| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 6/7/2022 through 6/9/2022. Corrections are required for compliance with 42 CFR 483.73, Requirement for Long Term Care facilities. | E 000 | This plan of correction is respectfully submitted as an allegation of compliance. | |
| E 013 SS=C | Development of EP Policies and Procedures<br>CFR(s): 483.73(b)<br><br>§403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).<br><br>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.<br><br>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.<br><br>*Additional Requirements for PACE and ESRD Facilities:<br><br>*[For PACE at §460.84(b):] Policies and | E 013 | E013- Development of EP Policies and Procedures<br><br>1.The facility reviewed and updated the Emergency Preparedness Policy and Procedure Manual.<br>2.Quality review conducted by the ED (executive director)/designee of the emergency preparedness policies and procedures to ensure all are reviewed and updated at least annually and as needed.<br>3.ED/DCS (Director of Clinical services) re-educated by the RDCS (Regional Director of Clinical Services)/designee related to the development of EP policies and procedures; the LTC facility must develop and implement emergency preparedness policies and procedures based on the emergency plan and the policies and procedures must be reviewed and updated at least annually. | 7/19/22 |

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

Executive Director | 8-24-22

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

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| E 013 | Continued From page 1<br>procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.<br><br>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to review and update the Emergency Preparedness Policy and Procedure on an annual basis. The census in the facility was 122 residents. | E 013 | 4.The RDCS/Market Leader/designee to conduct quality monitoring of the facilities emergency preparedness policies and procedures to ensure policies and procedures are reviewed and updated, monthly x 3 months. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/ designee. | |

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| E 013 | Continued From page 2<br>The findings were:<br><br>At approximately 8:15 a.m. on 6/9/2022, the facility's Emergency Preparedness Plan was reviewed with the Administrator and the Director of Maintenance. Asked to provide documentation the Emergency Preparedness Policy and Procedure was reviewed and updated on an annual basis, neither the Administrator nor the Maintenance Director was able to do so. | E 013 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 6/7/2022 through 6/9/2022. Eight complaints were investigated during the survey. VA00050505 was unsubstantiated with no deficient practice. VA00050782 was unsubstantiated with no deficient practice. VA00051859 was unsubstantiated with no deficient practice. VA00051915 was unsubstantiated with no deficient practice. VA00053764 was unsubstantiated with no deficient practice. VA00054065 was unsubstantiated with no deficient practice. VA00054403 was substantiated with deficient practice. VA00054580 was unsubstantiated with no deficient practice. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 170 certified bed facility was 122 at the time of the survey. The survey sample consisted of 24 current resident reviews and seven closed record reviews. | F 000 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1) | F 600 | | |

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| F 600 | Continued From page 3<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on complaint investigation, clinical record review, facility document review, and staff interview, the facility failed to ensure three of 31 residents in the survey sample, Residents # 169, 24, and 168 were free from abuse. Resident # 169 was physically abused and Residents # 24 and 168 were verbally abused by a facility staff member.<br><br>The findings include:<br><br>1. Resident # 169 was admitted to the facility with diagnoses that included Non-Alzheimer's Dementia, dementia with behavioral disturbance, anxiety disorder, depression, hypothyroidism, Vitamin-D deficiency, dysphagia, and history of COVID-19. According to a Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/15/2022, the resident was unable to respond to questions and be assessed under Section C (Cognitive Patterns). Under | F 600 | Past noncompliance: no plan of correction required. | 7/19/22 |

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| F 600 | Continued From page 4<br>Section G (Functional Status), the resident was assessed as totally dependent with one person physical assist for eating.<br><br>Review of the Progress Notes in the resident's closed Electronic Health Record (EHR) revealed the following:<br>10/29/2021 - Nursing Progress Note - "Resident was involved in an incident with a CNA (Certified Nursing Assistant) at dinner time. An investigation has been initiated...."<br><br>A written statement given by CNA # 6 during the facility's investigation included the following regarding Resident # 169: "...Then during dinner (Resident # 169) grabbed (Resident # 168's) food (sandwich). CNA # 7 grabbed (Resident # 169's) wrist bent it fighting over the sandwich. Also forced (Resident # 169) to sit down so she could have the sandwich then she shoved the sandwich in her mouth and laughed about it..."<br><br>A written statement given by LPN (Licensed Practical Nurse) # 9 included the following: "... (CNA # 7) grabbed resident (Resident # 169) by wrist and bent it back to grab food out of (Resident # 169's) hands. (CNA # 7) then took resident (Resident # 169) to a chair and forced her to sit and crammed a sandwich into resident's (Resident # 169) mouth."<br><br>Further review of the Progress Notes in Resident # 169's closed EHR revealed the following:<br>11/1/2021 - Social Service Progress Note - "This writer up to check on resident following an incident with a staff member. Resident is basically nonverbal but was showing no signs or symptoms of distress. Resident at baseline, babbling and smiling with this writer. Staff to | F 600 | | |

