DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495344	A. BUILDING ______ B. WING ______	C 08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGS DAUGHTERS COMMUNITY HEALTH & REHAB	1410 NORTH AUGUSTA STREET STAUNTON, VA 24401

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 8/2/2022 through 8/4/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Nine complaints were investigated during the survey and are as follows: VA00055243 allegations were substantiated with deficiencies cited. VA00055170 allegations were substantiated with deficiencies cited. VA00054340 allegations were substantiated with deficiencies cited. VA00055388 allegations were substantiated with deficiencies cited. VA00054119 allegations were unsubstantiated without deficiencies cited. VA00052076 allegations were substantiated without deficiencies cited. VA00054948 allegations were substantiated without deficiencies cited. VA00055530 allegations were unsubstantiated without deficiencies cited. VA00052194 allegations were unsubstantiated without deficiencies cited. The census in this 117 certified bed facility was 95 at the time of the survey. The survey sample	F 000	This plan of correction is respectfully submitted as an allegation of compliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charles E Phillips Jr | TITLE: ED | (X6) DATE: 8-26-22

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

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F 000	Continued From page 1 consisted of 8 current resident reviews (Residents #1 through #6, #12 and #13) and 5 closed record reviews (Residents #7 through #11).	F 000	F635- Admission Physician Orders for Immediate Care	
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to ensure physician's orders were obtained for the immediate care upon admission for one of 13 residents in the survey sample, Resident #7. Resident #7 had no physician's orders for skin care and/or treatment. Resident # 7 was admitted with diagnoses that included partial intestinal obstruction, difficulty walking, hyperlipidemia, generalized muscle weakness, abnormal uterine and vaginal bleeding, and restless leg syndrome. According to a Medicare 5-Day Minimum Data Set with an Assessment Reference Date of 5/24/2022, the resident was assessed under Section C (Cognitive Patterns) as having no short and long term memory problems with moderately impaired daily decision making skills. Under Section M (Skin Condition), the resident was assessed as not having any unhealed pressure ulcers. Resident # 7 resided in the facility for five days. Review of the resident's hospital Surgical Discharge Summary, dated 5/20/2022, noted the	F 635	1.Resident #7 was discharged from facility on 5/24/2022. 2.Quality review conducted by the DCS/designee of Admissions/ Re-admissions in the past 30 days to ensure admission orders are reviewed (medication reconciliation, consultant Pharmacist review Admission Medication Regimen Review) and transcribed per Physician orders, and identified skin issues will have Physician's orders for skin care and/or treatment. 3.All nurses (RN/LPN) re-educated by the DCS/designee related to Admission orders at the time each resident is admitted, the facility must have physician orders for the resident's immediate care. The Admission & Re-Admission Process: Admission/Re-Admission Date Collection Form, Medication Reconciliation and verify medication with Physician and notify Pharmacy of Admission. Interdisciplinary team will review all new admission/ re-admission records in the AM clinical meeting to ensure Physician orders are transcribed in the medical record and obtained for immediate care upon admission and review the skin assessments to ensure there are orders for skin care and/or treatments as indicated. 4.The ED/DCS/designee to conduct quality monitoring during clinical morning meeting of new admission/ re-admission records to ensure orders are transcribed per Physician orders and obtained for the immediate care upon admission and review the skin assessments to ensure there are orders for skin care and/or treatments as indicated, 3 times a week x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	9/07/2022

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F 635 Continued From page 2 — F 635

following: "Patient was treated by the wound care team for skin maceration of the entire right buttocks associated with incontinence of urine. This improved rapidly leaving behind very superficial small areas of ulceration. She did not have a decubitus ulcer."

At 2:00 p.m. on 8/2/2022, a copy of the resident's skin assessment was requested. At 8:30 a.m. on 8/3/2022, the Medical Records clerk reported there was no skin assessment in Resident # 7's closed Electronic Health Record.

At 8:40 a.m. on 8/3/2022, the Director of Nursing (DON), who had only been in the position for two days at the time of the survey, was interviewed regarding Resident # 7's skin assessment. The DON said the skin assessment "...was not done." There were also no entries in the Progress Notes related to the macerated skin area or any other skin issues.

During the interview, the DON provided a copy of the Order Summary Report, detailing the orders for Resident # 7, including treatment and medication. There were two treatment orders, "Consult Wound Care PRN (As Needed)" and "Skin: Pressure reducing mattress", related to skin issues. Both orders were dated 5/24/2022, the day the resident was discharged back to the hospital.

There were no orders for the assessment and/or immediate care and treatment of the macerated area on the resident's right buttocks.

COMPLAINT DEFICIENCY

F 655 SS=D Baseline Care Plan — F 655

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F 655	Continued From page 3 CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and	F 655	F655- Baseline Care Plan 1.Resident #7 was discharged from facility on 5/24/2022. 2.Quality review conducted by the DCS/designee of current resident's admitted in the past 30 days to ensure a baseline care plan was initiated. 3.All nurses (RN, LPN)/ MDS nurses (Minimum Data Set) re-educated by the DCS/designee related to Comprehensive Person-Centered Care Planning Baseline Care Plans The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must— be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary to properly care for a resident. 4.The ED/DCS/designee to conduct quality monitoring during clinical morning meeting of new admission/ re-admissions to ensure each resident has a baseline care plan initiated, 3 times a week x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	9/07/2022

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dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on complaint investigation, clinical record review, and staff interview, the facility failed for one of 13 residents in the survey sample, Resident # 7, to develop a baseline careplan. Resident # 7 was a resident of the facility for five days, during which time a baseline care plan was not developed.

The findings were:

Resident # 7 was admitted with diagnoses that included partial intestinal obstruction, difficulty walking, hyperlipidemia, generalized muscle weakness, abnormal uterine and vaginal bleeding, and restless leg syndrome. According to a Medicare 5-Day Minimum Data Set with an Assessment Reference Date of 5/24/2022, the resident was assessed under Section C (Cognitive Patterns) as having no short and long term memory problems with moderately impaired daily decision making skills.

At 2:00 p.m. on 8/2/2022, a copy of the resident's baseline care plan was requested. At 8:30 a.m. on 8/3/2022, the Medical Records clerk reported there was no baseline care plan in the resident's closed Electronic Health Record.

