STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING _____ B. WING _____	C 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 8/29/2022 through 8/31/2022. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 037 SS=E	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The	E 037	E037 1)Facility staff have received annual emergency preparedness training. 2) Current staff have the potential to be affected. 3) Administrator/designee will provide education to Human Resource Generalist on the annual requirement to complete emergency preparedness education with staff. 4)Evidence of training for staff will be audited weekly times 1 month to ensure EP training is completed. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 9/28/2022	

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

[signature] LNHA 9-16-22

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E 037	Continued From page 1 hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF	E 037	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	

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E 037	Continued From page 2 must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The	E 037		

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E 037	Continued From page 3 CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 4 procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation of the facility's annual emergency preparedness training offerings for five of five sampled facility staff, CNA's (certified nursing assistant) #4, #5, #6, #7 and #8. The findings include: On 8/30/2022 at 3:45 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1, the administrator. Review of the facility's emergency preparedness plan documented planned annual training of facility staff via computerized learning. A request was made to ASM #1 for evidence of	E 037		

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E 037	Continued From page 5 completed annual emergency preparedness training for a sample of five CNA staff members (CNA #4, #5, #6, #7 and #8) who were employed at the facility greater than one year and currently employed at the facility. On 8/31/2022 at 9:57 a.m., ASM #3, the regional director of clinical services stated that they did not have evidence of emergency preparedness training to provide for the five requested CNA staff. The facility assessment tool dated August 2022 documented in part, "...Staff training/education and competencies...The following training is used: ...Disaster planning and procedures- active shooter, elopement, fire, flood, power outage, tornado..." On 8/31/2022 at approximately 10:00 a.m., ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of this concern. No further information was obtained prior to exit.	E 037		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/29/22 through 8/30/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Four complaints were investigated during the survey (VA00054206- substantiated with deficiency, VA00055915-substantiated with related deficiency, VA00055602-substantiated without deficiency and VA00055077-substantiated without deficiency). The Life Safety Code survey/report will follow.	F 000		

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F 000	Continued From page 6 The census in this 177 certified bed facility was 112 at the time of the survey. The survey sample consisted of 40 current resident reviews and 7 closed record reviews.	F 000		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced	F 563	F563 1) Resident #701 no longer resides in the facility. 2) Current residents in the facility have the potential to be affected. 3) Administrator and Receptionist re-educated on visitation policy. 4) Administrator/designee will randomly audit visitation log weekly for 1 month to ensure visitation occurred. Results of audits will be reviewed at the monthly QAPI meeting. Any discrepancies will be addressed immediately. 5) Compliance Date: 9/28/2022	

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F 563	Continued From page 7 by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to honor a resident's rights to visitation for 1 of 47 residents in the survey sample; Resident #701. The facility staff denied Resident #701 family visitation on Christmas Day 2021. The findings include: Resident #701 was admitted to the facility on 4/22/21 and discharged on 5/10/22. On the most recent MDS (Minimum Data Set) an annual assessment with an ARD (Assessment Reference Date) of 4/1/22, the resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 15 out of 15 on the BIMS (Brief Interview for Mental Status). A review of the progress notes in the clinical record failed to reveal anything regarding visitation for Christmas Day 2021. A review of a "Concern Form" dated 12/25/21 documented, "Documentation of concern: Resident's [family member] stated [they] was told [they] could not visit (the resident) on Christmas but other facilities were having visitors....Results of action taken: Visits had been suspended d/t (due to) outbreak status (COVID-19)....Resolution of concern: [Family member] informed that visits had been suspended at that time d/t outbreak status of the facility. Visitation has since resumed with the issuance of an updated policy." A review of the facility policy, most recently dated	F 563		

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F 563	Continued From page 8 11/2021 (the policy that was in effect at the time of the incident), "Visitation and Resident Outings during the COVID-19 Pandemic" documented, "....Visitation during an Outbreak: During an outbreak, visitors must be allowed into the facility. However, the facility must ensure the following: Visitors are made aware of potential risks; Visitors adhere to the core principles of infection prevention; Visitors wear full PPE (N95, face shield, gown) regardless of vaccination status; Visits should occur in resident room unless roommate is unvaccinated or immunocompromised...." On 8/30/22 at 2:35 PM an interview was conducted with LPN #9 (Licensed Practical Nurse), the current Infection Preventionist, who had also worked with Resident #701. She stated that the resident should have been allowed to visit. She stated that she did not know who told the family member they could not visit. She stated that per the written concern form, the family was denied visitation. She stated that was an inaccurate practice if that happened, based on the policy that was in place at the time. On 8/30/22 at 2:41 PM, ASM #2 and ASM #3 (Administrative Staff Member) the Regional Vice President of Operations and the Regional Director of Clinical Services, respectively, were made aware of the findings. No further information was provided. Complaint deficiency.	F 563	F600 1) Resident #317 no longer resides in the facility. Resident #32 remains in the facility and feels safe and free from abuse. 2) Current residents have the potential to be affected. 3) Current Staff will be educated on Abuse policy and procedure. 4) The Administrator or designee will conduct random audits weekly for 1 month to ensure that residents feel safe and are free from abuse. Results of audits will be reviewed at the monthly QAPI meeting. Any discrepancies will be addressed immediately.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and	F 600	5) Compliance Date: 9/28/2022	

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F 600	Continued From page 9 Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, facility document review and in the course of a complaint investigation, it was determined that the facility staff failed to protect two of 47 residents in the survey sample from abuse, Residents #32 (R32) and (R317). The findings include: 1. The facility staff failed to protect (R32) from a facility housekeeper pinching (R32's) right nipple. (R32) was admitted to the facility with diagnoses that included but were not limited to: stroke, bipolar disorder (1), hemiplegia (2) and depression. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/29/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions.	F 600		

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F 600	Continued From page 10 The Facility Reported Incident (FRI) dated 07/09/2022 documented, "Incident Date: 07/09/2022. Incident type: Allegation of abuse/mistreat (mistreatment). Describe the incident, including location and action taken: Resident reported while asleep in bed, awoken by pinch to right nipple by (Name of OSM (other staff member) #7, housekeeper)." The facility's progress note for (R32) dated 07/09/2022 documented, "SBAR (Situation, Background, Assessment, Response) Situation: Resident self report to writer male housekeeper awoke her from her sleep when he pinched her on right nipple. Background: HX (history): Cerebral Infarct Unspecified, Anxiety disorder, Bipolar disorder, Hemiplegia/Hemiparesis affecting right dominant side, DNR (do not resuscitate) under MD (medical doctor) (Name of Doctor) care. Assessment: Resident assessed for any redness or bruising none observed by writer, resident encouraged to notify of needs or concerns and provided with staff support. Response: NP (nurse practitioner) (Name of nurse practitioner) updated no new orders given, Resident self RP (responsible party) with son (Name of Son) on as contact which resident stated she would notify herself, writer made notification to (Name of County) Sheriffs Dept. (department) and spoke to (Name of Sheriff) who stated would initiate report and have a Detective follow-up." The 'Psychiatric Periodic Evaluation" for (R32) dated 07/11/2022 documented in part, "History of Present Illness: ...Patient specifically mentioned that her right breast was roughly and inappropriately touched by a male housekeeping	F 600		

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F 600	Continued From page 11	F 600		

staff. She was sleeping at the time and was awakened by such an inappropriate gesture. Brief supportive psychotherapy provided during this visit and she reflected on her feelings of anger and hurt. She denies nightmares and flashbacks ..."

The nurse practitioner note for (R32) dated 08/13/2022 documented in part, "ATSP (asked to see patient) by nursing for evaluation of recent incident; patient reports being "touched really hard" on her right breast by a housekeeper ...Patient denies injury. Patient does have anxiety. This writer advised patient that she can reach out if she needs to speak with an=one for psychosocial support. Patient verbalized understanding. Pt (patient) has anyone (diagnoses of CVA (cerebral vascular disease), anxiety; Pt voicing no further acute concerns; staff negative for any further acute pt. concerns on today ..."

Review of OSM #7's employee record revealed a document titled "Sworn Statement or Affirmation." The sworn statement documented in part, "I have no criminal convictions in or outside of the Commonwealth of Virginia." Further review of the document revealed OSM #7's signature dated 0719/2021.

Review of OSM #7's employee record revealed a document from (Name of Service Group) that documented in part, "PHYSICAL ABUSE includes, but not limited to hitting, slapping, pinching, running into with objects and kicking. This also includes controlling behaviors through corporal punishment." The form further documented, "I have been provided with a copy of the requirements of the Patients'/Residents'

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F 600	Continued From page 12	F 600		

Rights and the Resident/Patient Abuse Policies, as well as informed of my obligation to report suspected crimes under the Elder Justice Act." Further review revealed OSM #7's signature dated 0727/2021.

Review of OSM #7's employee record revealed two reference checks.

Review of OSM #7's employee record revealed a Virginia State Police background check for OSM #7 dated 07/19/2022. The background check documented in part, "Status: NO IDENTIFIABLE RECORD(S)."

On 08/30/2022 at approximately 9:50 a.m., an interview was conducted with (R32) about the incident when they were inappropriately touched by staff member. (R32) stated that while they were asleep, they felt a pain in their right breast and saw the housekeeper pinching their nipple. (R32) stated that they pushed the housekeeper away and they left the room. (R32) stated that they left their room and went to the nurse and told them what happened. When asked how they felt at the time of the incident (R32) stated that they were upset at the time but when they knew the housekeeper had left (R32) stated they felt better and safe. When asked if the nurse assessed them for any injuries (R32) stated yes and that they did not have any injuries. When asked if they experienced any residual pain (R32) stated no.