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| F 600 | Continued From page 5<br>continue to monitor."<br><br>2. Resident # 24 in the survey sample was admitted with diagnoses that included dementia with behavioral disturbance, cerebrovascular disease, epilepsy, frontotemporal dementia, schizoaffective disorder, major depressive disorder, polyosteoarthritis, anxiety disorder, thrombocytopenia, psychosis, Vitamin D deficiency, acute cystitis, convulsions, anorexia, hypotension, dysphagia, difficulty walking, history of COVID-19, and altered mental status. According to a Significant Change MDS with an ARD of 3/17/2022, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 00 out of 15.<br><br>Review of the Progress Notes in the resident's EHR revealed the following entry: 10/29/2021 - Nursing Progress Note - "Resident was involved in an incident with a CNA at dinner time. An investigation has been initiated...."<br><br>A written statement given by CNA # 6 during the facility's investigation included the following regarding Resident # 24: "In the beginning of the shift I heard (CNA # 7) yelling and cussing and telling (Resident # 24) to sit down, continuously telling staff she is gonna (sic) punch residents..."<br><br>Further review of the Progress Notes in Resident # 24's EHR revealed the following entry: 11/1/2021 - Social Service Progress Note - "This writer up to speak with resident after incident with staff member. Resident found sitting at the breakfast table, eating. Resident unable to express any recollection of incident due to her impaired cognition. Resident was not tearful or | F 600 | | |

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| F 600 | Continued From page 6<br>crying and when ask (sic) how she was she stated 'fine'. Staff to continue to monitor."<br><br>3. Resident # 168 in the survey sample as admitted with diagnoses that included dementia with behavioral disturbance, Alzheimer's Disease, hypothyroidism, depressive disorder, dysphagia, urinary incontinence, nocturia, and history of COVID-19. According to a Quarterly MDS with an ARD of 12/9/2021, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 01 out of 15.<br><br>Under Section G (Functional Status), the resident was assessed as not walking in the unit corridor or having locomotion off the unit; as only walking in the room with one person physical assist only once or twice; as needing supervision with one person physical assist for transfer and eating; as needing extensive assistance with one person physical assist for locomotion on the unit, dressing, and personal hygiene; and as totally dependent with one person physical assist for bathing.<br><br>Review of the Progress Notes in the resident's closed EHR revealed the following entry: 10/29/2021 - Nursing Progress Note - "Resident was involved in an incident with a CNA at dinner time. An investigation has been initiated...."<br><br>A written statement given by LPN # 9 during the facility's investigation included the following regarding Resident # 168: "(Resident # 168) was observed reaching for a pudding on top of nursing cart. This nurse heard (CNA # 7) scream 'No'. This nurse looked up and saw (CNA # 7) with a hand up in the air in an attempt to strike | F 600 | | |

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| F 600 | Continued From page 7<br>resident..."<br><br>A written statement by CNA # 6 included the following: "...during dinner (CNA # 7) whispered in my ear to confirm that she did smack (Resident # 168's) hand."<br><br>Further review of the Progress Notes in Resident # 168's closed EHR revealed the following:<br>11/1/2021 - Social Service Progress Note - "This writer up to check on resident following incident with CNA. Resident unable to express remembering the incident due to cognitive impairment. Resident sitting in the dayroom, yelling out at staff and banging on the table, which is normal behavior for resident. Staff to continue to monitor."<br><br>The Policy and Procedure on "Abuse, Neglect, Exploitation & Misappropriation" furnished by the facility included the following Definitions:<br><br>"Abuse: Abuse in the willful infliction of injury, unreasonable confinement, intimidation, or punishment...."<br>"Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm:<br>Physical Abuse includes but is not limited to: hitting, slapping....<br>Mental and Verbal Abuse include, but are not limited to: Harassing a resident, Yelling or hovering over a resident, with the intent of intimidate...."<br><br>The facility's investigation report of the incident involving CNA # 7 and Residents # # 169, 24, and 168, included the following action taken: | F 600 | | |