At 8:40 a.m. on 8/3/2022, the Director of Nursing (DON), who had only been in the position for two days at the time of the survey, was interviewed

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F 655	Continued From page 5 regarding Resident # 7's baseline care plan. The DON said no baseline care plan was developed for the resident. "The baseline care plan was due 48 hours after the resident was admitted," the DON said. "It was not done." The findings were discussed during a meeting at 4:00 p.m. on 8/3/2022 that included the Administrator, Director of Nursing, and the survey team.	F 655	F658- Services Provided Meet Professional Standards 1.Resident #3 was transferred to the hospital on 6/4/2022 without appropriate assessment and documentation to include Change in Condition. Resident #3 readmitted to the facility on 6/8/2022, facility staff completed Admission/Readmission Data Collection assessment on admission. Resident #7 was discharged from facility on 5/24/2022. 2.Quality review conducted by the DCS/designee of Admissions/Re- Admissions in the past 30 days to ensure the Admission/Re-Admission Process was completed. Quality review conducted by the DCS/designee of	9/07/2022
F 658 SS=D	COMPLAINT DEFICIENCY Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to follow professional standards of practice for two of thirteen residents in the survey sample. There was no assessment or documented circumstances regarding a change in condition for Resident #3 that resulted in a transfer and admission to the hospital. Resident #7 was not assessed by nursing at the time of admission. The findings include: 1. Resident #3 was admitted to the facility with diagnoses that included cerebrovascular accident (stroke), hypertension, diabetes, dysphasia and	F 658	Hospital Transfers in the past 30 days to ensure the Hospital Transfer Process was completed to include Change in Condition. 3.All Nurses (RN/LPN) re-educated by the DCS/designee related to Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must— Meet professional standards of quality. The DCS/designee will conduct Skills Competency Assessments: Medical Systems & Processes with All Nurses (RN/LPN), to include the Admission/Re-Admission Process and the Hospital Transfer Process to include Change in Condition. 4.The ED/DCS/designee to conduct quality monitoring during clinical morning meeting of the Admission/Re-Admission Process, Hospital Transfer Process, 3 times a week x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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F 658	Continued From page 6 gastroesophageal reflux disease. The minimum data set (MDS) dated 7/13/22 assessed Resident #3 with severely impaired cognitive skills. Resident #3's clinical record documented a readmission on 6/8/22 following a hospitalization. Hospital records documented Resident #3 was admitted to the emergency room on 6/4/22 following a change of condition at the nursing facility. The hospital discharge summary dated 6/8/22 documented, "...the nursing home staff thought that she was more lethargic, difficult to arouse. Her mother arrived at the nursing facility was concerned that she had some left-sided facial droop. They sent her into the emergency department later in the evening [6/4/22] as a stroke alert...Patient was admitted..." The discharge summary documented the resident was diagnosed and treated for new onset of seizure and discharged back to the nursing facility on 6/8/22. Resident #3's clinical record documented no assessment of the resident of 6/4/22, no change of condition and no circumstances surrounding the transfer to the emergency department on 6/4/22. There were no clinical/nursing notes on 6/4/22. There were no vital signs and no documented notification to the provider or resident representative regarding the change of condition. There was no indication in the clinical record of the transfer other than the readmission date of 6/8/22. On 8/3/22 at 10:00 a.m., the licensed practical nurse (LPN #4) caring for Resident #3 was interviewed about the resident's transfer on 6/4/22. LPN #4 stated she did not know why there was no documentation about the change in	F 658		

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F 658	Continued From page 7	F 658		

condition and transfer.

On 8/3/22 at 10:05 a.m., the registered nurse unit manager (RN #2) was interviewed about the resident's transfer on 6/4/22. RN #2 stated she was not working in June 2022 and did not know why there was no information about the change of condition and transfer.

On 8/4/222 at 9:15 a.m., the director of nursing (DON) was interviewed about Resident #3's transfer on 6/4/22. The DON stated she found no documentation or assessment regarding Resident #3's transfer to the emergency department on 6/4/22. The DON stated nurses were expected to assess residents when there was a change in condition and notify the provider and resident representative. The DON stated nurses were expected to complete a transfer form that was part of the electronic health record at the time of transfer. The DON stated this form provided space for documenting the rationale for the transfer and assessment of the resident.

The facility's form titled SNF/NH to Hospital Transfer Form (version 2) included space for nursing documentation that included, demographics, diagnoses, resident representative, name of hospital receiving resident, physician's name, resident's health history, current change of condition, most recent vital signs, resuscitation status, allergies and date/time of the transfer.

The facility's policy titled Notification of Change in Condition (revised 12/16/2020) documented, "...The nurse to notify the attending physician and Resident Representative when there is a...Significant change in the patient/resident's

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physical, mental, or psychosocial status...Need to alter treatment significantly...A transfer or discharge of the Patient/Resident from the Center...The nurse to complete an evaluation of the Patient/Resident. Document evaluation in the medical record...Document notification in the medical record...Complete SBAR [situation/background/assessment/recommendati on] as indicated..."

The Lippincott Manual of Nursing Practice 11th edition on page 15 documents concerning standards of care, "...A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events...Legal claims most commonly made against professional nurses include the following departures from appropriate care...failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record..." (1)

This finding was reviewed with the administrator and director of nursing on 8/3/22 at 3:20 p.m.

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

2. Resident # 7 was admitted with diagnoses that included partial intestinal obstruction, difficulty

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walking, hyperlipidemia, generalized muscle weakness, abnormal uterine and vaginal bleeding, and restless leg syndrome. According to a Medicare 5-Day Minimum Data Set with an Assessment Reference Date of 5/24/2022, the resident was assessed under Section C (Cognitive Patterns) as having no short and long term memory problems with moderately impaired daily decision making skills. The resident resided in the facility for five days.

At 2:00 p.m. on 8/2/2022, a copy of the resident's admission assessment was requested. At 8:30 a.m. on 8/3/2022, the Medical Records clerk reported there was no admission assessment in the resident's closed Electronic Health Record.

At 8:40 a.m. on 8/3/2022, the Director of Nursing (DON), who had only been in the position for two days at the time of the survey, was interviewed regarding Resident # 7's admission assessment. The DON provided an Admission/Readmission Data Collection form (Admission Assessment) and said, "It is blank. It was not done."

The findings were discussed during a meeting at 4:00 p.m. on 8/3/2022 that included the Administrator, Director of Nursing, and the survey team.