On 08/30/2022 at approximately 2:26 p.m., a telephone interview was conducted with LPN (licensed practical nurse) #5. When asked about the incident of (R32) being inappropriately touched by a facility staff member on 07/23/2022

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F 600	Continued From page 13 LPN #5 stated that during the evening shift (3:00 p.m. to 11:00 p.m.) (R32) came to them and stated that someone came into their room and pinched their nipple while they were sleeping. LPN #5 stated that they called the director of nursing and the sheriff's department and assessed (R32). LPN #5 stated that when they assessed (R32) there was evidence of redness or bruising of the nipple or breast. When asked about (R32's) disposition at the time LPN #5 stated that (R32) was upset by the incident but was not afraid to go back to their room and go to bed. When asked about the perpetrator, LPN #5 stated that they had left the building and never came back. The facility's policy "Resident Abuse-Staff to Resident" documented in part, "Policy: Protocol to follow in instances of reported staff to resident abuse/neglect as defined in regulations F600, F602, F603, F607, F609, F610 of the federal guidelines for long-term care facilities. "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or pain, or mental anguish, or deprivation by an individual, including a caretaker of good and services that are necessary to attain or maintain physical, mental and psychosocial well-being. This includes verbal abuse, sexual abuse, physical abuse, mental abuse and involuntary seclusion." On 08/30/2022 at approximately 5:30 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, regional vice president of operations, and ASM # 3, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit.	F 600		

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F 600	Continued From page 14 Complaint deficiency References: (1) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (2) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. Paralysis can be complete or partial. It can occur on one or both sides of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 2. The facility staff failed to prevent resident to resident abuse for Resident #317 (R317). On 2/18/22, Resident #49 (R49) willfully slapped R317 in the face four times. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/22/22, R317's cognitive skills for daily decision making were coded as severely impaired. R317 discharged from the facility on 7/22/22. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/13/22, R49 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. A review of R317's clinical record revealed a nurse's note dated 2/18/22 that documented,	F 600		

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F 600	Continued From page 15 "Resident was involved in an altercation with another resident and other resident smacked resident. Other resident was removed and redirected away from resident. Resident alert and verbal. Resident shook her head that she was 'okay' when asked. Resident right side of face reddened (where she was hit)..." A review of R49's clinical record revealed a nurse's note dated 2/18/22 that documented, "Writer was providing another resident medication when writer heard and (sic) altercation in room (number). Writer observed (R49) standing over (R317) resident yelling 'shut up' and repeatedly slapping resident in (the resident's) face (4 time). Writer asked (R49) stop hitting resident and resident did stop hitting resident. CNA (Certified nursing assistant) on duty assisted writer in re-directing resident back to (R49's) room. When writer asked (R49) why (the resident) was hitting he, (sic) resident stated because (the resident) keep yelling. Writer explained to resident that (R317) was not yelling it was (R317's roommate) yelling. Resident stated 'I dont care!' went back to room. RP (Responsible party) called and notified of residents actions. Resident was informed that (the resident) was to be on a one to one and resident stated 'I am not a child, close my F***ing Door now.'" A FRI (facility reported incident) submitted to the SA (state agency) on 2/18/22 documented, "On 2/18/22 (R49) slapped (R317) in the face while yelling shut the hell up. Residents immediatley (sic) seperated (sic) and (R49) placed on 1:1. No injuries noted. (R49) has a (BIMS 14)..." A final reported submitted to the SA on 2/22/22 documented, "On 2-18-22 (R49) was heard	F 600		

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F 600	Continued From page 16	F 600		

yelling 'shut the hell up' in (R317's) room and the nurse (name) LPN (licensed practical nurse) immediately responded and observed (R49) slap (R317) four times quickly in the face. The nurse separated the residents and 1:1 was initiated with (R49). A red area was noted to the Left check (sic) of (R317) that dissipated without marks or bruising..." The report further documented the following interventions after the incident: both residents were assessed by the nurse practitioner, families of both residents were updated, R49 was moved to a private room on a different unit, and one to one supervision continued with R49 until the resident was assessed by the psychiatric nurse practitioner.

The nurse who documented the above nurses' notes was no longer employed at the facility and could not be interviewed.

On 8/30/22 at 1:59 p.m., an interview was conducted with OSM (other staff member) #2 (the social services director). OSM #2 stated resident to resident abuse occurs, "When two residents have a physical altercation, rather it's both towards each other or one resident to another." OSM #2 was read the first sentence of the above final report. OSM #2 stated "It would have been labeled a resident to resident altercation. It's abuse. It is abuse if you hit or slap someone."

On 8/30/22 at 2:57 p.m., an interview was conducted with LPN #3. LPN #3 stated resident to resident abuse occurs when a resident hits another resident and makes contact. LPN #3 was read the first sentence of the above final report. LPN #3 stated "That's a resident to resident physical altercation. It's abuse because the resident hit another resident but it depends on

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F 600	Continued From page 17 the cognition, if someone can't defend themselves and not in their right mind then it's abuse." On 8/30/22 at 4:15 p.m., an interview was conducted with R49. R49 stated the resident did not slap anyone in February 2022. On 8/30/22 at approximately 5:45 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional vice president of operations) and ASM #3 (the regional director of clinical services) were made aware of the above concern. The facility policy titled, "Resident Abuse-Resident to Resident" documented, "Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals. 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or pain, or mental anguish, or deprivation by an individual, including a caretaker, of goods and services that are necessary to attain or maintain physical, mental and psychosocial wellbeing. This includes verbal abuse, sexual abuse, physical abuse, mental abuse, involuntary seclusion, and misappropriation of resident property." No further information was presented prior to exit.	F 600	F622 1) Resident #116 is no longer in the center. Residents #56, #16, #90, #94 remain safely in the facility. 2) Current residents in the facility that are transferred to the hospital have the potential to be affected. 3) The DON/designee provided re-education of the documentation requirement of transfers to the hospital to licensed providers. 4) Transfers will be audited weekly for 1 month to ensure appropriate paperwork was provided to the receiving facility. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately.	
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge-	F 622	5) Compliance Date: 9/28/2022	

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F 622	Continued From page 18 §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger	F 622		

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F 622	Continued From page 19 that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;	F 622		

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F 622	Continued From page 20 (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined the facility staff failed to provide evidence that all required information was provided to the hospital staff when five out of 47 residents in the survey sample were transferred to the hospital; Residents #56, #94, #90, #16 and #116. The findings include: 1. The facility staff failed to evidence provision of required resident information to a receiving facility at the time of transfer for Resident #56. Resident #56 was transferred to the hospital on 7/4/22. Resident #56 was admitted to the facility on 4/11/22 with diagnoses that included but were not limited to: Alzheimer's disease, dementia and cerebral infarction. The most recent MDS (minimum data set) assessment, a 5 day Medicare assessment, with an ARD (assessment reference date) of 7/14/22, coded the resident as scoring a 05 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, locomotion bathing and hygiene; supervision for eating.	F 622		

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F 622	Continued From page 21 A review of the comprehensive care plan with a revision date of 7/26/22, revealed, "FOCUS: Resident is at risk for FALLS related to: New environment, crawling on floor looking for items, history of falls, Alzheimer's disease, use of psychotropic medication. I slipped coming from the bathroom I didn't have on non-skid socks, as I will also take them off and turn the non-skid side upside down. I have poor safety awareness and had a fall when getting out of bed, ambulating in the hallway instead of using wheelchair, walker. Non-compliance mobility aides and non-slip footwear. INTERVENTIONS: Assess for pain. Bed in low position. Call light or personal items available and in easy reach. Concave mattress. Education to use wheelchair for mobility and call bell when in need of assistance. Encourage resident to call for assistance while transferring. Ensure proper footwear is on while ambulating. Fall Mat to Left Side of bed. Falling Star Program. Non-skid socks as tolerated. Non-slip strips outside of bathroom doorway and bedside. Observe for side effects of Medications. Orientation to new room and roommate. Room Closer to Nurse's Station." There was no evidence of hospital transfer documents sent with the resident to the hospital on 7/4/22. A review of the nursing progress note dated 7/4/22 at 9:00 AM, revealed, "Situation: Resident status post fall. Right sided hip pain. Background: Resident found on previous shift on the floor of her room. Resident assessed, assisted to bed and neuro checks performed. Hospice notified and came and assessed resident. Assessment: Resident complained of	F 622		

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F 622	Continued From page 22 extreme right sided hip pain. Resident in distress while ADL's (activities of daily living) performed. Assessed and this nurse decided to send to ER (emergency room). Response: NP (nurse practitioner) and RP (responsible party) notified." A request for clinical documents sent to the receiving facility with the resident was made on 8/30/22 at 4:00 PM. An interview was conducted on 8/30/22 at 9:55 AM, with LPN (licensed practical nurse) #2. When asked what documents are sent with the resident to the hospital, LPN #2 stated, "We are to send the medication list and any recent labs. I believe the orders and maybe the care plan." An interview was conducted on 8/30/22 at 4:20 PM, with RN (registered nurse) #2. When asked what documents are sent with the resident to the hospital, RN #2 stated, "Nursing sends out transfer documents, we are supposed to send out labs, SBAR (situation/background/assessment/recommendation), vital signs. We do not even have a chance to fill out the paperwork. We give a verbal report to the EMS (emergency medical squad) and the hospital. I am not so sure we send the care plan. We give verbal report to the nurse." When asked how do you evidence what was sent to the hospital, RN #2 stated, "I document that I gave the verbal report." On 8/30/22 at 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings.	F 622		

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F 622	Continued From page 23 A review of the facility's "Transfer of Residents from the Facility" policy, dated 12/2020, revealed the following: "Procedure: Emergency transfers of residents for medical reasons will be completed promptly. Family notifications will occur as soon as possible, or within twenty-four (24) hours. Emergency transfers are for: A. Health problems: Emergency medical care is needed at a level not available in the nursing home. Discharge materials are provided (see discharge planning procedure)." A review of the facility's "Discharge Planning Documentation" policy, dated 11/2020, revealed the following: "At the time of discharge, a discharge summary and home-going instructions are provided to the resident or the resident's caregiver which will include the following: A. Current diagnosis, B. Rehabilitation potential, C. Summary of prior treatment, D. Physician's orders for immediate care and E. Pertinent social information. No further information was provided prior to exit. 2. The facility staff failed to evidence provision of required resident information to a receiving facility at the time of discharge for Resident #94. Resident #94 was transferred to the hospital on 7/26/22. Resident #94 was admitted to the facility on 10/19/21 with diagnoses that included but were not limited to: cerebrovascular accident, hemiplegia, diabetes mellitus (DM), pneumonia and hypertension. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an	F 622		

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F 622	Continued From page 24 ARD (assessment reference date) of 8/2/22, coded the resident as scoring a 99 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was unable to complete the interview. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bathing, bed mobility, transfer, dressing and hygiene; supervision for eating. A review of the comprehensive care plan dated 10/19/21, revealed, "FOCUS: Resident has alteration in Blood Glucose due to: Hyperglycemic Episodes, Diabetes Mellitus. I am often non-compliant with my diet and will consume many snacks throughout the day and refuse my meals at times. INTERVENTIONS: Observe for low blood sugar symptoms - flushed face, sweating, change in usual mental status, lethargy, irritability, fruity breath odor, coma, nervousness, trembling, difficulty concentrating, light headedness. Observe for high blood sugar symptoms - increased thirst, increased hunger and increased urinary output." There was no evidence of hospital transfer documents sent with the resident to the hospital on 7/26/22. A review of the nursing progress note dated 7/26/22 at 11:52 AM, revealed, "Situation: Resident lethargic, feeling very week, AMS (altered mental status), resident has nausea/vomiting yesterday, did not eat breakfast, had sips of water. Background: A case of hypertension, DM, cerebral infarction. Assessment: Resident in bed, lethargic, stated " I don't feel good "skin warm and dry to touch, lungs sound diminished on bases, abdomen soft,	F 622		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 25	F 622		

resident refusing to eat and drink, she will open eyes when talk to, later go back to sleep, vital signs: blood pressure 139/75, temperature 97.6, pulse 98, respirations18, oxygen saturation 92% on room air, blood sugar 168. Response: Resident seen by NP (nurse practitioners), order to send resident to ER (emergency room) for evaluation and treatment, RP notified, resident sent to ER, all paper work completed and sent with patient."