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|---|---|---|---|---|
| F 600 | Continued From page 8 | F 600 | | |

"1. (CNA # 7's) employment with Envoy of Staunton was terminated on November 3, 2021.
2. A report was made to the Virginia Department of Health Professions Enforcement Division regarding the abuse allegations on November 3, 2021.
3. Social Services staff have spoken with (Residents # 169, 24, and 168) to ensure that there is no psychosocial sequela from this incident.
4. (Name psychiatrist) evaluated (Residents # 169, 24, and 168) for any signs of psychological sequela, with none noted in her notes.
5. All staff are receiving re-education on Abuse, The Elder Justice Act and signs and symptoms of abuse. The target date for completion of this is 11/8/2021.
6. All personnel files have been reviewed by (name), Director of Human Resources, ensuring all current staff have background checks completed.
7. (Name), LPN Unit Manager and (name), LPN have been re-educated on abuse and reporting requirements, and will receive written disciplinary action on their next scheduled work days."

At approximately 8:45 a.m. on 6/9/2022, the Administrator was interviewed regarding the incident involving Residents # 169, 24, and 168. Asked when he was notified of the incident, the Administrator stated he was not the Administrator at the time, that he has only been at the facility since January of 2022.

The Director of Nursing who conducted the investigation was no longer employed at the facility.

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| F 600 | Continued From page 9<br>The above concern was discussed during a meeting at 9:30 a.m. on 6/9/2021 that included the Administrator, the incoming Administrator, Director of Nursing, Director of Social Services, and the survey team.<br><br>COMPLAINT DEFICIENCY - Past Non-compliance | F 600 | | |
| F 607 SS=E | Develop/Implement Abuse/Neglect Policies<br>CFR(s): 483.12(b)(1)-(3)<br><br>§483.12(b) The facility must develop and implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of employee files, facility policy review, and staff interview, the facility failed to implement their policy for Abuse, neglect, and Exploitation. Six of 25 employee files reviewed did not contain either a criminal record check, a sworn statement, or references,<br><br>The findings were:<br><br>Twenty-five employee files were reviewed on 06/08/2022 beginning at approximately 3:30 p.m. The files were reviewed for sworn statements, criminal background checks, license verification, | F 607 | F607- Develop/Implement Abuse/Neglect, etc. Policies<br><br>1.HR (human resources) Coordinator/ Payroll: Hired 05/27/2021; Criminal Background check completed on 6/24/2022, employment is terminated.<br>LPN (Licensed practical nurse): Hired 03/09/2021; Criminal Background check completed on 6/24/2022, employment is terminated.<br>LPN/MDS (Minimum data set): Hired 12/01/2020; Sworn statement completed on 6/26/2022, Criminal Background check completed on 6/24/2022, References completed on 6/27/2022.<br>NA (nursing assistant): Hired 10/13/2020; References completed on 6/27/2022.<br>Activities Hired 10/27/2020; employment is terminated.<br>RN (registered nurse): Hired 01/26/2021; employment is terminated. | 7/19/22 |