COMPLAINT DEFICIENCY

F 677 SS=D — ADL Care Provided for Dependent Residents
CFR(s): 483.24(a)(2) — F 677

§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;

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F 677	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and in the coarse of a complaint investigation, the facility failed to ensure showers were being offered or provided for two of 13 resident's in the survey sample. Resident #2 and Resident #8 were not provided showers. The Findings Include: 1. Diagnoses for Resident #2 included: Dementia, congestive heart failure, chronic pain, and kidney disease. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/20/22. Resident #2's cognitive score was a 11 indicating that they were moderately cognitively intact. On 8/2/22 Resident #2's medical chart was reviewed. According to ADL (Activity of Daily Living) form, Resident #2 was totally dependant with 1 person assist for bathing/shower. Resident #2's shower records were then reviewed for the months of March, April and May 2022. Documentation showed Resident #2 received a shower 3 times in the month of March, 6 times in April, and 4 times in May. All other documentation indicated a bed bath was provided or partial bed bath was performed. The shower schedule for Resident #2 was reviewed and indicated Resident #2 was to receive a shower twice weekly on Wednesday and Saturday.	F 677	F677- ADL Care Provided for Dependent Residents 1.Resident #2 has been receiving showers as scheduled. Resident #8 was discharged from facility on 6/07/2022. 2.Quality review conducted by the DCS/designee with Residents to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and PRN cleansing. 3.All Direct Care staff (RN/LPN/CNA) re-educated by the DCS/designee related to A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Showers: Assistance with showering and bathing will be provided at least twice a week and PRN to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and PRN cleansing. The resident's frequency and preferences for bathing will be reviewed at least quarterly during care conference. 4.The ED/DCS/designee to conduct quality monitoring during clinical morning meeting of Resident Showers for completion/refusal and documentation, 3 times a week x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/ Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	9/07/2022

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On 8/2/22 at 12:45 PM Resident #2 was interviewed regarding showers. Resident #2 said she has been receiving showers as scheduled for the past month, but before that, she had not been getting showers and said the facility had a problem with the water not getting hot at times.

On 8/2/22 at 2:45 PM registered nurse RN #1 was interviewed, RN #1 said she was the interim director of nursing (DON) at the time of the concern (over not receiving showers). RN #1 verbalized that there had been some concerns from resident's and family regarding resident's not getting showers. it was determined that the staff was entering shower schedules into the electronic system incorrectly and then the showers were not populating (on the electronic chart) to be done and there was no place to document information about showers. RN #1 went onto say, another contributing factor of resident's not receiving showers was due to a mechanical problem with hot water, but that issue has been resolved.

RN #1 said, regardless of the staff not entering the shower schedule into the system correctly did not excuse the staff from giving showers as there was a shower book with a shower schedule that the staff could have got the information from.

On 8/3/22 at 3:15 PM the above information was presented to the DON and administrator.

No other information was presented prior to exit conference on 8/4/22

This was a complaint deficiency.

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2. Resident #8 was not provided showers.

The Findings Included:

Diagnoses for Resident #8 included: Obesity, diabetes, decreased mobility, and fracture to left fibula. The most current MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 3/5/22. Resident #8's cognitive score was a 14 indicating cognitively intact.

On 8/2/22 Resident #8's medical chart was reviewed. According to the ADL (Activity of Daily Living) form, Resident #8 was totally dependant, requiring a 2-person assist for bathing/shower.

Resident #8's shower records were then reviewed for the months of March, April and May 2022. Documentation showed Resident #8 did not receive a shower in the month of March, documentation of 1 shower in April, and 2 showers in May. All other documentation indicated a bed bath was provided or partial bed bath was performed.

The shower schedule for Resident #3 was reviewed and indicated Resident #8 was to receive a shower twice weekly on Wednesday and Saturday or Tuesday and Friday (depending on what room Resident #8 was in for the months reviewed).

On 8/2/22 at 2:45 PM registered nurse RN #1 was interviewed, RN #1 said she was the Interim Director of Nursing (DON) at the time of the concern (over not receiving showers). RN #1 verbalized that there had been some concerns from residents and family regarding residents not

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F 677	Continued From page 13 getting showers. It was determined that the staff was entering shower schedules into the electronic system incorrectly and then the showers were not populating (on the electronic chart). There was no place to document information about showers. RN #1 went onto say, another contributing factor of residents not receiving showers was due to a mechanical problem with hot water, but that issue had been resolved. RN #1 said, regardless of the staff not entering the shower schedule into the system correctly did not excuse the staff from giving showers as there was a shower book with a shower schedule that the staff could have got the information from. On 8/3/22 at 3:15 PM the above information was presented to the DON and administrator. No there information was presented prior to exit conference on 8/4/22 This was a complaint deficiency.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review	F 684		

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F 684	Continued From page 14 and complaint investigation, the facility staff failed to follow physician orders for one of thirteen residents in the survey sample and failed to perform skin assessments for one of thirteen residents in the survey sample. Resident #3 had no weights obtained for three consecutive months when a physician's order required monthly weights. Resident #7 had no skin assessment related to moisture associated skin damage (MASD). The findings include: 1. Resident #3 was admitted to the facility with diagnoses that included cerebrovascular accident (stroke), hypertension, diabetes, dysphagia and gastroesophageal reflux disease. The minimum data set (MDS) dated 7/13/22 assessed Resident #3 with severely impaired cognitive skills. Resident #3's clinical record documented a physician's order dated 2/28/22 for monthly weights. There were no weights obtained during May 2022, June 2022 or July 2022. The last weight recorded for Resident #3 was on 4/12/22. There was no documentation that the resident refused weights. The most recent nutrition review by the facility's registered dietitian (RD) was dated 7/13/22. The RD documented on this review form, "...No wt [weight] since 4/12/22...Recommend to obtain updated weight per MD [physician] Orders..." On 8/2/22 at 2:40 p.m., the licensed practical nurse (LPN #1) caring for Resident #3 was interviewed about the monthly weights. LPN #1	F 684	F684- Quality of Care 1.Resident #3 current weight obtained per Physician order. Resident #7 was discharged from facility on 5/24/2022. 2.Quality review will be conducted by the Director of Clinical Services/designee to identify that all resident weights are obtained per Physician order in the last 30 days. Quality review will be conducted by the Director of Clinical Services/designee to identify that all residents have a current skin assessment completed in the last 7 days 3.All licensed nurses (RN/LPN) re-educated by the Director of Clinical Services/designee related to Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-care, following Physician orders and completing weekly skin assessments. 4.The Director of Clinical Services/designee to conduct quality monitoring during clinical morning meeting to ensure weights are obtained per Physician order and that weekly skin assessments are completed per schedule, 3 times a week x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	9/07/2022

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stated the resident did not like getting out of bed or being moved. LPN #1 stated she did not know for sure why the weights were not obtained.

On 8/2/22 at 2:45 p.m., the certified nurses' aide (CNA #4) was interviewed about Resident #3's weights. CNA #3 stated they used a mechanical lift with a scale to weigh Resident #3. CNA #3 stated she thought she had weighed Resident #3 "not too long ago."

On 8/3/22 at 10:05 a.m., the registered nurse unit manager (RN #2) was interviewed about Resident #3's weights. RN #2 reviewed the clinical record and did not find any weights since April (2022). RN #2 stated if the resident was weighed, the weights were supposed to be entered into the clinical record. RN #2 stated she did not know why the resident had not been weighed since April.