A request for clinical documents sent to the receiving facility with the resident was made on 8/29/22 at 1:45 PM.

An interview was conducted on 8/30/22 at 9:55 AM, with LPN (licensed practical nurse) #2. When asked what documents are sent with the resident to the hospital, LPN #2 stated, "We are to send the medication list and any recent labs. I believe the orders and maybe the care plan."

An interview was conducted on 8/30/22 at 4:20 PM, with RN (registered nurse) #2. When asked what documents are sent with the resident to the hospital, RN #2 stated, "Nursing sends out transfer documents, we are supposed to send out labs, SBAR (situation/background/assessment/recommendation), vital signs. We do not even have a chance to fill out the paperwork. We give a verbal report to the EMS (emergency medical squad) and the hospital. I am not so sure we send the care plan. We give verbal report to the nurse." When asked how do you evidence what was sent to the hospital, RN #2 stated, "I document that I gave the verbal report."

On 8/30/22 at 5:30 PM, ASM (administrative staff

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F 622	Continued From page 26 member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings. A review of the facility's "Transfer of Residents from the Facility" policy, dated 12/2020, revealed the following: "Procedure: Emergency transfers of residents for medical reasons will be completed promptly. Family notifications will occur as soon as possible, or within twenty-four (24) hours. Emergency transfers are for: A. Health problems: Emergency medical care is needed at a level not available in the nursing home. Discharge materials are provided (see discharge planning procedure)." A review of the facility's "Discharge Planning Documentation" policy, dated 11/2020, revealed the following: "At the time of discharge, a discharge summary and home-going instructions are provided to the resident or the resident's caregiver which will include the following: A. Current diagnosis, B. Rehabilitation potential, C. Summary of prior treatment, D. Physician's orders for immediate care and E. Pertinent social information. No further information was provided prior to exit. 3. The facility staff failed to evidence provision of required resident information to a receiving facility at the time of discharge for Resident #90. Resident #90 was transferred to the hospital on 7/6/22. Resident #90 was admitted to the facility on 5/16/22 with diagnoses that included but were not limited to: diabetes mellitus (DM), congestive	F 622		

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F 622	Continued From page 27 heart failure (CHF) alcoholic cirrhosis and hypertension. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/2/22, coded the resident as scoring a 04 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bathing, bed mobility, transfer, dressing, eating and hygiene. A review of the comprehensive care plan dated 5/16/22, revealed, "FOCUS: Resident has physical functioning deficit related to: weakness, unsteadiness on feet, COPD (chronic obstructive pulmonary disease), Bipolar disorder, depression. INTERVENTIONS: Encourage choices with care, assistance with my ADL care, call bell within reach." There was no evidence of hospital transfer documents sent with the resident to the hospital on 7/6/22. A review of the nursing progress note dated 7/6/22 at 1:56 PM, revealed, "Situation: Resident alert and responsive with confusion. Resident baseline oriented x 1-2. Observed with decline with cognitive function and AMS (altered mental status) with (R) sided weakness. Background: Alcoholic Cirrhosis of the liver, Encephalopathy, DM2, CHF. Assessment: vital signs: blood pressure 108/81, pulse 87, temperature 97.0, respirations 18, oxygen saturation 94% on room air. Resident with noticeable lean to (R) side in wheelchair. Unable to performed baseline ADLs	F 622		

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F 622	Continued From page 28 (activities of daily living) within Resident's normal levels. Confusion noted. Response: Condition reported to NP (nurse practitioner) and then assessed. Resident given new order to be sent out to emergency room. RP made aware. Resident left facility via stretcher at 12:30pm." A request for clinical documents sent to the facility with the resident was made on 8/29/22 at 1:45 PM. An interview was conducted on 8/30/22 at 9:55 AM, with LPN (licensed practical nurse) #2. When asked what documents are sent with the resident to the hospital, LPN #2 stated, "We are to send the medication list and any recent labs. I believe the orders and maybe the care plan." An interview was conducted on 8/30/22 at 4:20 PM, with RN (registered nurse) #2. When asked what documents are sent with the resident to the hospital, RN #2 stated, "Nursing sends out transfer documents, we are supposed to send out labs, SBAR (situation/background/assessment/recommendation), vital signs. We do not even have a chance to fill out the paperwork. We give a verbal report to the EMS (emergency medical squad) and the hospital. I am not so sure we send the care plan. We give verbal report to the nurse." When asked how do you evidence what was sent to the hospital, RN #2 stated, "I document that I gave the verbal report." On 8/30/22 at 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings.	F 622		

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F 622	Continued From page 29 A review of the facility's "Transfer of Residents from the Facility" policy, dated 12/2020, revealed the following: "Procedure: Emergency transfers of residents for medical reasons will be completed promptly. Family notifications will occur as soon as possible, or within twenty-four (24) hours. Emergency transfers are for: A. Health problems: Emergency medical care is needed at a level not available in the nursing home. Discharge materials are provided (see discharge planning procedure)." A review of the facility's "Discharge Planning Documentation" policy, dated 11/2020, revealed the following: "At the time of discharge, a discharge summary and home-going instructions are provided to the resident or the resident's caregiver which will include the following: A. Current diagnosis, B. Rehabilitation potential, C. Summary of prior treatment, D. Physician's orders for immediate care and E. Pertinent social information. No further information was provided prior to exit. 4. During the course of a complaint investigation, it was determined that the facility staff failed to evidence written communication to the receiving healthcare provider for a facility initiated transfer on 4/2/2022. For Resident #16 (R16), there was no evidence of the facility providing contact information of the practitioner responsible for care of the resident, resident representative information, advance directive information, instructions for ongoing care and comprehensive care plan goals at the time of transfer. This deficiency was unrelated to the complaint allegations.	F 622		

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F 622	Continued From page 30 On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/4/2022, the resident scored 99 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section J documented R16 having one fall with injury since the previous assessment. The progress notes for R16 documented in part, - "4/2/2022 13:38 (1:38 p.m.) Situation: At 1210pm Resident fall out of chair in lounge room with laceration to left temporal/bleeding heavy...Awake and responsive to staff pressure applied to wound. Response: [Name of hospice] notified, son [Name of son] (wife) updated, NP (nurse practitioner) [Name of NP] updated, Sent via EMS (emergency medical services) to [Name of hospital]." - "4/2/2022 13:51 (1:51 p.m.) Report called in to [Name of staff member] in ER (emergency room) department [Name of hospital]." - "4/2/2022 18:48 (6:48 p.m.) Resident to return to facility this evening per [Name of hospital]." - "4/2/2022 19:20 (7:20 p.m.) Resident arrived back at facility at this time via [Name of transport]. No new orders. NP and resident family made aware of residents return to facility." R16's clinical record failed to evidence documentation of information provided to the hospital on 4/2/2022. On 8/29/2022 at approximately 3:30 p.m., a request was made to ASM (administrative staff member) #1, the administrator, for evidence of information provided to the receiving provider for the facility-initiated transfer on 4/2/2022 for R16.	F 622		

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F 622	Continued From page 31 On 8/30/2022 at 4:25 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated that when residents were transferred to the hospital they sent any recent labs and a SBAR (situation, background, assessment, recommendation) note with the resident. RN #2 stated that they gave a verbal report to the EMS provider and to the emergency room. RN #2 stated that they were not sure if the care plan goals were sent or not because it was different at each facility. RN #2 stated that they documented what was provided to the hospital in the progress notes because there were times when the documents went missing. On 8/30/2022 at 3:32 p.m., ASM #2, the regional vice president of operations stated that they did not have evidence to provide of the documents provided to the hospital for the facility-initiated transfer on 4/2/2022 for R16. On 8/30/2022 at approximately 5:30 p.m., ASM #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit. 5. For Resident #116 (R116), The facility staff failed to evidence transfer documentation was provided to the receiving facility for a facility-initiated transfer on 7/15/2022. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/28/2022, the resident scored 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was	F 622		

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F 622	Continued From page 32 cognitively intact for making daily decisions. The progress notes for R116 documented in part, - "7/15/2022 18:55 (6:55 p.m.) Situation: Resident presenting with s/s (signs, symptoms) of altered mental status...Response: On-Call NP (nurse practitioner) [Name of NP] notified and made aware of the RP's (responsible parties) concerns and agreed to send resident to ER (emergency room) for further evaluation." - "7/15/2022 23:00 (11:00 p.m.) Resident admitted to [Name of hospital] Dx: (diagnoses) Altered Mental Status, UTI (urinary tract infection) with hematuria." - "7/18/2022 15:50 (3:50 p.m.) Please note that his family declined a bed hold d/t (due to) the resident discharging to another facility from the hospital." R116's clinical record failed to evidence documentation of information provided to the hospital on 7/15/2022. On 8/30/2022 at approximately 5:30 p.m., a request was made to ASM (administrative staff member) #1, the administrator, for evidence of information provided to the receiving provider for the facility-initiated transfer on 7/15/2022 for R116. On 8/30/2022 at 4:25 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated that when residents were transferred to the hospital they sent any recent labs and a SBAR (situation, background, assessment, recommendation) note with the resident. RN #2 stated that they gave a verbal report to the EMS provider and to the emergency room. RN #2 stated that they were not sure if the care plan	F 622		

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F 622	Continued From page 33 goals were sent or not because it was different at each facility. RN #2 stated that they documented what was provided to the hospital in the progress notes because there were times when the documents went missing. On 8/31/2022 at 7:53 a.m., ASM #3, the regional director of clinical services stated that they did not have evidence to provide of the documents provided to the hospital for the facility-initiated transfer on 7/15/2022 for R116. On 8/31/2022 at approximately 10:00 a.m., ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.	F 622	F623 1) Resident #116 is no longer in the center. Resident's #56, #94, #90, #34, #16, remains safely in the center and evidence of written RP and ombudsman notification is available for current hospital transfers. 2) Current Residents in the facility that have been transferred to the hospital have the potential to be affected.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623	3) The DON/designee provided re-education to the Social Services team regarding the notification to the Ombudsman and written notification being sent to the Resident representative. Results of audits will be reviewed at the monthly QAPI meeting. Any discrepancies will be addressed immediately.	

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F 623	Continued From page 34 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and	F 623	4) Transfers will be audited weekly for 1 month to ensure there is evidence of notification to the Ombudsman and written notification to the Resident representative. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 9/28/2022	

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F 623	Continued From page 35 telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review,	F 623		

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F 623	Continued From page 36	F 623		

facility document review and in the course of a complaint investigation, it was determined the facility staff failed to provide evidence of written RP (responsible party) and/or ombudsman notification when six out of 47 residents in the survey sample were transferred to the hospital; Residents #56, #94, #90, #34, #16 and #116.