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|---|---|---|---|---|
| F 607 | Continued From page 10<br>and references. Four of the files reviewed did not have a criminal background check completed, three of the files did not have sworn statements, and two of the files did not have reference checks.<br><br>The six files included the following:<br><br>1. HR (human resources) Coordinator/Payroll: Hired 05/27/2021. No criminal record check.<br>2. LPN (Licensed practical nurse): Hired 03/09/2021. No criminal record check.<br>3. LPN/MDS (Minimum data set): Hired 12/01/2020. No sworn statement, no criminal record check, and no references.<br>4. NA (nursing assistant): Hired 10/13/2020. No reference checks.<br>5. Activities: Hired 10/27/2020. No sworn statement or criminal background check.<br>6. RN (registered nurse): Hired 01/26/2021. No sworn statement.<br><br>The facility policy, "Abuse, Neglect, Exploitation & Misappropriation" contained the following: "Persons applying for employment with the center will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. This included but is not limited to: Employment history, Criminal Background check, Abuse check with appropriate licensing board and registries, prior to hire, Sworn Disclosure Statement prior to hire, Licensure or Registration verification prior to hire...Information from former employers..."<br><br>The facility policy "Background Checks" contained the following: "It is the policy of The Company to conduct background checks to include criminal background checks...required by | F 607 | 2.Quality review conducted by the DCS (Director of Clinical Services)/designee of all current employee files to validate that each employee has a completed background check, a completed sworn statement, and completed references.<br>3.Human Resource Coordinator re-educated by the ED (Executive Director)/designee related to Abuse, Neglect, Exploitation & Misappropriation; Persons applying for employment with the center will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. This includes but not limited to: Employment history, Criminal Background check, Abuse check with appropriate licensing board and registries, prior to hire, Sworn Disclosure Statement prior to hire, Licensure or Registration verification prior to hire, Documentation of status of any disciplinary actions form licensing or registration boards and other registries, Information from former employers The center will ensure that all prospective consultants, contractors, volunteers, caregivers, and students are pre-screened as required by law.<br>4.The ED (Executive Director)/DCS/designee to conduct quality monitoring of new hires to ensure Criminal background checks, sworn statements, and References are completed prior to the employee starting to work, weekly x 6 weeks. The findings of these quality monitoring's to be reported to | |

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| ENVOY OF STAUNTON, LLC | 512 HOUSTON STREET STAUNTON, VA 24401 |

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| F 607 | Continued From page 11<br>federal regulation.... Each care center or office will maintain a copy of and comply with their respective state law requiring criminal background checks. Criminal background inquiries shall be maintained in a secure file...."<br><br>At approximately 4:00 p.m. OS (other staff) #8 was interviewed. She stated, "I haven't been here long...there is a box with papers in it that we are going through trying to find what is needed..."<br><br>The above information was discussed during an end of the day meeting on 06/08/2022 at approximately 4:45 p.m. | F 607 | the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized | F 656 | F656- Develop/Implement Comprehensive Care Plan<br><br>1.IDT (Interdisciplinary Team) reviewed Resident#23, and updated the comprehensive care plan to reflect the current needs of the resident related to the resident's gastrostomy. 7/19/22<br>2.Quality review conducted by the DCS/ designee of all residents with a gastrostomy to ensure their comprehensive care plan reflects the current needs of those residents with a gastrostomy.<br>3.MDS (Minimum data set) nurses re-educated by the DCS/designee related to Developing and Implementing comprehensive care plan, person centered care plan for each resident, consistent with | |

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| F 656 | Continued From page 12<br>rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of thirty-one residents in the survey sample, Resident #23. Resident #23 had no care plan regarding care of a gastrostomy.<br><br>The findings include:<br><br>Resident #23 was admitted to the facility with diagnoses that included cerebral infarction, dysphagia with gastrostomy, chronic pulmonary embolism, severe protein-calorie malnutrition, history of COVID-19, dementia, anemia and diaphragmatic hernia. The minimum data set (MDS) dated 3/9/22 assessed Resident #23 with severely impaired cognitive skills. This MDS listed the resident received 51% or more of total | F 656 | the resident rights and, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs.<br>4.The ED/DCS/designee to conduct quality monitoring of care plans through the care plan meeting process to ensure the care plan reflects the current needs of the resident(s), weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee. | |

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| F 656 | Continued From page 13<br>caloric intake through a feeding tube.<br><br>Resident #23's clinical record documented a physician's order dated 3/2/22 to cleanse the resident's PEG (percutaneous endoscopic gastrostomy) with wound cleanser each day along with a drain sponge. The record documented a physician's order dated 3/15/22 for bolus administration of Osmolite formula four times per day through a feeding tube for nutrition.<br><br>Resident #23's plan of care (revised 4/6/22) included no problems, goals and/or interventions regarding the resident's gastrostomy. The nutrition section of the plan listed the resident received part of his calories via the PEG but there were no goals and/or interventions regarding care/maintenance of the PEG.<br><br>On 6/8/22 at 11:00 a.m., accompanied by licensed practical nurse (LPN) #4, Resident #23's gastrostomy site/tube were observed. The site had no signs of complications and a clean drain sponge was in place as ordered<br><br>On 6/8/22 at 1:20 p.m., the registered nurse (RN #1) responsible for MDS and care plan development was interviewed about Resident #23's gastrostomy. RN #1 reviewed the resident's plan of care and stated she did not see a plan specifically about the PEG. RN #1 stated the care plan should include a separate entry regarding the care and maintenance of the gastrostomy.<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 6/8/22 at 5:00 p.m. | F 656 | | |

