerator. On 07/19/2022 at 4:22 p.m., the administrator, nurse educator, regional director of clinical services, DON, and medical records director were informed of the above observations. No further information was provided prior to the exit conference.	F 761		
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-	F 842	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) 1. Resident #59 has no pharmacy recommendations currently. MD updated on pharmacy recommendation from Jan.2022 and no new orders were received. Missed medication audit report reviewed for resident #32 and #42 to assure documentation of medication administration. 2. Full audit of all July pharmacy recommendations to assure completion and scanned into the residents' medical records. 3. All licensed nursing staff reeducated regarding medication administration and medical documentation policies by Director of Nursing/ or designee. 4. Director of Nursing/ or designee	08/07/2022

			will audit monthly x 3 months pharmacy recommendations to assure completion and scanned into the residents' medical records. Director of Nursing/ or designee will audit twice weekly for six weeks then monthly x 2 months resident's medications to ensure proper administration and documentation of resident medications. Audits and audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan. 5. Allegation of compliance set for 08/07/2022	

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F 842	Continued From page 59 (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,	F 842		

	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;			

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F 842	Continued From page 60 (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 interviews, facility document review, and clinical record review, the facility staff failed to maintain complete and/or accurate clinical records for three (3) of 19 sampled current residents, Resident #32, Resident, #42, and Resident #59. For Resident #59, the facility staff failed to	F 842		

document the results of monthly medication regime reviews (MRRs) completed by a pharmacist.

For Resident #32, the facility staff failed to document that medications were administered as ordered.

For Resident #42, the facility staff failed to document that medications were administered as ordered.

The findings include:

1. Resident #59's clinical record failed to include the results of monthly medication regime reviews (MRRs) completed by a pharmacist.

Resident #59's minimum data set (MDS)

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assessment, with an assessment reference date (ARD) of 7/5/22, was signed as completed on 7/7/22. Resident #59 was assessed as able to make self understood and as able to understand others. Resident #59's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact or borderline cognition. Resident #59 was assessed as requiring assistance with bed mobility, transfers, dressing, and personal hygiene. Resident #59's diagnoses included, but were not limited to: anemia, high blood pressure, diabetes, anxiety, depression, and dementia.

The following information was found in a facility policy titled "Addressing Medication Regimen Review Irregularities" (with a reviewed/revised date of 10/28/22):
- "Any irregularities noted by the pharmacist during this review must be documented on a

separate, written report which may be in paper or electronic form."
- "The report will be sent to the attending physician, the facility's medical director and director of nursing and lists, at minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified."
- "The attending physician must document in the resident' [sic] 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."
- "If no irregularities were identified during the review, the pharmacist includes a signed and dated statement to that effect."

Resident #59's clinical record included notes

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indicating medication regime reviews were completed on the following dates: 1/27/22; 2/26/22; 3/29/22; 4/29/22; 5/25/22; and 6/29/22. The documentation did not indicate whether or not concerns or issues were identified as part of the aforementioned medication regime reviews.

On 7/19/22 at 8:20 a.m., a medical record employee (Staff Member (SM) #3) was interviewed about Resident #59's medication regime reviews. SM #3 reported the facility does not get a hard copy of the MRRs from the pharmacy. SM #3 reported the MRRs are accessed through the pharmacy website.

On 7/19/22 at 08:32 a.m., SM #3 and the facility's Director of Nursing (DON) were unable to find the MRRs on the pharmacy's website.

On 7/19/22 at 11:05 a.m., the facility's Clinical

Nurse Educator (CNE) reported the outcomes of Resident #59 MRRs were not in the resident's clinical record. The CNE provided the survey team a copy of an email which indicated Resident #59's January 2022 MRR had a recommendation written for the medical provider; this email also indicated Resident #59's MRRs for February 2022, March 2022, April 2022, Mary 2022, and June 2022 had no medical provider recommendations.

Resident #59's MRR information for the 1/27/22 pharmacist review identified the following concern documented on a "Consultant Pharmacist Recommendation to Physician" form: "Resident currently has order for: - Metoprolol tartrate 50mg: 1t po QD (one (1) tablet by mouth every day) ... Metoprolol is available in two different formulations, tartrate and succinate. Metoprolol

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tartrate is typically dosed every 12 hours. Metoprolol succinate is typically dosed every 24 hours. Can you please clarify which formulation this resident should be taking? Thank you!" This form included a section for a medical provider to: (a) respond to the pharmacist recommendation, (b) sign the form, and (c) date the form. This form did not include: (a) a medical provider response, (b) medical provider signature, and/or (c) a date documented by the medical provider.

On 7/19/22 at 11:28, the facility's CNE reported the results of Resident #59's MRRs for January 2022, February 2022, March 2022, April 2022, May 2022, and June 2022 were not contained in Resident #59's clinical record.

The following information was found in a facility policy titled "Documentation in Medical Record" (with a reviewed/revised date of 10/28/22):

	- "Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation." - "Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy." - "Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred." The failure of the facility staff to ensure Resident #59's MRR results were documented as part the resident's clinical record was discussed with the			

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F 842	Continued From page 64 facility's Regional Director of Operations, Clinical Nurse Educator, Director of Nursing, Regional Director of Clinical Services, and a Medical Records employee on 7/19/22 at 4:21 p.m. 2. Resident #32's face sheet listed diagnoses which included but not limited to morbid obesity, respiratory failure, depression, bipolar disorder, and hypothyroidism. The most recent minimum data set with an assessment reference date of 06/02/22 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.	F 842		