The findings include:

1. The facility staff failed to provide evidence of written RP notification when Resident #56 was transferred to the hospital on 7/4/22.

Resident #56 was admitted to the facility on 4/11/22 with diagnoses that included but were not limited to: Alzheimer's disease, dementia and cerebral infarction.

The most recent MDS (minimum data set) assessment, a 5 day Medicare assessment, with an ARD (assessment reference date) of 7/14/22, coded the resident as scoring a 05 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired.

A review of the nursing progress note dated 7/4/22 at 9:00 AM, revealed, "Situation: Resident status post fall. Right sided hip pain. Background: Resident found on previous shift on the floor of her room. Resident assessed, assisted to bed and neuro checks performed. Hospice notified and came and assessed resident. Assessment: Resident complained of extreme right sided hip pain. Resident in distress while ADL's (activities of daily living) performed. Assessed and this nurse decided to send to ER (emergency room). Response: NP (nurse

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F 623	Continued From page 37 practitioner) and RP (responsible party) notified." A request for evidence of written RP and ombudsman notification was made to the facility on 8/30/22 at 4:00 PM. Ombudsman notification was provided, however there was no evidence of written RP notification. An interview was conducted on 8/30/22 at 9:55 AM, with LPN (licensed practical nurse) #2. When asked how RPs are notified of a hospital transfer, LPN #2 stated, we call them but we do not send anything in writing. An interview was conducted on 8/30/22 at 4:20 PM, with RN (registered nurse) #2. When asked how the RPs are notified of a hospital transfer, RN #2 stated, we call the RP and document it in a progress note. When asked if they send any notification in writing to the RP, RN #2 stated, we do not do that. An interview was conducted on 8/30/22 at 4:35 PM, with OSM (other staff member) #2, the social services director. When asked who provides written notification to the RP and ombudsman, OSM #2 stated, "My responsibility is to contact RPs afterward to offer them the bed hold. I do not send any type of written notification of transfer, I only speak to them on the phone so they know they are in the hospital. I only send anything if I cannot reach the RP by phone. I would send it out by mail then. Ombudsman notification is sent every month. I send out a list of all residents discharged from the facility. At beginning of month send out the discharges from previous month. I do the discharged out, some may have been to the hospital, includes all of	F 623		

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F 623	Continued From page 38	F 623		

them. I have a binder where I keep the fax cover sheet, I send to the local ombudsman."

On 8/30/22 at 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings.

A review of the facility's "Family Notification" policy dated 12/2020, revealed the following: "The family will be notified of any resident changes. i.e.: A. Room changes, B. Health problems and C. Accomplishments."

No further information was provided prior to exit.

2. The facility staff failed to provide evidence of written RP notification for Resident #94 when transferred to the hospital on 7/26/22.

Resident #94 was admitted to the facility on 10/19/21 with diagnosis that included but were not limited to: cerebrovascular accident, hemiplegia, diabetes mellitus (DM), pneumonia and hypertension.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/2/22, coded the resident as scoring a 99 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was unable to complete the interview.

A request for evidence of written RP and ombudsman notification was made to the facility on 8/29/22 at 1:45 PM.

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F 623	Continued From page 39 Ombudsman notification was provided, however there was no evidence of written RP notification. A review of the nursing progress note dated 7/26/22 at 11:52 AM, revealed, "Situation: Resident lethargic, feeling very week, AMS (altered mental status), resident has nausea/vomiting yesterday, did not eat breakfast, had sips of water. Background: A case of hypertension, DM, cerebral infarction. Assessment: Resident in bed, lethargic, stated " I don't feel good "skin warm and dry to touch, lungs sound diminished on bases, abdomen soft, resident refusing to eat and drink, she will open eyes when talk to, later go back to sleep, vital signs: blood pressure 139/75, temperature 97.6, pulse 98, respirations18, oxygen saturation 92% on room air, blood sugar 168. Response: Resident seen by NP (nurse practitioners), order to send resident to ER (emergency room) for evaluation and treatment, RP notified, resident sent to ER, all paper work completed and sent with patient." An interview was conducted on 8/30/22 at 9:55 AM, with LPN (licensed practical nurse) #2. When asked how RPs are notified of a hospital transfer, LPN #2 stated, we call them but we do not send anything in writing. An interview was conducted on 8/30/22 at 4:20 PM, with RN (registered nurse) #2. When asked how the RPs are notified of a hospital transfer, RN #2 stated, we call the RP and document it in a progress note. When asked if they send any notification in writing to the RP, RN #2 stated, we do not do that. An interview was conducted on 8/30/22 at 4:35	F 623		

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F 623	Continued From page 40 PM, with OSM (other staff member) #2, the social services director. When asked who provides written notification to the RP and ombudsman, OSM #2 stated, "My responsibility is to contact RPs afterward to offer them the bed hold. I do not send any type of written notification of transfer, I only speak to them on the phone so they know they are in the hospital. I only send anything if I cannot reach the RP by phone. I would send it out by mail then. Ombudsman notification is sent every month. I send out a list of all residents discharged from the facility. At beginning of month send out the discharges from previous month. I do the discharged out, some may have been to the hospital, includes all of them. I have a binder where I keep the fax cover sheet, I send to the local ombudsman." On 8/30/22 at 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings. A review of the facility's "Family Notification" policy dated 12/2020, revealed the following: "The family will be notified of any resident changes. i.e.: A. Room changes, B. Health problems and C. Accomplishments." No further information was provided prior to exit. 3. The facility staff failed to provide evidence of written RP notification for Resident #90 when transferred to the hospital on 7/6/22. Resident #90 was admitted to the facility on 5/16/22 with diagnosis that included but were not limited to: diabetes mellitus (DM), congestive	F 623		

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F 623	Continued From page 41 heart failure (CHF) alcoholic cirrhosis and hypertension. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/2/22, coded the resident as scoring a 04 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A request for evidence of written RP and ombudsman notification was made to the facility on 8/29/22 at 1:45 PM. Ombudsman notification was provided, however there was no evidence of written RP notification. A review of the nursing progress note dated 7/6/22 at 1:56 PM, revealed, "Situation: Resident alert and responsive with confusion. Resident baseline oriented x 1-2. Observed with decline with cognitive function and AMS (altered mental status) with (R) sided weakness. Background: Alcoholic Cirrhosis of the liver, Encephalopathy, DM2, CHF. Assessment: vital signs: blood pressure 108/81, pulse 87, temperature 97.0, respirations 18, oxygen saturation 94% on room air. Resident with noticeable lean to (R) side in wheelchair. Unable to performed baseline ADLs (activities of daily living) within Resident's normal levels. Confusion noted. Response: Condition reported to NP (nurse practitioner) and then assessed. Resident given new order to be sent out to emergency room. RP made aware. Resident left facility via stretcher at 12:30pm." An interview was conducted on 8/30/22 at 9:55 AM, with LPN (licensed practical nurse) #2.	F 623		

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F 623	Continued From page 42 When asked how RPs are notified of a hospital transfer, LPN #2 stated, we call them but we do not send anything in writing. An interview was conducted on 8/30/22 at 4:20 PM, with RN (registered nurse) #2. When asked how the RPs are notified of a hospital transfer, RN #2 stated, we call the RP and document it in a progress note. When asked if they send any notification in writing to the RP, RN #2 stated, we do not do that. An interview was conducted on 8/30/22 at 4:35 PM, with OSM (other staff member) #2, the social services director. When asked who provides written notification to the RP and ombudsman, OSM #2 stated, "My responsibility is to contact RPs afterward to offer them the bed hold. I do not send any type of written notification of transfer, I only speak to them on the phone so they know they are in the hospital. I only send anything if I cannot reach the RP by phone. I would send it out by mail then. Ombudsman notification is sent every month. I send out a list of all residents discharged from the facility. At beginning of month send out the discharges from previous month. I do the discharged out, some may have been to the hospital, includes all of them. I have a binder where I keep the fax cover sheet, I send to the local ombudsman." On 8/30/22 at 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings. A review of the facility's "Family Notification" policy dated 12/2020, revealed the following:	F 623		

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F 623	Continued From page 43 "The family will be notified of any resident changes. i.e.: A. Room changes, B. Health problems and C. Accomplishments." No further information was provided prior to exit. 4. The facility staff failed to provide evidence of written RP notification was provided for Resident #34 when transferred to the hospital on 7/29/22. Resident #34 was admitted to the facility on 12/14/19 with diagnosis that included but were not limited to: diabetes mellitus (DM), chronic obstructive pulmonary disease (COPD), hemiplegia and sick sinus syndrome. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/28/22, coded the resident as scoring a 09 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A request for evidence of written RP and ombudsman notification was made to the facility on 8/29/22 at 1:45 PM. Ombudsman notification was provided, however there was no evidence of written RP notification. A review of the nursing progress note dated 7/29/22 at 10:00 AM, revealed, "Situation: Chest pain. Background: Resident complained of chest pain in the middle of her chest. Resident crying and this nurse went into her room to see what was wrong. Not radiating anywhere else. Vitals were normal blood pressure 127/67, temperature 97.8, pulse 75, respirations 18 and oxygen	F 623		

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F 623	Continued From page 44 saturation 94%. Assessment: NP (nurse practitioner) notified and came to evaluate the resident. Advised to send resident to the ER (emergency room). Response: Resident sent by rescue squad to hospital. RP notified." An interview was conducted on 8/30/22 at 9:55 AM, with LPN (licensed practical nurse) #2. When asked how RPs are notified of a hospital transfer, LPN #2 stated, we call them but we do not send anything in writing. An interview was conducted on 8/30/22 at 4:20 PM, with RN (registered nurse) #2. When asked how the RPs are notified of a hospital transfer, RN #2 stated, we call the RP and document it in a progress note. When asked if they send any notification in writing to the RP, RN #2 stated, we do not do that. An interview was conducted on 8/30/22 at 4:35 PM, with OSM (other staff member) #2, the social services director. When asked who provides written notification to the RP and ombudsman, OSM #2 stated, "My responsibility is to contact RPs afterward to offer them the bed hold. I do not send any type of written notification of transfer, I only speak to them on the phone so they know they are in the hospital. I only send anything if I cannot reach the RP by phone. I would send it out by mail then. Ombudsman notification is sent every month. I send out a list of all residents discharged from the facility. At beginning of month send out the discharges from previous month. I do the discharged out, some may have been to the hospital, includes all of them. I have a binder where I keep the fax cover sheet, I send to the local ombudsman."	F 623		