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| F 684 | Continued From page 14 | F 684 | F684- Quality of Care | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to follow physician orders for one of thirty-one residents in the survey sample, Resident #72. Notification was not made to the provider regarding weight gain for Resident #72 as ordered by the physician.<br><br>The findings include:<br><br>Resident #72 was admitted to the facility with diagnoses that included dementia, ventricular fibrillation, tachycardia, cervical disc disorder, COPD (chronic obstructive pulmonary disease), hypertension, chronic kidney disease, heart failure, atrial fibrillation, depression, anxiety, sleep apnea and benign prostatic hyperplasia. The minimum data set (MDS) dated 5/4/22 assessed Resident #72 with severely impaired cognitive skills.<br><br>Resident #72's clinical record documented a physician's order dated 5/18/22 for daily weights (same scale before breakfast) with instructions to notify the nurse practitioner of weight gain greater than 2 pounds (lbs.) in one day or 5 lbs. in one | F 684 | 1.Resident #72's clinical record reviewed to include current Physician orders, to include daily weights- use same scale and weigh before breakfast. Notify NP of weight gain >2lbs in one day or 5lbs in one week. Daily weights reviewed and NP notified of current weight.<br>2.Quality review conducted by the DCS/ designee of all residents Physician orders for weights to ensure weights are obtained per Physician orders and notification is made per Physician orders.<br>3.UMs (unit managers) and all nurses (RN/LPN) re-educated by the DCS/designee related to Weights and Notification/ documentation per Physician order; to ensure residents receive treatment and care in accordance with professional standards of practice.<br>4.The DCS/designee to conduct quality monitoring of resident weights and notification/documentation per Physician order, 3 x weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee. | 7/19/22 |

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| F 684 | Continued From page 15<br>week.<br><br>Resident #72's clinical record documented the resident weighed 207 lbs. on 6/1/22 and weighed 212 lbs. on 6/2/22 indicating a 5 lb. increase in one day. There was no notification to the provider regarding the weight gain.<br><br>On 6/8/22 at 11:06 a.m., the licensed practical nurse unit manager (LPN #6) was interviewed about any notification regarding Resident #72's weight gain. LPN #6 stated nurses were supposed to notify the provider with a phone call and document the notification in the clinical record. LPN #6 reviewed Resident #72's clinical record and stated she did not see anything in the notes about the weight gain or notification to the provider regarding the gain.<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 6/8/22 at 5:00 p.m. | F 684 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)<br><br>§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-<br><br>§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 | F 692 | F692- Nutrition/Hydration Status Maintenance<br><br>1.Resident #117's clinical record reviewed by RD (registered dietitian) to include current Physician orders and diet order, diet order updated to include large portions; NP/RD notified of current weight. Resident's care plan reviewed and updated to reflect current needs. | 7/19/22 |

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| F 692 | Continued From page 16<br>preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review the facility staff failed to implement interventions to prevent weight loss for one of 31 residents in the survey sample, Resident #117.<br><br>Findings include:<br><br>Resident #117's diagnoses included, but were not limited to: cerebral infarction, Vitamin D deficiency, localized edema, pre-diabetes, vascular dementia, insomnia, and major depression.<br><br>The most recent MDS (minimum data set) was a quarterly assessment dated 05/26/22. This MDS assessed the resident with a cognitive score of 3 indicating the resident had severe impairment in daily decision making skills. The resident was assessed as requiring supervision with one person physical assistance for eating. Resident #117's weight was documented as 163.0 pounds. The resident was also coded as having weight loss (not physician prescribed).<br><br>On 06/07/22 at 12:48 PM, Resident #117 was observed eating in the dining room, feeding himself. The resident ate 100 % of his meal. When asked if the food was good and Resident #117 stated, "yes". | F 692 | 2.Quality review conducted by the RD/DCS/ designee of all residents with a significant weight loss (5% in 30 days, 7.5% in 90 days, 10% in 180 days) and ensure appropriate interventions are implemented to prevent further weight loss.<br>3.UMs (unit managers) and all nurses (RN/LPN) re-educated by the DCS/designee related to maintaining 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.<br>4.The DCS/designee to conduct quality monitoring of residents' weights to identify any significant weight loss and ensure appropriate interventions are implemented, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee. | |