This finding was reviewed with the administrator and director of nursing during a meeting on 8/3/22 at 3:20 p.m.

2. Resident # 7 was admitted with diagnoses that included partial intestinal obstruction, difficulty walking, hyperlipidemia, generalized muscle weakness, abnormal uterine and vaginal bleeding, and restless leg syndrome. According to a Medicare 5-Day Minimum Data Set with an Assessment Reference Date of 5/24/2022, the resident was assessed under Section C (Cognitive Patterns) as having no short and long term memory problems with moderately impaired daily decision making skills. Under Section M (Skin Condition), the resident was assessed as not having any unhealed pressure ulcers. Resident # 7 resided in the facility for five days.

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Review of the resident's hospital Surgical Discharge Summary, dated 5/20/2022, noted the following: "Patient was treated by the wound care team for skin maceration of the entire right buttocks associated with incontinence of urine. This improved rapidly leaving behind very superficial small areas of ulceration. She did not have a decubitus ulcer."

At 2:00 p.m. on 8/2/2022, a copy of the resident's skin assessment was requested. At 8:30 a.m. on 8/3/2022, the Medical Records clerk reported there was no skin assessment in Resident # 7's the closed Electronic Health Record.

At 8:40 a.m. on 8/3/2022, the Director of Nursing (DON), who had only been in the position for two days at the time of the survey, was interviewed regarding Resident # 7's skin assessment. The DON said the skin assessment "...was not done." There were also no entries in the Progress Notes related to the macerated skin area or any other skin issues.

Upon request, the DON provided a copy of the facility's policy and procedure on Skin Evaluation which noted the following:

"POLICY:
A Licensed nurse will complete a total body evaluation on each resident weekly, and prior to a hospital or other facility transfer/discharge, paying particular attention to any skin tears, bruises, stasis ulcers, rashes, pressure injury, lesions, abrasions, reddened areas and skin problems.
PROCEDURE:
1. A Licensed Nurse will complete a total body evaluation on each resident weekly and

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F 684	Continued From page 17 document the observation on the 'Skin Evaluation' form. 2. The evaluating nurse must date and sign each review. 3. If a resident is assessed as having a skin problem, the evaluating nurse will initiate the appropriate form. For pressure areas complete the 'Pressure Injury Record'. For all other skin conditions, complete the 'Non-Pressure Skin Condition Record'. 4. A Licensed Nurse will complete a total body evaluation on each resident prior to a hospital or other facility transfer/discharge. 5. The Licensed Nurse will document the observation on the Skin evaluation form." There was no documentation of a skin assessment at the time of admission or during the time Resident # 7 was in the facility. On 5/24/2022, Resident # 7 was transferred to the hospital and subsequently admitted. There was no documentation of a skin evaluation prior to the resident's transfer. The findings were discussed during a meeting at 4:00 p.m. on 8/3/2022 that included the Administrator, Director of Nursing, and the survey team. COMPLAINT DEFICIENCY	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		

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F 686	Continued From page 18 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility failed to ensure interventions were implemented for the treatment and prevention of pressure ulcers regarding pressure relief for two of 13 residents in the survey sample (Resident #4 and Resident #5) and failed to accurately assess and monitor one of 13 residents (Resident #9) for pressure ulcers. 1. Resident #4's pressure relief mattress was not set to the appropriate weight setting for the treatment and prevention of pressure ulcers, based on the resident's actual weight. 2. Resident #5's pressure relief mattress was not set to the appropriate weight setting for the treatment and prevention of pressure ulcers, based on the resident's actual weight. 3. The facility failed to assess and monitor Resident #9 for pressure ulcers. Findings include: 1. Resident #4's pressure relief mattress was not set to the appropriate weight setting for the treatment and prevention of pressure ulcers, based on the resident's actual weight. The	F 686	F686- Treatment /Services to Prevent/Heal Pressure Ulcers 1.Resident #4 pressure relief mattress was replaced. Resident #5 pressure relief mattress was replaced Resident #9 was discharged from facility on 4/21/2021 2.All residents with wounds have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Director of Clinical Services/designee of all wounds in house to ensure supporting assessments/documentation and treatment are in place, and residents with pressure relief mattresses are set to the appropriate weight setting. 3.All licensed nurses (RN/LPN) re-educated by the Director of Clinical Services/Assistant related to Skin Integrity, wound program and documentation expectations of wounds including Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that— A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Education to include pressure relief mattress settings. Interdisciplinary team will review all new wounds in the AM clinical meeting to ensure proper assessment/ documentation and treatment order are in the medical record.	9/07/2022

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F 686	Continued From page 19 pressure relief mattress had a pressure setting based on the resident's weight. Resident #4's bed was set at 590 lbs (pounds), it was documented that the resident weight was 195 lbs on 07/06/22. Resident #4's diagnoses included, but were not limited to: history of stroke, muscle weakness, bilateral (AKA) above the knee amputations, chronic pain, morbid obesity and pressure ulcers. The resident's most current MDS (minimum data set) was a quarterly assessment dated 07/12/22. The resident was assessed with a cognitive score of 15, indicating the resident was intact for daily decision making skills. The resident was also assessed as requiring extensive to full assistance of at least two staff for all ADL's (activities of daily living). Additionally, the resident was assessed as having a stage 4 pressure ulcer on this MDS and also assessed as having a pressure reducing device for the bed. On 08/02/22 at approximately 11:00 am, Resident #4 was interviewed and observed in her room. The resident's pressure relief mattress was observed. The pressure relief mattress was a weight setting bed (based on the resident's weight), the bed was set at 590 lbs (pounds). The bed was set to rotation and set to rotate every 20 minutes. The resident stated that she needed someone to slide her bed over on to the frame that she felt it had shifted. The resident used the call bell and called for CNA (certified nursing assistant) #5. The CNA came into the room and adjusted the resident's pressure relief mattress. The resident's clinical record documented a	F 686	4.The Director of Clinical Services/Assistant to conduct quality monitoring during clinical morning meeting of wounds and their documentation and treatment orders and monitor pressure relief mattress to ensure proper settings, 3 times a week x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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weight for the resident of 195 lbs (pounds) on 07/06/22.

The resident's current physician's orders were reviewed and documented, "...Pressure reducing mattress...(Order date: 11/27/2020)..." There were no orders and/or instructions for the pressure relief mattress settings.

The resident's CCP (comprehensive care plan) was reviewed. The CCP documented, "...has a stage 4 pressure injury to sacrum...follow facility policies/protocols for the prevention/treatment of skin breakdown (date initiated: 11/20/2018)...LAL (low air loss mattress) to bed. Check placement and function as ordered. Optimal positioning while in bed to ensure optimal safety (dated initiated: 07/08/2020)..."