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F 623	Continued From page 45 On 8/30/22 at 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings. A review of the facility's "Family Notification" policy dated 12/2020, revealed the following: "The family will be notified of any resident changes. i.e.: A. Room changes, B. Health problems and C. Accomplishments." No further information was provided prior to exit. 5. During the course of a complaint investigation, it was determined that the facility staff failed to evidence written notification of transfer to the responsible party or notification to the ombudsman for a facility-initiated transfer on 4/2/2022 for Resident #16 (R16). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/4/2022, the resident scored 99 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section J documented R16 having one fall with injury since the previous assessment. The progress notes for R16 documented in part, - "4/2/2022 13:38 (1:38 p.m.) Situation: At 1210pm Resident fall out of chair in lounge room with laceration to left temporal/bleeding heavy...Awake and responsive to staff pressure applied to wound. Response: [Name of hospice] notified, son [Name of son] (wife) updated, NP (nurse practitioner) [Name of NP] updated, Sent via EMS (emergency medical services) to [Name of hospital]."	F 623		

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F 623	Continued From page 46 - "4/2/2022 13:51 (1:51 p.m.) Report called in to [Name of staff member] in ER (emergency room) department [Name of hospital]." - "4/2/2022 18:48 (6:48 p.m.) Resident to return to facility this evening per [Name of hospital]." - "4/2/2022 19:20 (7:20 p.m.) Resident arrived back at facility at this time via [Name of transport]. No new orders. NP and resident family made aware of residents return to facility." R16's clinical record failed to evidence documentation of written notification of transfer to the responsible party or notification to the ombudsman of the facility-initiated transfer on 4/2/2022. On 8/29/2022 at approximately 3:30 p.m., a request was made to ASM (administrative staff member) #1, the administrator, for evidence of written notification of transfer to the responsible party and notification to the ombudsman for the facility-initiated transfer on 4/2/2022 for R16. On 8/30/2022 at 4:25 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated that when residents were transferred to the hospital they sent any recent labs and a SBAR (situation, background, assessment, recommendation) note with the resident. RN #2 stated that nursing did not provide a written notification of transfer to the responsible party and they only verbally notified them. RN #2 stated that they did not know who provided the bed hold notice. RN #2 stated that the documents that they provided to the emergency room would be documented in the progress notes. On 8/30/2022 at 4:35 p.m., an interview was	F 623		

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F 623	Continued From page 47 conducted with OSM (other staff member) #2, the social services director. OSM #2 stated that the nurses provided the clinical information to the hospital for resident transfers and sent a bed hold notice with them. OSM #2 stated that their responsibility was to contact the responsible party after they were admitted to the hospital to offer the bed hold. OSM #2 stated that they did not send any type of written notification of transfer. OSM #2 stated that they spoke with the responsible party over the telephone and they already knew they were in the hospital at that point. OSM #2 stated that they sent a letter to the responsible party if they were unable to reach the responsible party by telephone. OSM #2 stated that they send out the ombudsman notification monthly and used a list that they pulled from the electronic medical record. OSM #2 stated that they kept a binder with the fax cover sheet and confirmation in their office. OSM #2 stated that they did not have evidence of ombudsman notification for the facility-initiated transfer of R16 on 4/2/2022 because the computer did not put them on the list when they ran it for April. OSM #2 stated that they went by what printed out on the report and sent that to the ombudsman and that it should include discharges and hospitalizations. On 8/30/2022 at 3:32 p.m., ASM #2, the regional vice president of operations stated that they did not have evidence to provide of written notification of transfer to the responsible party or notification to the ombudsman for the facility-initiated transfer on 4/2/2022 for R16. On 8/30/2022 at approximately 5:30 p.m., ASM #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional	F 623		

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F 623	Continued From page 48 director of clinical services were made aware of the findings. No further information was provided prior to exit. 6. For Resident #116 (R116), the facility staff failed to evidence written notification of transfer provided to the responsible party for a facility-initiated transfer on 7/15/2022. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/28/2022, the resident scored 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. The progress notes for R116 documented in part, - "7/15/2022 18:55 (6:55 p.m.) Situation: Resident presenting with s/s (signs, symptoms) of altered mental status...Response: On-Call NP (nurse practitioner) [Name of NP] notified and made aware of the RP's (responsible parties) concerns and agreed to send resident to ER (emergency room) for further evaluation." - "7/15/2022 23:00 (11:00 p.m.) Resident admitted to [Name of hospital] Dx: (diagnoses) Altered Mental Status, UTI (urinary tract infection) with hematuria." - "7/18/2022 15:50 (3:50 p.m.) Please note that his family declined a bed hold d/t (due to) the resident discharging to another facility from the hospital." R116's clinical record failed to evidence written notification of transfer to the responsible party provided for the facility-initiated transfer on 7/15/2022.	F 623		

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F 623	Continued From page 49 On 8/30/2022 at approximately 5:30 p.m., a request was made to ASM (administrative staff member) #1, the administrator, for evidence of written notification of transfer to the responsible party provided for the facility-initiated transfer on 7/15/2022 for R116. On 8/30/2022 at 4:25 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated that when residents were transferred to the hospital they sent any recent labs and a SBAR (situation, background, assessment, recommendation) note with the resident. RN #2 stated that nursing did not provide a written notification of transfer to the responsible party and they only verbally notified them. RN #2 stated that they did not know who provided the bed hold notice. RN #2 stated that the documents that they provided to the emergency room would be documented in the progress notes. On 8/30/2022 at 4:35 p.m., an interview was conducted with OSM (other staff member) #2, the social services director. OSM #2 stated that they did not send any type of written notification of transfer. OSM #2 stated that they spoke with the responsible party over the telephone and they already knew they were in the hospital at that point. OSM #2 stated that they sent a letter to the responsible party if they were unable to reach the responsible party by telephone. On 8/31/2022 at 7:53 a.m., ASM #3, the regional director of clinical services stated that they did not have evidence to provide of written notification of transfer to the responsible party for the facility-initiated transfer on 7/15/2022 for R116.	F 623		

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FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

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F 623	Continued From page 50 On 8/31/2022 at approximately 10:00 a.m., ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.	F 623	F625 1) Residents #56, #94, #90 and #34 remain safely in the center and evidence of bed hold policy being sent for hospital transfers is available. 2) Current Residents that are transferred to the hospital have the potential to be affected. 3) The DON/designee provided re-education to the Social Services and Business Office regarding the Transfer to Hospital policy related to bed holds. 4) Transfers will be audited weekly for 1 month to ensure evidence of bed hold policy was provided. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 9/28/2022	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		

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by:
Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence that bed hold notification was provided when four out of 47 residents in the survey sample were transferred to the hospital; Residents #56, #94, #90 and #34.

The findings include:

1. The facility staff failed to provide evidence of that a bed hold notification was provided when Resident #56 was transferred to the hospital on 7/4/22.

Resident #56 was admitted to the facility on 4/11/22 with diagnosis that included but were not limited to: Alzheimer's disease, dementia and cerebral infarction.

The most recent MDS (minimum data set) assessment, a 5 day Medicare assessment, with an ARD (assessment reference date) of 7/14/22, coded the resident as scoring a 05 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired.

A review of the nursing progress note dated 7/4/22 at 9:00 AM, revealed, "Situation: Resident status post fall. Right sided hip pain. Background: Resident found on previous shift on the floor of her room. Resident assessed, assisted to bed and neuro checks performed. Hospice notified and came and assessed resident. Assessment: Resident complained of extreme right sided hip pain. Resident in distress while ADL's (activities of daily living) performed. Assessed and this nurse decided to send to ER

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(emergency room). Response: NP (nurse practitioner) and RP (responsible party) notified."

A request for evidence of bed hold was made to the facility on 8/30/22 at 4:00 PM. There was no evidence of bed hold.

An interview was conducted on 8/30/22 at 9:55 AM, with LPN (licensed practical nurse) #2. When asked who provides the bed hold for residents transferred to the hospital, LPN #2 stated, we may send the bed hold policy, not sure that we do though.

An interview was conducted on 8/30/22 at 4:20 PM, with RN (registered nurse) #2. When asked how the bed hold is provided upon hospital transfer, RN #2 stated, the bed hold is to go with the resident to the hospital.

An interview was conducted on 8/30/22 at 4:35 PM, with OSM (other staff member) #2, the social services director. When asked who provides the bed hold, OSM #2 stated, nurses have the bed hold policy attached to the paperwork that goes with the resident to the hospital. My responsibility is to contact residents afterwards to offer them the bed hold.

On 8/30/22 at 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings.

A review of the facility's "Bed Hold- Pre Admission Reservation" policy dated 11/2020, revealed the following: "Policy: A potential resident's bed will be held vacant for that resident if payment is

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F 625	Continued From page 53 made for each day the resident awaits admission." No further information was provided prior to exit. 2. The facility staff failed to provide evidence of that a bed hold notification was provided for Resident #94 when transferred to the hospital on 7/26/22. Resident #94 was admitted to the facility on 10/19/21 with diagnoses that included but were not limited to: cerebrovascular accident, hemiplegia, diabetes mellitus (DM), pneumonia and hypertension. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/2/22, coded the resident as scoring a 99 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was unable to complete the interview. A review of the nursing progress note dated 7/26/22 at 11:52 AM, revealed, "Situation: Resident lethargic, feeling very week, AMS (altered mental status), resident has nausea/vomiting yesterday, did not eat breakfast, had sips of water. Background: A case of hypertension, DM, cerebral infarction. Assessment: Resident in bed, lethargic, stated " I don't feel good "skin warm and dry to touch, lungs sound diminished on bases, abdomen soft, resident refusing to eat and drink, she will open eyes when talk to, later go back to sleep, vital signs: blood pressure 139/75, temperature 97.6, pulse 98, respirations18, oxygen saturation 92% on room air, blood sugar 168. Response:	F 625		

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F 625	Continued From page 54 Resident seen by NP (nurse practitioners), order to send resident to ER (emergency room) for evaluation and treatment, RP notified, resident sent to ER, all paper work completed and sent with patient." A request for evidence of a bed hold was made to the facility on 8/29/22 at 1:45 PM. There was no evidence of bed hold. An interview was conducted on 8/30/22 at 9:55 AM, with LPN (licensed practical nurse) #2. When asked who provides the bed hold for residents transferred to the hospital, LPN #2 stated, we may send the bed hold policy, not sure that we do though. An interview was conducted on 8/30/22 at 4:20 PM, with RN (registered nurse) #2. When asked how the bed hold is provided upon hospital transfer, RN #2 stated, the bed hold is to go with the resident to the hospital. An interview was conducted on 8/30/22 at 4:35 PM, with OSM (other staff member) #2, the social services director. When asked who provides the bed hold, OSM #2 stated, nurses have the bed hold policy attached to the paperwork that goes with the resident to the hospital. My responsibility is to contact residents afterwards to offer them the bed hold. On 8/30/22 at 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings. A review of the facility's "Bed Hold- Pre Admission	F 625		

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Reservation" policy dated 11/2020, revealed the following: "Policy: A potential resident's bed will be held vacant for that resident if payment is made for each day the resident awaits admission."