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| F 692 | Continued From page 17<br><br>Resident #117's physician's orders included, "Regular diet, regular texture, Regular/Thin liquids...active 06/21/21..." No additional diet or supplement orders were found in the current physician's orders.<br><br>Resident #117's weights were documented as follows:<br><br>05/01/22 - 172.4 pounds<br>05/24/22 - 162.8 (a difference of 9.6 lbs in less than 30 days).<br><br>Resident #117's clinical records documented the following:<br><br>On 05/14/22, Resident #117 was seen by RD (Registered Dietitian) #1. RD #1 documented the following,"... most recent weight 172.4 on 05/01/22... Diet order: regular with large portions, Supplements Ordered: none at this time. Other Food interventions in place: Large portions as noted above, continue to monitor as above..."<br><br>An RD progress note by RD #2 dated 05/25/22 at 9:12 am documented, "Weight Warning: 162.8...-5.0% change (5.6%, 9.6 LBS) Please refer to 05/25/22 nutritional review per the RD which addresses nutrition and weight status.<br><br>The RD Nutritional Review assessment dated 05/25/22 (referred to above) documented, "...162.8...Significant weight loss x 30 days, regular diet...tolerating diet as ordered...Summary Review: Resident...is on a regular diet...resident is noted for 9%...weight loss x 30 days...Resident is at risk for weight change related to heart disease diagnosis. Resident continues with | F 692 | | |

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| F 692 | Continued From page 18<br>adequate PO intake...RD updates as needed, updated care plan...signature of RD #2."<br><br>Resident #117's current care plan documented, "...is at risk for weight changes and altered nutrition/fluid status...will maintain adequate nutrition status...stable weight without change through next review...monitor and record weight per policy...provide and serve diet as ordered...provide, serve diet as ordered. Monitor intake and record every meal...RD to evaluate and make diet change recommendations PRN (as needed)...(03/29/21)...revision on 04/15/22..." There were no interventions or changes listed for the revision date, only a review date.<br><br>On 06/08/22 at 2:30 PM, the DON (director of nursing) was interviewed regarding the RDs and how often they are in the facility. The DON stated that RD #1 was a new RD and came each week on Wednesdays, but had called out this morning and as of today, would be out due to illness. The DON stated that she did not know when RD #1 would return from sick leave. The DON stated that RD #2 had been coming from another facility to help out. The DON was made aware of the above information regarding Resident #117's weight loss of 9.6 pounds and that neither RD (#1 or #2) had addressed the weight loss or implemented any interventions regarding the weight loss.<br><br>On 06/08/22 at 2:41 PM, RD #2 was interviewed regarding Resident #117. RD #2 was asked about any interventions implemented for Resident #117 regarding the weight loss. RD #2 stated, "That's a very valid question, I understand completely. A very good question and a very good point. Thank you for bringing that to my | F 692 | | |

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| F 692 | Continued From page 19<br>attention and going forward...I'll try to see what I can find and I will have to investigate it some."<br><br>On 06/08/22 at 3:32 PM, the DON stated that RD #1 was hired on 05/04/22 and that RD #2 had been helping out the facility prior to and during this transition.<br><br>On 06/08/22 at 4:50 PM, RD #2 stated that RD #1 would address any issues and/or concerns regarding Resident #117, when RD #1 returned back from sick leave.<br><br>On 06/09/22 at 8:20 AM, RD #2 was interviewed again and asked why were there no interventions implemented for weight loss for Resident #117. The RD stated, "Um, I understand your question, how I justified it, it was because I'm not in the facility, and due to CHF (congestive heart failure), with the heart failure is how I justified it. I wasn't able to see him, I am remote and at that time I didn't think any interventions needed to be implemented. I didn't think that (name of RD #1) needed to implement any interventions."<br><br>Resident #117's clinical record did not reveal an active diagnosis of CHF. The physician's orders did not reveal that the resident was on any type of diuretic and/or antihypertensive medication or any medications for CHF. The resident's CCP (comprehensive care plan) was did not address any concerns related to CHF.<br><br>On 06/09/22 at approximately 9:45 AM, the administrator, DON and corporate nurse were made aware of the above concerns.<br><br>No further information and/or documentation was presented prior to the exit conference on | F 692 | | |