The resident was observed multiple times on 08/02/22 and the resident's pressure relief mattress/bed was at the same setting (590 lbs) at each observation.

On 08/03/22 at 7:30 AM, Resident #4 was observed again with the resident's pressure relief mattress at the same settings as observed on 08/02/22.

On 08/03/22 at 9:10 AM, LPN #2 was interviewed regarding pressure relief mattresses. The LPN stated that the SW orders the bed and who ever delivers it, will set it up. The LPN was asked if a physician's order is required. The LPN stated that she would expect to see an order, but stated that she hasn't actually seen one. The LPN then stated, "You can't do it if there ain't no order." The LPN stated that as far as settings, no one is supposed to mess with it unless the order is

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F 686	Continued From page 21 changed. LPN #3 was interviewed at 9:15 AM, the LPN was asked who sets up the pressure relief beds for resident's as far as the settings. The LPN stated, "That's a really good question." The LPN further stated that she checks to be sure it (pressure relief mattress) is on and that it's at the correct weight setting for that resident and stated it's based on the resident's weight. The LPN stated that she would expect to see a physician's order if there were specific settings for a resident. On 08/03/22 at 9:30 AM, Resident #4 was observed again with the resident's pressure relief mattress at the same settings as above. On 08/03/22 at 9:45 AM, the DON (director of nursing) was interviewed regarding pressure relief mattresses. The DON stated that, "...you have to know what the resident's weight is to set the bed, if there are more options (on the bed control) there should be a physician's order (on instruction and how to manage)." The DON then stated that a potential problem of the air mattress not being set at the resident's correct weight, is that if the resident's weight is more than what the bed is actually set for then the bed would be too soft, if the resident's weight is less and the bed is set to more then the bed would be too firm. The DON stated that it should be included on the resident's CCP and that she would like to have a physician's order, but that it could be a nursing intervention. On 08/03/22 at 10:50 AM. the DON, administrator, SW (social worker) and regional director of clinical services were made aware of concerns with Resident #4's pressure relief	F 686		

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mattress/bed. A policy was requested on pressure ulcer prevention and manufacturer's instructions on the resident's specific pressure relief bed.

The policy was presented titled, Skin and Wound." The policy documented, "...Provide pressure redistribution...evaluate for adaptive equipment/positioning devices/specialty mattress...monitor weight trends...review and update care plan reflecting interventions..."

The user manual for Resident #4's bed documented, "...This product is intended to help and reduce the incidence of pressure ulcers while optimizing patient comfort
...pressure adjust levels...when turning up, the output pressure will increase...vice versa for decreasing air pressure. Higher-pressure output will support the heavier weight patient...Users can adjust pressure of air mattress to a desired softness by adjusting the comfort key. Please consult your physician for a suitable settings...According to the weight and height of the patient, adjust the pressure setting...According to the weight and height of the patient, adjust the pressure setting to the most comfortable level without bottoming out..."

On 08/03/22 at 12 noon, Resident #4 was observed again with the resident's pressure relief mattress had been set to 330 lbs (again the resident's last weight on 07/06/22 was 195).

On 08/04/22 at 8:30 AM, the resident's bed was again observed and weight setting on 330 lbs. The resident stated that her bed still feels a little hard.

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No further information and/or documentation was presented prior to the exit conference on 08/04/22.

2. Resident #5's pressure relief mattress was not set at the appropriate setting for the treatment and prevention of pressure ulcers. The pressure relief mattress was a pressure setting based on the resident's weight. Resident #5's bed was set at 450 lbs (pounds), it was documented the resident's weight was 175 lbs on 05/10/22.

Resident #5's diagnoses included, but were not limited to: brain cancer, high blood pressure, thrombocytopenia, muscle weakness, anxiety and fibromyalgia.

The resident's most current MDS (minimum data set) was a significant change assessment dated 07/16/22. The resident was assessed as requiring extensive to full assistance for all ADL's (activities of daily living) with assistance of at least two staff. The resident was also assessed as having one unstageable pressure ulcer on this MDS and also assessed as having a pressure reducing device for the bed.

On 08/03/22 at 7:45 AM, Resident #5 was observed in bed. LPN (Licensed Practical Nurse) #5 was asked about Resident #5's pressure relief mattress settings. The resident's bed was set to 450 lbs (the resident's last weight was documented as 175 lbs on 05/10/22), the resident's bed was also on mute and was on an alternating schedule of every 25 minutes. The LPN stated that she did not know why it was set to 450 lbs, as the resident did not weigh that much.

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The resident's current physician's orders were reviewed. There were no physician's orders for the pressure relief bed for Resident #5.

The resident's current CCP (comprehensive care plan) was reviewed and documented, "...pressure injury...related to immobility...Administer treatments as ordered and monitor for effectiveness...follow facility policies/protocols for the prevention/treatment of skin breakdown...follow facility protocols for treatment of injury..." There was no information/documentation on the resident's care plan regarding the Resident #5's pressure relief mattress.

On 08/03/22 at 10:00 AM, the DON was interviewed and stated that this resident is on hospice and that is who manages the resident's bed. The DON was asked if this intervention for the treatment and prevention of pressure ulcers should be on the resident's care plan. The DON stated, "I would think so, yes ma'am."

On 08/03/22 at 10:20 AM, the resident's hospice nurse was contacted for a telephone interview. The hospice nurse stated that the bed is initially set up by the people who deliver the bed. The nurse stated that the bed goes by the resident's weight and whoever sets the bed up should get the resident's weight from staff. The hospice nurse stated that she did recall an issue with the bed not inflating properly about a month ago and made a service call to have it checked and that was completed on 07/10/22. The hospice nurse stated that she was unaware why the bed is on mute. The hospice nurse stated that her bed should probably be set for about 200 lbs and she

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thought the standard alternating time is about every 15 minutes. The hospice nurse was made aware that the resident didn't have any physician's orders for the bed at all and there were no specific care instructions/settings for the pressure relief bed.

At 10:50 08/03/22 at 10:50 AM. the DON, administrator, SW (social worker) and regional director of clinical services were made aware of concerns with Resident #5's pressure relief mattress/bed. A policy was requested on pressure ulcer prevention and manufacturer's instructions on the resident's specific pressure relief bed.

The policy was presented titled, Skin and Wound." The policy documented, "...Provide pressure redistribution...evaluate for adaptive equipment/positioning devices/specialty mattress...monitor weight trends...review and update care plan reflecting interventions..."

A manual presented for Resident #5's bed documented, "...INTENDED USE...are designed and constructed to reduce the incidence of pressure ulcers while optimizing patient comfort... The WEIGHT SETTING Buttons (+) and (-) can be used to adjust the pressure of the inflated cells based on the patient's weight..."