No further information was provided prior to exit.

3. The facility staff failed to provide evidence that a bed hold notification was provided for Resident #90 when transferred to the hospital on 7/6/22.

Resident #90 was admitted to the facility on 5/16/22 with diagnosis that included but were not limited to: diabetes mellitus (DM), congestive heart failure (CHF) alcoholic cirrhosis and hypertension.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/2/22, coded the resident as scoring a 04 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired.

A review of the nursing progress note dated 7/6/22 at 1:56 PM, revealed, "Situation: Resident alert and responsive with confusion. Resident baseline oriented x 1-2. Observed with decline with cognitive function and AMS (altered mental status) with (R) sided weakness. Background: Alcoholic Cirrhosis of the liver, Encephalopathy, DM2, CHF. Assessment: vital signs: blood pressure 108/81, pulse 87, temperature 97.0, respirations 18, oxygen saturation 94% on room air. Resident with noticeable lean to (R) side in wheelchair. Unable to performed baseline ADLs (activities of daily living) within Resident's normal

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F 625	Continued From page 56	F 625		

levels. Confusion noted. Response: Condition reported to NP (nurse practitioner) and then assessed. Resident given new order to be sent out to emergency room. RP made aware. Resident left facility via stretcher at 12:30pm."

A request for evidence of a bed hold was made to the facility on 8/29/22 at 1:45 PM. There was no evidence of bed hold.

An interview was conducted on 8/30/22 at 9:55 AM, with LPN (licensed practical nurse) #2. When asked who provides the bed hold for residents transferred to the hospital, LPN #2 stated, we may send the bed hold policy, not sure that we do though.

An interview was conducted on 8/30/22 at 4:20 PM, with RN (registered nurse) #2. When asked how the bed hold is provided upon hospital transfer, RN #2 stated, the bed hold is to go with the resident to the hospital.

An interview was conducted on 8/30/22 at 4:35 PM, with OSM (other staff member) #2, the social services director. When asked who provides the bed hold, OSM #2 stated, nurses have the bed hold policy attached to the paperwork that goes with the resident to the hospital. My responsibility is to contact residents afterwards to offer them the bed hold.

On 8/30/22 at 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings.

A review of the facility's "Bed Hold- Pre Admission

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Reservation" policy dated 11/2020, revealed the following: "Policy: A potential resident's bed will be held vacant for that resident if payment is made for each day the resident awaits admission."

No further information was provided prior to exit.

4. The facility staff failed to provide evidence of that a bed hold notification was provided for Resident #34. Resident #34 was transferred to the hospital on 7/29/22.

Resident #34 was admitted to the facility on 12/14/19 with diagnosis that included but were not limited to: diabetes mellitus (DM), chronic obstructive pulmonary disease (COPD), hemiplegia and sick sinus syndrome.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/28/22, coded the resident as scoring a 09 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired.

A review of the nursing progress note dated 7/29/22 at 10:00 AM, revealed, "Situation: Chest pain. Background: Resident complained of chest pain in the middle of her chest. Resident crying and this nurse went into her room to see what was wrong. Not radiating anywhere else. Vitals were normal blood pressure 127/67, temperature 97.8, pulse 75, respirations 18 and oxygen saturation 94%. Assessment: NP (nurse practitioner) notified and came to evaluate the resident. Advised to send resident to the ER (emergency room). Response: Resident sent by

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F 625	Continued From page 58	F 625		

rescue squad to hospital. RP notified."

A request for evidence of a bed hold was made to the facility on 8/29/22 at 1:45 PM. There was no evidence of bed hold.

An interview was conducted on 8/30/22 at 9:55 AM, with LPN (licensed practical nurse) #2. When asked who provides the bed hold for residents transferred to the hospital, LPN #2 stated, we may send the bed hold policy, not sure that we do though.

An interview was conducted on 8/30/22 at 4:20 PM, with RN (registered nurse) #2. When asked how the bed hold is provided upon hospital transfer, RN #2 stated, the bed hold is to go with the resident to the hospital.

An interview was conducted on 8/30/22 at 4:35 PM, with OSM (other staff member) #2, the social services director. When asked who provides the bed hold, OSM #2 stated, nurses have the bed hold policy attached to the paperwork that goes with the resident to the hospital. My responsibility is to contact residents afterwards to offer them the bed hold.

On 8/30/22 at 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings.

A review of the facility's "Bed Hold- Pre Admission Reservation" policy dated 11/2020, revealed the following: "Policy: A potential resident's bed will be held vacant for that resident if payment is made for each day the resident awaits

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F 625	Continued From page 59 admission." No further information was provided prior to exit.	F 625	F641 1) Resident #116 discharge MDS was immediately corrected to reflect discharged to hospital and Resident #31 annual assessment section O was immediately corrected. 2) Audit of discharged residents MDS in the last 30 days to ensure appropriate coding and an audit of current hospice residents annual MDS to ensure section O was coded appropriately. 3) Administrator/ Designee re-educated MDS department on properly coding per the RAI manual. 4) Hospice patients annual MDS section O and discharged residents MDS audited weekly for 1 month to ensure accurate coding. Results of audits will be reviewed at the monthly QAPI meeting. Any discrepancies will be addressed immediately. 5) Compliance Date: 9/28/2022	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to maintain an accurate MDS (minimum data set) assessment for two of 47 residents in the survey sample, Resident #116 and Resident #31. The findings include: 1. For Resident #116 (R116), the facility staff failed to accurately code a discharge MDS (minimum data set) assessment. The discharge MDS (minimum data set) for R116 with the ARD (assessment reference date) of 7/15/2022 coded R116 as being discharged to the community, however the progress notes reflected that R116 was admitted to the hospital on 7/15/2022. On the most recent prior MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/28/2022, the resident scored 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions.	F 641		

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F 641	Continued From page 60 Review of the clinical record revealed a list of R116's MDS assessments. The list revealed that a discharge MDS was completed on 7/15/2022. Section A of the assessment documented R116 with an unplanned discharge to the community with a return to the facility anticipated. The progress notes for R116 documented in part: - "7/15/2022 18:55 (6:55 p.m.) Situation: Resident presenting with s/s (signs, symptoms) of altered mental status...Response: On-Call NP (nurse practitioner) [Name of NP] notified and made aware of the RP's (responsible parties) concerns and agreed to send resident to ER (emergency room) for further evaluation." - "7/15/2022 23:00 (11:00 p.m.) Resident admitted to [Name of hospital] Dx: (diagnoses) Altered Mental Status, UTI (urinary tract infection) with hematuria." - "7/18/2022 15:50 (3:50 p.m.) Please note that his family declined a bed hold d/t (due to) the resident discharging to another facility from the hospital." On 8/30/2022 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #6, MDS coordinator. LPN #6 stated that they used the RAI (resident assessment instrument) as a guide when completing the MDS assessments. LPN #6 stated that they were made aware of resident discharges through morning meetings, the progress notes or the social worker. LPN #6 stated that they would review R116's MDS with the ARD of 7/15/2022 to determine if the coding for discharge to the community was accurate. On 8/30/2022 at 2:10 p.m., LPN #6 stated that they had reviewed the MDS with the ARD of	F 641		

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F 641	Continued From page 61 7/15/2022 for R116 and that it had been coded wrong. LPN #6 stated that the other MDS coordinator was correcting it to reflect that R116 was discharged to the hospital rather than home..." According to the RAI manual Version 3.0 Chapter 3, Section A2100: OBRA Discharge Status, documented in part, "...Steps for Assessment, 1. Review the medical record including the discharge plan and discharge orders for documentation of discharge location. On 8/30/2022 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit. 2. The facility staff failed to complete an accurate MDS (minimum data set); annual assessment for Resident #31. Resident #31 was admitted to the facility on 9/20/18 with diagnosis that included but were not limited to: dementia, atrial fibrillation, pacemaker and encephalopathy. The most recent MDS (minimum data set) assessment, a 5 day Medicare assessment, with an ARD (assessment reference date) of 6/15/22, coded the resident as scoring a 99 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was unable to complete the interview. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility,	F 641		

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	495240	A. BUILDING _____ B. WING _____	C 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 641	Continued From page 62 transfer, dressing, hygiene and bathing; supervision for locomotion and for eating. Section O-special procedures/treatments coded the resident as hospice "no". A review of the comprehensive care plan dated 6/17/22, which revealed, "FOCUS: The resident is on Hospice care related to: End of life care. INTERVENTIONS: coordinate care plan with Hospice. Notify hospice of any change in condition or medication changes. Provide emotional support to patient and family during decline in the dying process." A review of physician orders, dated 6/17/22, revealed the following, "Under services of Hospice as of 6/16/22." An interview was conducted on 8/30/22 at 1:41 PM with LPN (licensed practical nurse) #6, the MDS coordinator. When asked if a resident has an order for hospice, how the resident should be coded in Section O-Special Procedures and Treatments, LPN #6 stated, they should be coded as "yes". When asked what is the process followed for the MDS, LPN #6 stated, we follow the RAI (resident assessment instrument). On 8/30/22 at 2:11 PM, LPN #4 stated, "I went ahead and corrected it." On 8/30/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings. A review of the RAI "(MDS must be completed for	F 641		

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F 641	Continued From page 63 any resident residing in the facility, including: o All residents of Medicare (Title 18) skilled nursing facilities (SNFs) or Medicaid (Title 19) nursing facilities (NFs). This includes certified SNFs or NFs in hospitals, regardless of payment source. o Hospice residents: When a SNF or NF is the hospice resident's residence for purposes of the hospice benefit, the facility must comply with the Medicare or Medicaid participation requirements, meaning the resident must be assessed using the RAI, have a care plan and CMS's RAI Version 3.0 Manual CH 2: Assessments for the RAI be provided with the services required under the plan of care. This can be achieved through cooperation of both the hospice and long-term care facility staff (including participation in completing the RAI and care planning) with the consent of the resident." No further information was provided prior to exit.	F 641	F656 1) Resident #30 care plan is being implemented. 2) Audit of current Residents comprehensive care plans that have dialysis care to ensure they are being implemented. 3) Licensed staff will be re-educated on implementing dialysis care plans. 4) Audits of residents with dialysis will be conducted weekly for 1 month to ensure comprehensive care plans are being implemented. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 9/28/2022	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		

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F 656	Continued From page 64 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review and facility document review, it was determined the facility staff failed to implement the care plan for one of 47 residents in the survey sample, Resident #30. The findings include: The facility staff failed to implement the comprehensive care plan for dialysis care for Resident #30.	F 656		