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| F 692 | Continued From page 20<br>06/10/22. | F 692 | F693- Tube Feeding Mgmt/Restore Eating Skills | |
| F 693 SS=E | Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)<br><br>§483.25(g)(4)-(5) Enteral Nutrition (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-<br><br>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and<br><br>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review, the facility staff failed to provide gastrostomy care as ordered for one of thirty-one residents in the survey sample, Resident #23. A physician's order to cleanse and apply a daily dressing to Resident #23's gastrostomy site was not implemented for over three months.<br><br>The findings include: | F 693 | 1.Resident #23's Physician order to cleanse and apply a daily dressing to the gastrostomy site has been implemented.<br>2.Quality review conducted by the DCS/ designee of all residents with a gastrostomy to ensure the care for their gastrostomy sites are implemented per Physician order of those residents with a gastrostomy.<br>3.UMs (unit managers) and all nurses (RN/LPN) re-educated by the DCS/designee related to residents who are fed by enteral means receive the appropriate treatment and services per Physician order.<br>4.The ED/DCS/designee to conduct quality monitoring of residents with a gastrostomy to ensure the care for their gastrostomy sites are implemented per Physician order 3 x weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee. | 7/19/22 |

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|---|---|---|---|---|
| F 693 | Continued From page 21 | F 693 | | |

Resident #23 was admitted to the facility with diagnoses that included cerebral infarction, dysphagia with gastrostomy, chronic pulmonary embolism, severe protein-calorie malnutrition, history of COVID-19, dementia, anemia and diaphragmatic hernia. The minimum data set (MDS) dated 3/9/22 assessed Resident #23 with severely impaired cognitive skills. This MDS listed the resident received 51% or more of total caloric intake through a feeding tube.

Resident #23's clinical record documented a physician's order dated 3/2/22 to cleanse the resident's PEG (percutaneous endoscopic gastrostomy) with wound cleanser and apply a drain sponge each day for care of the PEG site.

Resident #23's clinical record documented no implementation of the order for daily cleansing and dressing application to the gastrostomy site. The resident's treatment administration records (TARs) from 3/3/22 through 6/8/22 included no entries or order listing for the daily cleansing/dressing for the PEG.

Resident #23's plan of care included no problems, goals and/or interventions regarding care and maintenance of the PEG.

On 6/8/22 at 11:00 a.m., accompanied by licensed practical nurse (LPN) #4, Resident #23's gastrostomy site was observed. An undated gauze was in place around the tube site. The PEG site and surrounding skin had no signs of irritation, infection or complications. LPN #4 was interviewed at this time about the care orders for the PEG. LPN #4 stated she thought there was an order on the TAR for daily care. LPN #4 reviewed the clinical record and stated she did

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| F 693 | Continued From page 22<br>not see a current order on the TAR regarding the cleansing and dressing application to the PEG.<br><br>On 6/8/22 at 11:03 a.m., LPN #5 that routinely cared for Resident #23 was interviewed about care provided to the PEG site. LPN #5 reviewed the clinical record and stated an order was entered on 3/2/22 for daily cleansing and dressing application to the PEG site. LPN #5 stated the order was listed but did not get put on the TAR. LPN #5 stated the resident was readmitted from the hospital on 3/2/22 and the order had not been added to the TAR since the readmission. LPN #5 stated no schedule was designated for the order when entered.<br><br>On 6/8/22 at 11:05 a.m., the unit manager (LPN #6) was interviewed about the care orders for Resident #23's gastrostomy. LPN #6 stated the order had not been implemented because it was not entered correctly in the electronic health record. LPN #6 stated she thought the nurses checked the site but there was nothing showing that the daily cleansing and dressing changes were implemented as ordered.<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 6/8/22 at 5:00 p.m. | F 693 | | |
| F 727 SS=F | RN 8 Hrs/7 days/Wk, Full Time DON<br>CFR(s): 483.35(b)(1)-(3)<br><br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. | F 727 | F727- RN 8 Hours/7 days/Week, Full Time DON<br><br>1.The facility utilizes the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week | 7/19/22 |