Resident #32's physician's order summary for the month of June 2022 was reviewed and contained orders which read in part "ARIPiprazole Tablet 5 mg. Give 1 tablet by mouth one time a day for Bipolar for 30 days", "fentaNYL Patch 72 Hour 12 MCG/HR. Apply 1 patch transdermally one time a day every 3 day(s) for pain and remove per schedule", "FLUoxetine HCl Capsule 20 mg. Give 1 capsule by mouth one time a day foe abscess and cellulitis of gluteal region", "Levothyroxine Sodium Tablet 125 MCG. Give 1 tablet by mouth one time a day for hypothyroidism", "Multiple Vitamins-Minerals Tablet. Give 1 tablet by mouth one time a day for Supplement", "Pantoprazole Sodium Tablet Delayed Release 40 mg. Give 1 Tablet by mouth one time a day for abscess and cellulitis of gluteal region", "Rivaroxaban Tablet 10 mg. Give 1 tablet by mouth one time a day for sacral decubitus ulcer stage IV", "Sennosides

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F 842	Continued From page 65 Tablet 8.6 mg. Give 1 Tablet by mouth at bedtime for sacral decubitus ulcer stage IV", Magnesium Oxide Tablet 400 (240 Mg) MG. Give 1 tablet by mouth two times a day for supplement", "Nystatin Powder 100000 UNIT/GM. Apply to under breast and groin topically every shift for redness/moisture", "Pro-Stat Profile two times a day", "Acetaminophen Tablet 325 MG. Give 3 tablet by mouth three times a day for pain", and "Gabapentin Capsule 300 MG. Give 3 capsules by mouth three times a day for neuropathy" Resident #32's electronic medication administration record (eMAR) for the month of June 2022 was reviewed and contained entries as above. None of these entries had been initialed as being administered on 06/01/22 or 06/02/22. The entries for sennosides, acetaminophen, and gabapentin were not initialed as being administered on 06/07/22 at 9 pm. The	F 842		

entries for magnesium oxide and Pro-Stat were not initialed as being administered on 06/21/22 at 9 pm.

Resident #32's nurses' progress notes were reviewed and surveyor could not find any corresponding notes to the blanks on the eMAR.

Surveyor spoke with the clinical nurse educator (CNE) on 07/19/22 at 11:00 am. Surveyor pointed out the blank areas on Resident #32's eMAR and CNE stated there should not be blanks on the eMAR. CNE also stated if the eMAR was blank, there was no way to know if the resident received their medications.

The surveyor requested and was provided with a facility policy entitled "Charting and Documenting" which read in part "2. The following information is

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to be documented in the resident medical record: b. Medications administered; c. Treatments or services performed;"

The concern of the resident's eMAR not being initialed was discussed with the administrative staff (administrator, director of nursing, clinical nurse educator, medical records, regional director of clinical services) on 07/19/22 at 4:20 pm.

No further information was provided prior to exit.

3. Resident #42's face sheet listed diagnoses which included but not limited to traumatic subdural hemorrhage with loss of consciousness, dysphagia, depression, convulsions, and cognitive communication deficit.

Resident #42's most recent quarterly minimum

data set (MDS) with an assessment reference date (ARD) of 06/12/22 failed to assign the resident a brief interview for mental status (BIMS) score in section C, cognitive patterns. The quarterly MDS with an ARD of 03/12/22 assigned the resident a BIMS score of 4 out of 15 in section C. This indicates that the resident is severely cognitively impaired.

Resident #42's clinical record was reviewed and contained a physician's order summary for the month of June 2022, which read in part "Miralax Powder (polyethylene Glycol 3350). Give 1 scoop via PEG (percutaneous endoscopic gastrostomy)-Tube one time a day for constipation", "traZODone HCl Tablet 100 MG. Give 1 tablet via PEG-Tube at bedtime for major depressive disorder", "Amantadine HCl Solution 50 MG/ML. Give 10 ml via PEG-Tube two times

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a day for paralysis", "Keppra Tablet 500 MG (LevETIRAcetam). Give 1 tablet by mouth two times a day for seizure activity", "Senna-Plus Tablet 8.6-50 MG (Sennosides-Docusate Sodium). Give 1 tablet via PEG-Tube two times a day for stool softener", "Dantrolene Sodium Capsule 25 mg. Give 1 capsule via PEG-Tube three times a day for muscle relaxant", "Gabapentin Capsule 300 MG. Give 2 capsules via PEG-Tube three times a day for seizures" and "Sodium Chloride Tablet 1 GM. Give 4 tablet via PEG-Tube three times a day for sodium loss".

Resident #42's electronic medication administration record for the month of June 2022 was reviewed and contained entries as above. The entry for Miralax was not initialed on 06/08/22 or 06/28/22 at 6 am. The entries for Trazodone, amantadine, Keppra, Senna-Plus, and dantrolene were not initialed on 06/07/22 at 9 pm. The

entries for gabapentin and sodium chloride were not initialed on 06/07/22 at 9 pm, 06/08/22, 06/28/22 or 06/30/22 at 6 am.

Resident #42's nurses' progress notes were reviewed and surveyor could not find any corresponding notes to the blanks on the eMAR.

Surveyor spoke with the clinical nurse educator (CNE) on 07/19/22 at 11:00 am. Surveyor pointed out the blank areas on Resident #32's eMAR and CNE stated there should not be blanks on the eMAR. CNE also stated if the eMAR was blank, there was no way to know if the resident received their medications.

The surveyor requested and was provided with a facility policy entitled "Charting and Documenting" which read in part "2. The following information is

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to be documented in the resident medical record: b. Medications administered; c. Treatments or services performed;"

The concern of the resident's eMAR not being initialed was discussed with the administrative staff (administrator, director of nursing, clinical nurse educator, medical records, regional director of clinical services) on 07/19/22 at 4:20 pm.

No further information was provided prior to exit.