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F 656	Continued From page 65 Resident #30 was admitted to the facility on 10/14/21 with diagnosis that included but were not limited to: end stage renal disease, peripheral vascular disease and gangrene. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/25/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; limited assistance for locomotion and supervision for eating. Section O-special procedures/treatments coded the resident as dialysis "yes". A review of the comprehensive care plan dated 10/15/21, which revealed, "FOCUS: The resident has alteration in Kidney Function Due to End Stage Renal Disease (ESRD), evidenced by hemodialysis. INTERVENTIONS: Written communication form with review of weights and any changes in condition between dialysis provider and living center." A review of physician orders, dated 10/18/21, revealed the following, "Dialysis Monday, Wednesday and Friday at 6AM in the morning related to END STAGE RENAL DISEASE, please send dialysis communication book." A review of Resident #30's dialysis communication book revealed missing communication to the dialysis facility for 15 of 53 visits from 5/1/22-8/31/22. The facility failed to	F 656		

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F 656	Continued From page 66 provide communication to the dialysis facility for 6 of 13 visits in May 2022, 4 of 13 visits in June 2022, 2 of 13 visits in July 2022 and 3 of 14 visits in August 2022. An interview was conducted on 8/29/22 at 4:00 PM with Resident #30. When asked if she takes her dialysis communication book with her to the dialysis center, Resident #3 stated, "Yes, I take the book with me. I did not have it when I returned today. I do not know if it is at the dialysis center or in the transportation van." An interview was conducted on 8/31/22 at 8:20 AM with LPN (licensed practical nurse) #4. When asked what information is provided to the dialysis facility when a resident is sent for hemodialysis, LPN #4 stated, the purpose of the dialysis communication sheet is to inform the center of resident's vital signs, weight and any pertinent information. The center sends back any pertinent information also. We check the bruit / thrill if they have a fistula and document that on the form. When asked if the care plan which reveals interventions of providing written communication to the dialysis center, and the information is not provided, is the care plan followed, LPN #4 stated, no, the care plan is not followed. On 8/31/22 at approximately 9:30 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.	F 656	F658 1) Professional Standards of Practice during administration of Symbicort inhaler are being followed. 2) Med pass audits of current residents on Symbicort conducted to ensure professional standards of practice are being followed. 3) DON/Designee re-educated Licensed nurses on professional standards of practice for administration of Symbicort. 4) Random audits of med pass will be conducted weekly for 1 month to ensure professional standards of practice are followed for Symbicort. Results of audits will be reviewed at the monthly QAPI meeting. Any discrepancies will be addressed immediately. 5) Compliance Date: 9/28/2022	
F 658 SS=D	Services Provided Meet Professional Standards	F 658		

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F 658	Continued From page 67 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 observation, staff interview, clinical record review and facility document review, it was determined facility staff failed to follow professional standards of practice during medication administration for one of five residents observed during the medication administration observation, Resident #83. The findings include: For Resident #83 (R83), the facility staff failed to follow medication administration standards of practice following the administration of a Symbicort inhaler (1). The facility staff did not have the resident rinse their mouth after administration of the inhaler. R83 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease (2). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (Assessment Reference Date) of 7/30/2022, the resident scored 5 out of 15 on the BIMS (brief interview for mental status) assessment indicating the resident was severely impaired for making daily decisions. On 8/30/2022 at 8:11 a.m., an observation of	F 658		

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F 658	Continued From page 68	F 658		

medication administration for R83 was conducted with LPN (licensed practical nurse) #8. LPN #8 prepared medications to administer to R83 including a Symbicort inhaler. LPN #8 administered the medications that were prepared to R83 and then handed the Symbicort inhaler to the resident. R83 was observed to self-administer two puffs of the inhaler and return the device to LPN #8. LPN #8 was then observed to wash their hands and return the inhaler back to the medication cart. LPN #8 failed to have R83 rinse their mouth with water after administration of the Symbicort inhaler.

The physician orders for R83 documented in part, "Budesonide-Formoterol Fumarate Aerosol 160-4.5 mcg/act (micrograms per actuation) 2 (two) puff inhale orally two times a day for copd...Order Date: 12/23/2021."

The comprehensive care plan for R83 documented in part, "I have alteration in Respiratory Status due to asthma, CHF (congestive heart failure), pulmonary emboli, COPD with exacerbation, bronchitis, SOB (shortness of breath) at times. Date Initiated: 03/30/2020."

The eMAR (electronic medication administration record) dated 8/1/2022-8/31/2022 documented R83 receiving the Symbicort inhaler each day at 9:00 a.m. and 6:00 p.m.

On 8/30/2022 at 10:29 a.m., an interview was conducted with LPN #8. LPN #8 stated that R83 administered the Symbicort inhaler themselves and they supervised. LPN #8 stated that they did not do anything extra after administering the Symbicort inhaler because the instructions on the

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F 658	Continued From page 69 eMAR stated two puffs. LPN #8 stated that when inhalers require rinsing the mouth afterwards the instructions on the eMAR normally tell them. LPN #8 stated that they knew that certain powder inhalers required rinsing the mouth with water afterwards to remove any residue. LPN #8 stated that they were not aware of Symbicort requiring a mouth rinse after administration and would review the manufacturer's instructions for use to clarify. On 8/30/2022 at approximately 5:30 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy on medication administration and the manufacturers instructions for use of Symbicort. The facility provided document, "Oral Drug Administration" from Lippincott failed to evidence guidance on inhaler administration. The facility provided manufacturers instructions for use of Symbicort documented in part, "Symbicort 80/4.5 (budesonide 80mcg and formoterol fumarate dihydrate 4.5mcg) inhalation aerosol. Symbicort 160/4.5 (budesonide 160mcg and formoterol fumarate dihydrate 4.5mcg) inhalation aerosol...In clinical studies, the development of localized infections of the mouth and pharynx with Candida albicans has occurred in patients treated with Symbicort...Advise the patient to rinse his/her mouth with water without swallowing following inhalation to help reduce the risk of oropharyngeal candidiasis..." On 8/30/2022 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations, and ASM #3, the regional director of clinical services were made aware of	F 658		

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F 658	Continued From page 70 the findings. No further information was presented prior to exit. References: 1. Symbicort SYMBICORT 160/4.5 mcg is used long-term to improve symptoms of chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema, for better breathing and fewer flare-ups. This information was obtained from the website: https://www.mysymbicort.com/ 2. chronic obstructive pulmonary disease (COPD) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.	F 658	F695 1) Physicians' order was obtained for resident #316 oxygen order. 2) Audit of current residents on oxygen to ensure professional standards of physician order in place. 3) DON/Designee to re-educate staff on professional standards of obtaining a physician order for oxygen	
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, staff interview, facility document review and clinical record review, the facility staff failed to provide respiratory care and	F 695	4) Random audits of residents on oxygen will be conducted weekly for 1 month to ensure professional standards of physician order in place. Results of audits will be reviewed at the monthly QAPI meeting. Any discrepancies will be addressed immediately. 5) Compliance Date: 9/28/2022	

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F 695	Continued From page 71 services according to professional standards for one of 47 residents in the survey sample, Resident #316. The facility staff failed to obtain a physician's order for Resident #316's (R316) use of oxygen. The findings include: R316's admission MDS (minimum data set) assessment was not complete. R316's admission data collection form dated 8/18/22 documented the resident's ability to make decisions regarding daily tasks of life was moderately impaired. R316's baseline care plan with an implementation date of 8/19/22 documented R316 was to receive continuous oxygen at two liters per minute via a nasal cannula. A review of R316's active physician's orders as of 8/30/22 failed to reveal a physician's order for oxygen. On 8/29/22 at 3:52 p.m. and 8/30/22 at 8:20 a.m., R316 was observed lying in bed receiving oxygen via nasal cannula at a rate between two and a half and three liters. On 8/30/22 at 2:57 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated oxygen can be administered as a nursing measure for acute situations but there is usually a physician's order for someone who routinely uses oxygen. LPN #3 stated, "Everything" needs a doctor's order. LPN #3 stated nurses know how much oxygen to administer to a resident based on the physician's order.	F 695		

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F 695	Continued From page 72 On 8/30/22 at approximately 5:45 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional vice president of operations) and ASM #3 (the regional director of clinical services) were made aware of the above concern. The facility document regarding oxygen administration documented, "Verify the practitioner's order for the oxygen therapy, because oxygen is considered a medication and should be prescribed." No further information was presented prior to exit.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review, and facility document review, it was determined the facility staff failed to provide dialysis care and services for one of 47 residents in the survey sample, Resident #30. The findings include: The facility failed to provide communication to the dialysis facility for 6 of 13 visits in May 2022, 4 of 13 visits in June 2022, 2 of 13 visits in July 2022 and 3 of 14 visits in August 2022, for a total of 15 of 53 visits with no communication.	F 698	F698 1) Resident #30 has evidence of ongoing communication with the dialysis center. 2) Current residents that receive dialysis were audited to ensure evidence of ongoing communication with the dialysis center. 3) DON/Designee re-educated Licensed nurses on dialysis policy. 4) Weekly audits for 1 month will be conducted on dialysis residents to ensure evidence of ongoing communication with the dialysis center. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 9/28/2022	

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F 698	Continued From page 73 Resident #30 was admitted to the facility on 10/14/21 with diagnosis that included but were not limited to: end stage renal disease, peripheral vascular disease and gangrene. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/25/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; limited assistance for locomotion and supervision for eating. Section O-special procedures/treatments coded the resident as dialysis "yes". A review of the comprehensive care plan dated 10/15/21, which revealed, "FOCUS: The resident has alteration in Kidney Function Due to End Stage Renal Disease (ESRD), evidenced by hemodialysis. INTERVENTIONS: Written communication form with review of weights and any changes in condition between dialysis provider and living center." A review of physician orders, dated 10/18/21, revealed the following, "Dialysis Monday, Wednesday and Friday at 6AM in the morning related to END STAGE RENAL DISEASE, please send dialysis communication book." A review of Resident #30's dialysis communication book revealed missing communication to the dialysis facility for 15 of 53 visits from 5/1/22-8/31/22.	F 698		

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FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

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F 698	Continued From page 74 An interview was conducted on 8/29/22 at 4:00 PM with Resident #30. When asked if she takes her dialysis communication book with her to the dialysis center, Resident #3 stated, "Yes, I take the book with me. I did not have it when I returned today. I do not know if it is at the dialysis center or in the transportation van." On 8/29/22 at 5:00 PM a request was made for the dialysis communication forms for Resident #30. A review of the dialysis contract on 8/30/22 at 8:00 AM, revealed the following, "Facility shall ensure that all appropriate medical, social, administrative and other information accompany all designated residents at the time of transfer to Center. This information shall include, but in not limited to, where appropriate the following: Treatment presently being provided to the designated resident, any advance directives, appropriate medical records including history of illness, labs and x ray findings and any other information that will facilitate the adequate coordination of care, as reasonably determined by the Center." An interview was conducted on 8/31/22 at 8:20 AM with LPN (licensed practical nurse) #4. When asked what information is provided to the dialysis facility when a resident is sent for hemodialysis, LPN #4 stated, the purpose of the dialysis communication sheet is to inform the center of resident's vital signs, weight and any pertinent information. The center sends back any pertinent information also. We check the bruit / thrill if they have a fistula and document that on the form.	F 698		