The resident was observed at 12 noon and the resident's pressure relief mattress settings were the same as observed earlier.

The administrator, DON and corporate nurse were made aware of concerns in a meeting with the survey team, that the resident's bed for pressure ulcer treatment and prevention was not

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F 686	Continued From page 26 managed appropriately according to the instruction manual for Resident #5. No further information and/or documentation was presented prior to the exit conference on 08/04/22. 3. Resident #9 was admitted to the facility with diagnoses that included, dissection of the thoracic aorta, low back pain, congestive heart failure, osteoporosis, depression, anxiety, reduced mobility, muscle weakness, COPD, and alcohol abuse. The discharge minimum data set (MDS) dated 04/21/2021 assessed Resident #9 as having short term memory problems and moderately impaired for daily decision making. The MDS documented Resident #9 with an onset of delirium that included fluctuating periods of inattention and disorganized thinking. Under Section G - Functional Status, the MDS assessed Resident #9 as requiring extensive assistance for bed mobility, dressing, hygiene, and eating and total dependent for toileting, transfers and bathing. Under Section M - Skin, the MDS documented Resident #9 was discharged with a	F 686		

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pressure ulcer.

Resident #9's clinical record was reviewed on 08/03/2022.

The clinical record documented the following "weekly skin integrity reviews" for the buttocks and/or sacrum sites:

"03/12/2021 (admission) ....right inner buttocks 2 open areas noted .1 x .1 each..."
"03/19/2021 bilateral buttock opening, tx (treatment) in place..."
"03/27/2021 open wound sacrum, tx (treatment in place..."
"04/03/2021 MASD (moisture associated skin damage) sacrum, slow to blanch..."
"04/10/2021 sacrum, open pressure sore, treatment in place..."
"04/17/2021 open area noted to sacrum, tx (treatment) in place..."

Resident #9 was seen by the wound care provider on 04/08/2021. Observed on the wound summary was the following: "incontinence associated dermatitis." Treatment included "greers goo to irritated dermatitis q (every) shift and PRN (as needed) with peri care."

There was no descriptive assessment and/or staging of the open sacral pressure sore identified on 4/10/21 including size, appearance, condition of surrounding skin, pain and/or drainage. The "treatment in place" was previously prescribed by the wound physician for MASD. No new treatment was initiated for the pressure ulcer until 4/19/21 when the debriding agent Santyl was started.

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F 686	Continued From page 28 Resident #9 was transferred to the hospital on 04/21/2021. The clinical record documented a skin evaluation prior to discharge which documented the following pressure ulcer: "Site 106 (sacrum) wound bed necrotic with reddened, excoriated peri wound noted. Wound bed measures 3.1 x 2.9....." A review of the clinical records documented the following treatment orders related to the buttocks and/or sacrum sites: "03/19/2021 Cleanse wound with DWC, apply TAO (triple antibiotic ointment) & border gauze to buttocks every shift." "04/01/2021 Greer Goo Cream. Apply to buttocks topically every shift for treatment..." "04/01/2021 Greer Goo Cream. Apply to buttocks topically as needed for treatment every brief change and as needed." "04/07/2021 Cleanse open areas to bilateral buttocks with DWC, apply iodosorb and cover with adhesive dressing. Change q (every) day and PRN (as needed)." "04/19/2021 Cleans area to sacrum with DWC apply santyl and collagen powder, cover with calcium alginate and cover with adhesive foam dressing. Change q (every) shift for wound care." Resident #9's care plans included the following skin integrity focus area with goals and interventions: "(Resident #9) has a potential impairment to skin integrity r/t (related to) weakness and reduced mobility. Goals included: "The resident will maintain or develop clean and intact skin by the review date." Interventions included: "Administer treatments as ordered. Encourage good nutrition and hydration in order to promote healthier skin.	F 686		

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Keep skin clean and dry. Use lotion on dry skin. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations."

Resident #9 was assessed by nursing to have open areas to the sacrum on 03/27/2022; 04/10/2022; 04/17/2022 and 04/21/2021. The facility failed to access and provide ongoing monitoring to the above referenced skin integrity sites of the buttocks and/or sacrum. The weekly documentation did not include measurement of each area to include width, length, depth, tissue type, exudate (wound drainage/fluid), and other observations of the assessed wound sites.

On 08/03/2022 at 8:05 a.m., the facility's nurse practitioner (OS #10) who provided care for Resident #9 was interviewed regarding the allegations. OS #10 stated she could not remember Resident #9 because of the time frame referenced in the complaint. OS #10 stated she was no longer employed by the medical group and did not have access to the records because the medical group had been sold to another entity.

On 08/04/2022 at 8:24 a.m., the licensed practical nurse (LPN #1) was interviewed regarding the complaint allegations. LPN #1 stated she did work on the unit, however she could not recall providing care for Resident #9.

On 08/04/2022 at 10:45 a.m. the facility's administrator, DON and RN #1 were advised of the concerns that the skin evaluations did not include a full assessment and documentation of the observed skin/wound areas. The DON and

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RN #1 stated they would review the clinical record for additional supporting documentation. The facility was asked for the skin evaluation policy.

On 08/04/2022 at 11:15 a.m., RN #1 returned to the conference room and stated, "what you have is all we have. We could not locate anymore information." RN #1 was interviewed regarding the skin evaluation policy and procedure. RN #1 stated, "the LPNs are to complete a weekly skin/body evaluation and document their observations that includes how the skin/wound smells, looks, etc. on the the skin eval forms. If there is a skin problem, the LPN will initiate the "Pressure Wound" form if it's related to pressure and the "non-pressure" form for other skin problems. The LPNs are not able to stage a wound, however they are expected to assess, document, treat, and monitor the areas. Once they initiate the "pressure wound or non-pressure wound" form, then the RN will stage the area and notify the physician and/or the wound provider."

The director of nursing (DON) and unit manager who were employed during the time Resident #9 resided at the facility were no longer employed by the facility and could not be interviewed. Additional review of the as worked schedule noted other nursing staff who provided care for Resident #9 were no longer employed by the facility and could not be interviewed. The facility no longer contracted with the previous wound provider and could not be interviewed.

On 08/04/2022 at 11:30 a.m., the above findings were reviewed with the facility's administrator, DON and corporate consultants. The facility was asked if they had identified any concerns regarding skin evaluations. RN #1 stated "yes,

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we did identify a concern with the wound provider and that is why we no longer contract with them." RN #1 was asked if the facility had identified any concerns with nursing accurately assessing and documenting skin/wound observations. RN #1 stated, "yes we have."