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| F 727 | Continued From page 23<br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and facility document review, the facility staff failed to ensure a registered nurse was onsite at the facility for 8 consecutive hours on 06/05/2022.<br><br>Findings were:<br><br>The facility as worked schedule for the week of the survey and the week prior to the survey. On 06/01/2022, 06/03/2022, and 06/05/2022, there was no RN (registered nurse) scheduled.<br><br>CNA (certified nursing assistant) #1 who did staffing was interviewed on 06/08/2022 at 10:00 a.m. She stated, "The MDS (minimum data set) nurses are RNs and they are here for at least 8 hours a day Monday through Friday, so they were here on June 1st and June 3rd...they aren't on the schedule but they are in the building and here if needed...June 5th was a Sunday so there was not an RN here that day." She was asked why no RN was scheduled. She stated, "There are only three PRN (as needed) nurses who work here...two are on nights, one is on dayshift. They are required to work at least 20 hours per month, 1 weekend per month and one holiday per year. There are no full time RNs here right now...we are trying to hire some..." | F 727 | 2.Quality review conducted by the DCS/ designee of as worked scheduled for the last 30 days to ensure that the facility has utilized the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br>3.ED/DCS/Scheduler re-educated by the RDCS/designee related to regulations; the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br>4.The ED/DCS/designee to conduct quality monitoring of "as worked" schedule and upcoming schedule to ensure a registered nurse is scheduled to work/ or has worked 8 consecutive hours a day, 7 days a week, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee. | |

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| F 727 | Continued From page 24<br>The above information was discussed during an end of the day meeting on 06/08/2022.<br><br>No further information was obtained prior to the exit conference on 06/09/2022. | F 727 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§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 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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility document review, the facility staff failed to ensure drugs and biological's were labeled appropriately | F 761 | F761- Label/Store Drugs & Biologicals<br><br>1.The facility immediately discarded the unlabeled multi-dose vail of Tuberculin on Unit 3 New West.<br>2.Quality review conducted by the DCS/ designee of medication storage refrigerators on the nursing units in the facility to ensure drugs and biologicals to include Tuberculin solution is labeled and dated in accordance with currently accepted professional principles.<br>3.UMs (unit managers) and all nurses (RN/LPN) re-educated by the DCS/designee related to the labeling and storage of drugs and biologicals. Drugs and biologicals used in the facility must be labeled in accordance with the currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. | 7/19/22 |

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| F 761 | Continued From page 25<br>on one of two nursing units. The facility failed to appropriately label a multi- dose vial of Tuberculin on unit 3 New West.<br><br>Findings include:<br><br>On 06/08/22 at 8:41 AM, the 3 New West unit medication storage refrigerator was observed with license practical nurse (LPN #3, unit manager). The refrigerator had one vial of tuberculin medication in it's original box. The vial of Tuberculin had been opened with approximately half of the medication remaining in the vial. Neither the vial of Tuberculin, nor the original box had an open date, indicating when the medication had been opened/accessed. LPN #3 stated the vial of Tuberculin should have an open date on it and should be discarded after 30 days of being opened, and since there was no open date it would be discarded.<br><br>A policy titled, "Storage and Expiration Dating of Medications" documented, "...Once any medication or biological package is opened...follow manufacturer/supplier guidelines with respect to expiration dates for opened medication. Facility should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened... If a multidose vial of an injectable has been opened or accesses, the vial should be dated and discarded within 28 days unless the manufacturer specifies a different date for that opened vial."<br><br>On 6/8/22 at 4:45 PM the administrator and DON (director of nursing) were made aware of the above finding. | F 761 | 4.The DCS/designee to conduct quality monitoring of Tuberculin solution (drugs and biologicals) to ensure they are labeled and dated appropriately when opened 3 x weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee. | |

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| F 761 | Continued From page 26<br>No other information was presented prior to exit conference on 6/9/22. | F 761 | | |