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F 698	Continued From page 75 On 8/31/22 at 9:00 AM, the dialysis communication binder for Resident #30 was provided. On 8/31/22 at approximately 9:30 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings. A review of the facility's "Coordination of Hemodialysis Services" dated 1/2020, revealed the following, "There will be communication between the facility and the ESRD facility regarding the resident. The facility will establish a Dialysis Agreement/Arrangement if there are any residents requiring dialysis services. The agreement shall include how the residents care is to be managed. Procedure 1. A communication format will be initiated by the facility for any resident going to an ESRD facility for hemodialysis. (please note that the ERSD (sic) may be facility specific due to needs of individual dialysis clinic). 2. Nursing will collect information regarding the resident to send to the ESRD facility with the resident- information recommended but not limited to: A. Resident information - face sheet B. Copy of current physician orders C. Copy of plan of care D. Blank progress note E. Blank ESRD communication form 3. Nursing will send the resident information with	F 698		

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F 698	Continued From page 76 the resident to the designated appointments at the ESRD facility. Nursing will give a brief summary of the physical, mental and emotional condition, oral intake, activity tolerance and change in physician orders since the last appointment." No further information was provided prior to exit.	F 698		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined the facility staff failed to have a repair person present in the kitchen wear protective hair guard; store food properly in the walk-in refrigerator; dry dishware in a sanitary manner; store a scoop used for dry	F 812	F812 1) The Dietary Staff is ensuring repair personnel wear protective hair guard, food is stored properly in the walk-in refrigerator, dry dishware is in a sanitary manner, scoop used for dry goods is stored properly and food is stored in nourishment room according to professional standards for food service safety. 2) Audit of kitchen to ensure repair personnel wear protective hair guard, food is stored properly in the walk-in refrigerator, dry dishware is in a sanitary manner, scoop used for dry goods is stored properly and food is stored in nourishment room according to professional standards for food service safety.	

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F 812	Continued From page 77 goods properly; and store food in one of two nourishment room refrigerators in accordance with professional standards for food service safety. The findings include: 1. The facility failed to properly store food in the walk-in refrigerator, properly dry dishware, and properly store a scoop in dry goods in the main kitchen of the facility. On 8/29/2022 at 11:06 a.m., an observation was made of the facility kitchen with OSM (other staff member) #6, dietary manager in training. Observation of the kitchen revealed staff members actively preparing lunch for residents. A staff member was observed making repairs to the ice machine in the kitchen, OSM #6 identified the staff member as a maintenance vendor brought in to fix the ice machine. The staff member was observed wearing a facemask and a hair net. The staff member was observed with an approximately four inch long beard uncovered. OSM #6 stated that the maintenance vendor should probably have on a beard guard to cover the beard since they were in the kitchen area but were not sure because they were only repairing the machine. Observation of the walk-in refrigerator revealed a tray containing 13 plastic cups containing a brown liquid that were uncovered and open to air. The tray with the 13 plastic cups was observed to be on the second shelf of a stainless steel wire shelf with a 10 gallon bucket of pickles directly over the cups. OSM #6 stated that the containers were approximately 30 ml (milliliters) each and contained syrup. OSM #6 stated that they had run out of the single serve syrup packages and	F 812	3) The Dietary Manger/Designee re-educated staff on hair guards, the proper storage and labeling of food items, sanitary food service, scoop usage, dry dishware storage according to professional standards for food service safety. 4) The Dietary Manager/Designee will conduct weekly audits x 1 month to ensure repair personnel wear protective hair guard, food is stored properly in the walk-in refrigerator, dry dishware is in a sanitary manner, scoop used for dry goods is stored properly and food is stored in nourishment room according to professional standards for food service safety. Results of audits will be reviewed at the monthly QAPI meeting. Any discrepancies will be addressed immediately. 5) Compliance Date: 9/28/2022	

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F 812	Continued From page 78	F 812		

had poured the cups for use during breakfast. OSM #6 stated that the containers were not covered and should be covered up to keep anything out of them. Observation of the kitchen area revealed a 25 lb (pound) box of instant food thickener with a plastic scoop resting inside on the contents. OSM #6 stated that the staff had pulled out thickener for the lunch service and left the scoop inside. OSM #6 stated that after use the scoop was washed and stored with the utensils.

On 8/29/2022 at 1:40 p.m., an observation was made of the dishwashing area in the facility kitchen with OSM #3, dietary aide. The dishwashing area was observed to have two wall mounted fans on each corner of the room. One fan facing the clean side of the dishwasher line was observed to be on and blowing towards the dishes coming out of the completed cycle of the dishwasher. OSM #3 was observed taking the clean dishes and placing the dishes in racks to dry. The fan grille was observed with visible dust on it. When asked about the fan, OSM #3 stated that they used the fan to speed up the dish drying process. When asked about the dust on the fan, OSM #3 stated that they thought maintenance came in an cleaned the fan. OSM #3 turned off the fan and stated that they could see dust on the fan grille. OSM #3 stated that they wanted the fan to be free of dust to keep the dishes clean. OSM #3 stated that they would notify maintenance of the dust on the fan.

On 8/29/2022 at 1:55 p.m., an interview was conducted with OSM #4, maintenance assistant. OSM #4 stated that they thought that the fans in the kitchen were broken down once a week and run through the dishwasher to clean them. OSM

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F 812	Continued From page 79 #4 stated that they did not keep a log for cleaning the fan and would check with the previous maintenance director to see if the fan cleaning was documented. On 8/29/2022 at 3:40 p.m., OSM #4 provided documentation of kitchen inspection completed on 6/8/2022 and 7/20/2022 and stated that the fan was cleaned once a month. OSM #4 stated that they had spoken to the previous maintenance director and had not personally cleaned the fan. On 8/31/2022 at 9:22 a.m., ASM (administrative staff member) #2, the regional vice president of operations stated that the facility did not have a policy regarding use of beard guards or fans in the kitchen. The facility policy "Dry Food Storage" failed to evidence guidance on storage of scoops. On 8/30/2022 at approximately 5:40 p.m., ASM #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit. 2. The facility staff failed to store food in one of two nourishment room refrigerators in accordance with professional standards for food service safety. On 8/30/2022 at 9:15 a.m., an observation was made of the east two pantry with CNA (certified nursing assistant) #2. Observation of the pantry refrigerator revealed one unopened 46 fl. oz.	F 812		

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F 812	Continued From page 80	F 812		

(fluid ounce) thickened sweetened tea with lemon flavor dated "Useby: 07/27/22" and one unopened 46 fl. oz. thickened orange juice from concentrate dated "Useby: 07/13/22." Further observation of the refrigerator revealed a 64 oz. unsweetened black tea approximately one-quarter full without a date or name. The tea contained a manufacturer's date of "May 09 22." A lunchbox was observed inside the refrigerator without a date or name on it. CNA #2 opened the lunchbox which revealed a plastic bag inside with foil wrapped contents. There were no date or name observed on the contents of the lunchbox.

On 8/30/2022 at approximately 9:20 a.m., an interview was conducted with CNA #2. CNA #2 stated that all items in the refrigerator were for residents only. CNA #2 stated that the thickened tea and orange juice were expired and should be thrown away. CNA #2 stated that the 64 oz. unsweetened black tea should have a name and date on them. CNA #2 stated that they did not know who the lunchbox belonged to and it should have a name and date on it. CNA #2 stated that dietary managed the pantry items and came in twice a day to stock and remove any expired items. CNA #2 stated that they would notify the nurse of the expired items to call dietary to request replacements.

On 8/30/2022 at 9:45 a.m. an interview was conducted with OSM (other staff member) #5, dietary manager. OSM #5 stated that dietary provided snacks for the pantries on the nursing units. OSM #5 stated that nursing was responsible for checking the refrigerators and disposing of expired items.

On 8/30/2022 at 10:29 a.m., an interview was

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F 812	Continued From page 81 conducted with LPN (licensed practical nurse) #8. LPN #8 stated that all items in the pantry should be dated and have the residents name on them. LPN #8 stated that dietary staff came and checked the dates of items in the refrigerator and discarded any expired items. The facility policy "Use and Storage of Foods brought to residents by family and visitors" documented in part, "...Food item(s) will be labeled with the resident's name, content, the date it was prepared, if known, and a discard/use by date..." On 8/30/2022 at approximately 5:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.	F 812		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews	F 947	F947 1) Current CNAs have received the annual abuse, neglect and dementia training. 2) Current staff have the potential to be affected. 3) Re-education was provided to HR and Administrator on mandatory training for CNAs. 4) Evidence of mandatory training for CNAs will be audited weekly times 1 month to ensure abuse, neglect and dementia was completed. Results of audits will be reviewed at the monthly QAPI meeting. Any discrepancies will be addressed immediately. 5) Compliance Date: 9/28/2022	

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F 947	Continued From page 82 and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to evidence annual abuse, neglect and dementia training for five out of five CNAs (certified nursing assistants) reviewed who were employed for at least one year. The findings include: The facility staff failed to evidence annual abuse, neglect and dementia training for CNA #4, #5, #6, #7 and #8. On 8/29/2022 at approximately 3:10 p.m., a request was made to ASM (administrative staff member) #3, the regional director of clinical services for evidence of annual abuse, neglect and dementia training for CNA #4, CNA #5, CNA #6, CNA #7 and CNA #8. On 8/31/2022 at 10:28 a.m., an interview was conducted with OSM (other staff member) #9, human resource director. OSM #9 stated that they and the director of nursing were responsible for the CNA education. OSM #9 stated that they coordinated with the unit managers and assigned the education in the computer. OSM #9 stated that abuse, neglect and dementia were required annually and they notified the director of nursing when they were due for staff members.	F 947		

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F 947	Continued From page 83 The facility policy "Performance Management" documented in part, "Performance appraisals will generally be conducted after 90 days of employment and annually thereafter based on your date of hire." On 8/31/2022 at 9:57 a.m., ASM #3, the regional director of clinical services stated that they did not have evidence of abuse, neglect or dementia training to provide for the five sampled CNA staff. The facility assessment tool dated August 2022 documented in part, "...Staff training/education and competencies...Required in-service training for nurse aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. Include dementia management training and resident abuse prevention training..." On 8/31/2022 at approximately 10:00 a.m., ASM #2, the regional vice president of operations and ASM #3, the regional director of clinical services were made aware of this concern. No further information was obtained prior to exit.	F 947		