A review of the facility's policy titled "Skin Evaluation (rev 04/01/2017) documented the following:

"A Licensed Nurse will complete a total body evaluation on each resident weekly, and prior to a hospital or other facility transfer/discharge, paying particular to any skin tears, bruises, stasis ulcers, rashes, pressure injury, lesions, abrasions, reddened areas and skin problems."
"Procedure: 1. A Licensed Nurse will complete a total body evaluation on each resident weekly and document the observation on the Skin Evaluation form. 2. The evaluating nurse must date and sign each review. 3. If a resident is assessed as having a skin problem, the evaluating nurse will initiate the appropriate form. For pressure areas complete the "Pressure Injury Record." For all other skin conditions, complete the "Non-Pressure Skin Condition Record." 4. A Licensed Nurse will complete a total body evaluation on each resident prior to a hospital or other facility transfer/discharge. 5. The Licensed Nurse will document the observations on the Skin evaluation form."

The National Pressure Injury Advisory Panel (NPIAP) defines a pressure injury as, " ...localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be

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painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (1)

(1) NPIAP Pressure Injury Stages. National Pressure Injury Advisory Panel. 8/5/22. www.npiap.org/

This is a complaint deficiency.

F 802 SS=F Sufficient Dietary Support Personnel
CFR(s): 483.60(a)(3)(b)

§483.60(a) Staffing
The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.60(a)(3) Support staff.
The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.

§483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii).
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, group interview, and facility document review, the facility

F 686

F 802

F802- Sufficient Dietary Support Personnel

1.The facility recognizes that dietary support has been less than sufficient.
2.All residents have the potential to be impacted by the alleged deficient practice.
A quality review will be conducted by the Executive Director/Human Resource Coordinator of dietary staff for the upcoming week beginning 8/21/2022 to ensure sufficient dietary support personnel scheduled.
3.Dietary manager will be re-educated by the Executive Director/Human Resource Coordinator related to providing sufficient dietary staffing. Staffing the facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the
facility assessment. Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. A member of the Food and Nutrition Services staff must participate on the interdisciplinary team.
The Dietary manager will report in the AM meeting staffing patterns for the upcoming week to discuss any staffing concerns with plans for addressing.
The Executive Director will report to the Regional Administrator any anticipated staffing concerns following AM meeting or upon discovery.
4.The Executive Director/Human Resource Coordinator to conduct quality monitoring of dietary staffing, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/ Performance Improvement Committee monthly.
Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.

9/07/2022

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F 802	Continued From page 33 staff failed to employ sufficient staff in the main kitchen. Findings were: On 08/02/2022 during the lunch time meal observations were made that residents were served lunch using Styrofoam trays. Meals consisted of pizza from a local pizzeria. On 08/03/2022 a second observation was conducted during breakfast. The meal was again served on Styrofoam plates. On 8/3/22 at 7:50 AM The dietary manager (Other Staff, OS #5) was interviewed regarding serving residents on Styrofoam trays. OS #5 said the kitchen has been under staffed and have been serving on Styrofoam because there is no dishwasher person. OS #5 also verbalized that the dietary director is aware of the problem and is working on getting people hired. On 08/03/22 at 9:20 AM, Resident #12 (with a cognitive score of 14) was interviewed and stated that last night's meal consisted of a piece of pizza and a cup of pudding. The resident stated that the pizza was cold, but that was fine to her. The resident stated that she had not reported this information to anyone at the facility. At 9:50 a.m. on 8/3/2022, Resident #13 (with a cognitive score of 15) was interviewed regarding lunch on 8/2/2022. "Yesterday I got a little pile pork of on a Styrofoam plate, a roll with no butter, and a pea salad. They had pizza yesterday and I can't have tomato products, no green vegetables, and no pork. Pork gives me gout. We were	F 802		

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supposed to get watermelon, but I got ice cream."

On 8/3/22 at 10:30 a.m., a group of seven alert and oriented residents was interviewed about quality of
life/care issues in the facility. The group stated during this interview the dining room had been closed
since 2020 due to COVID concerns. Several residents stated they wanted to eat and converse with their friends during meals. The group stated when they asked about communal dining they were told the dining room had not been started back since COVID. Residents stated foam/paper products were used during meals "on and off" since the beginning of 2022 due to lack of staffing in the kitchen. The residents stated paper products were in use yesterday (8/2/22) and for breakfast today (8/3/22). Residents stated the food in the foam plates was cold. The residents stated pizza was purchased and served to them for lunch on 8/2/22 because there were not enough staff in the kitchen to prepare the menu items. Residents stated this had happened before when food was unable to be prepared due to lack of staff in the kitchen. Residents stated only one slice of pizza was served. Residents stated the pizza was just served without asking them if they wanted it. Residents stated the last couple of days they were missing milk, coffee and/or cereal on breakfast trays. Residents stated they have been short of help in the kitchen for months and even the maintenance director had been in the kitchen helping out to prepare meals.

At approximately 11:20 a.m., the as worked schedule for the months of June and July 2022 from the dietary department was obtained. The dietary manager was interviewed at 11:30 a.m.

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F 802	Continued From page 35 and asked to explain the schedule. She stated, that all staff arrived in the morning for their scheduled shift. She usually got to the facility between 4:00 a.m. and 5:00 a.m. She stated the rest of the staff arrived by 6:30 a.m. She stated that usually it was herself and two other staff members that worked in the kitchen. She stated the usual day was, "Fix breakfast, do the dishes, prep lunch, clean the dishes, fix dinner, and do the dishes." She stated when there was a break, desserts and cereal for the next day were prepped. She was asked how the shifts worked. She stated, "I come in, in the mornings, and I am here until 7:30 p.m. or so. Someone stays with me, they rotate that." She was asked how many total staff was currently working in the kitchen. She stated, "Three." She was asked how people got a day off. She stated,"When one of them is off it is two of us." She was asked when she got a day off. She stated, "I got a couple of hours in July." She stated, "We are short staffed." She was asked how long the kitchen had been short staffed. She stated, "A couple of months...probably since February." She was asked if any of her supervisors were aware that the kitchen was short staffed. She stated, "Yes, (Name of OS (Other staff) #8) is aware and so is (name of administrator)." She was asked about the use of Styrofoam plates. She stated, "(Name of administrator) told me it would be okay to use them for cold plates. I used them yesterday because there was no one here but me until lunchtime...the nursing staff helped with breakfast, the scheduler, the transport people, the person in supplies, ,the social worker, all came in to get breakfast out. There wasn't anyone at lunch so (Name of OS #8) ordered the pizza. I served pizza and salad. The mechanical soft diets got mac and cheese, I pureed that for	F 802		

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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 802	Continued From page 36	F 802		

the ones who need puree."

The administrator came to the conference room at approximately 11:45 a.m., and stated that the kitchen staff were all contract employees.

Other staff #6, the Director of Operations for Dining Services was interviewed at 12:30 p.m.. He was asked what the appropriate amount of staff for the kitchen should be. He stated, There should be two aids and a cook in the morning for breakfast and lunch, and a cook and an aid for evening shift, for a total of five staff per day. He stated, ideally there would be eight staff on the rooster in order to rotate and grant days off. He was told of the events of the previous day, and the conversation with the DM. He stated, he was not aware that staffing was that low. He stated he would contact the district dietary manager, OS #7 who was at the facility. He also stated, "I spoke with the administrator yesterday, I was not aware that it was at that bad."

OS #8 one of the district dietary managers called to speak with the survey team at approximately 12:45 p.m. She stated, "We have sent other staff in there to help. We are trying to hire..."

At approximately 1:00 p.m., OS #7, the district DM, and the facility DM came to the conference room. OS #7 stated, "I came here Sunday, I took the role as district DM on Monday, August 1. (Name of OS #8) told me there was a staffing issues...when I came in yesterday at lunchtime (Name of facility DM) was by herself...there had been two call-ins, one said they quit, but they didn't. One of them came in today, the other is coming back tomorrow." She was asked why the company had not brought anyone in to help until

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	495344	A. BUILDING ______ B. WING ______	C 08/04/2022

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F 802	Continued From page 37 positions could be filled. She stated, "We've asked people to come here but no one has volunteered....I really can't answer you as to why no one had been made to come here." She also stated, "We've had some other people come from other facilities for the day and we had a MIT (manager in training) here, but he wasn't here every day...I've been in seven different facilities in the last month. It's hard to get help." The DM was asked about the additional staff that OS #8 stated she had brought in to help in the kitchen. She was asked how many people worked in the kitchen each day. She stated, "It is usually three, sometimes two....yesterday it was just me, that's why we ordered the pizza." The above information was discussed during a meeting with the administrator, the DON (director of nursing) and other staff on 08/03/2022. No further information was obtained prior to the exit conference on 08/04/2022.	F 802		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		

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F 842	Continued From page 38 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842	F842- Resident Records- Identifiable Information 1.Resident #3 clinical record now reflects complete documentation of current activities of daily living. Resident #7 was discharged from facility on 5/24/2022. 2.Quality review conducted by the DCS/designee of all current residents to ensure clinical records documentation is reflective of current activities of daily living. 3.All Direct Care staff (RN/LPN/CNA) re-educated by the DCS/designee related to Resident-identifiable information. Complete; Accurately documented; Readily accessible; and Systematically organized The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, to include complete documentation of the residents activities of daily living. 4.The ED/DCS/designee to conduct quality monitoring during clinical morning meeting of activities of daily living documentation, 3 times a week x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	9/07/2022

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§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and complaint investigation, the facility staff failed to ensure a complete and accurate clinical record for two of thirteen residents in the survey sample. Resident #3 had incomplete documentation of activities of daily living for two months. Resident #7's clinical record had incomplete progress notes and assessments.

The findings include:

1. Resident #3 was admitted to the facility with diagnoses that included cerebrovascular accident (stroke), hypertension, diabetes, dysphasia and gastroesophageal reflux disease. The minimum data set (MDS) dated 7/13/22 assessed Resident #3 with severely impaired cognitive skills.

Resident #3's activities of daily living (ADL) records were reviewed for March 2022 and April 2022 as part of a complaint investigation. There were 80 out of 93 shifts during March 2022 with no documentation regarding bed mobility, toilet use, transfers and bladder function. There were 70 shifts in March 2022 with no documentation of

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meal intake percentages or meal assistance required. The April 2022 ADL records had no documentation of bed mobility, toilet use, transfers or bladder function for 73 out of 90 shifts. There were no meal intakes or meal assistance provided documented for 61 out of 90 shifts during April 2022.

On 8/3/22 at 10:05 a.m., the registered nurse unit manager (RN #2) was interviewed about the incomplete ADL documentation for Resident #3. RN #2 stated CNAs were supposed to enter ADL information prior to the end of each shift. On 8/3/22 at 2:40 p.m., RN #2 stated she reviewed the clinical record and stated the ADL information was not entered as required.

This finding was reviewed with the administrator and director of nursing during a meeting on 8/3/22 at 3:20 p.m.

2. Resident # 7 was admitted with diagnoses that included partial intestinal obstruction, difficulty walking, hyperlipidemia, generalized muscle weakness, abnormal uterine and vaginal bleeding, and restless leg syndrome. According to a Medicare 5-Day Minimum Data Set with an Assessment Reference Date of 5/24/2022, the resident was assessed under Section C (Cognitive Patterns) as having no short and long term memory problems with moderately impaired daily decision making skills.

At 2:00 p.m. on 8/2/2022, a copy of the Progress Notes in the resident's closed clinical record was requested. At 8:30 a.m. on 8/3/2022, the Medical Records clerk provided a copy of the Progress Notes consisting of three entries, all dated

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5/24/2022. The Medical Records clerk indicated those were the only Progress Notes in the resident's closed Electronic Health Record. The entries were as follows:

5/24/2022 - 10:21 a.m. Nursing Progress Note: "Resident seen by NP (Nurse Practitioner) this shift r/t (related to) nausea/vomiting. Resident states increased pain at the time r/t her ABD (abdomen). NP states to send to ER for further eval (evaluation) and treat. Own R/P (Responsible Party)."

5/25/2022 - 10:38 a.m. Nursing Progress Note: "Resident left via squad at this time. Took red bag containing a book and two tablets."

5/25/2022 - 5:00 a.m. Nursing Progress Note: "This nurse called over to AH (Augusta Hospital) to check status of resident. Resident was admitted to surgical unit with dx (diagnosis) of incarcerated hernia."

There were no other Progress Notes in Resident # 7's closed Electronic Health Record. Resident # 7 was in the facility for five days. Interviewed at 8:40 a.m. on 8/3/2022, the Director of Nursing, who had only been in the position for two days at the time of the survey, could offer no explanation as to why there were no other Progress Notes.

In addition to the lack of full and descriptive Progress Notes, the following documentation was also missing from the resident's Electronic Health Record: the Baseline Care Plan, the Admission/Readmission Data Collection form (Admission Assessment), the Non-Pressure Skin Condition Record, and skin assessments at admission, during the admission, and on

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F 842	Continued From page 42 discharge to the hospital. The findings were discussed during a meeting at 4:00 p.m. on 8/3/2022 that included the Administrator, Director of Nursing, and the survey team. COMPLAINT DEFICIENCY	F 842		