STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONVIEW REHABILITATION AND HEALTHCARE	7246 FOREST HILL AVE RICHMOND, VA 23225

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 08/09/22 through 08/10/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Seven complaints were investigated during the survey. VA00055903- Substantiated with deficiency VA00055905 - UnSubstantiated VA00055359- Substantiated with deficiency VA00055269 - Substantiated with deficiency VA00054995 - Substantiated with deficiency VA00054524 - Unsubstantiated VA00054426 - Substantiated with deficiency The census in this 196 certified bed facility was 147 at the time of the survey. The survey sample consisted of 11 resident reviews.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		9/24/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/02/2022

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F 584	Continued From page 1 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation and in the course of a complaint investigation, the facility staff failed to ensure a clean, comfortable, homelike environment for 1 of 3 shower rooms. This has the potential to affect multiple residents. The findings included: For the Residents on the third floor, the facility staff failed to ensure the shower room was clean and in good repair. On 8/10/22 at approximately 10:00 AM the	F 584	1. The Flooring in the shower room was repaired to ensure the subflooring was not exposed. The stains noted to be around the base of the toilet were Cleaned. The shower room floor was scrubbed to ensure it was cleaned. The stored equipment to include the shower stretchers and chairs were cleaned to be ready for use. The housekeeping director cleaned the shower room per policy and stored cleaning products and equipment per facility policy 2. And Audit of Shower rooms was	

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F 584	Continued From page 2 following observation was made of the shower room on the 3rd floor across from room 324: Shower room floor has 1 ft. X 2 ft. area where the flooring has torn off and sub-floor is exposed, there are dark yellow / amber stains around the base of the toilet, and obvious brownish black marks on the floor. The shower stretchers and chairs are stained and appear dirty. There are laundry / trash bins in the shower room and clean towels, bath products and incontinent brief sitting on the lids of bins. On 8/10/22 at approximately 10:30 AM, an interview was conducted with the Maintenance Director who stated that he has been here since January 2022 and the hole in the floor was there when he arrived. However he claims he patched it with silicone. When asked how long has it been the size it is now with the sub floor showing, he stated a few months. He further stated that he got an estimate for a replacement of the floor in July. The Maintenance Director provided a statement from a local flooring company however the estimate was not signed at the bottom where it read "Accepted by (and the space for signature & date was not filled in). On 8/10/22 at approximately 2:00 PM the Administrator was asked if she had seen the shower room on the third floor and she indicated that she had not been in there recently. Surveyor accompanied the Administrator to the shower room and the Administrator agreed that the shower equipment (shower chairs and stretchers), needed cleaning, the toiletries and towels should not be placed on top of the dirty linen bins, and the floor needed repair.	F 584	conducted to ensure proper maintenance was in place to ensure the physical environment was free of accident hazards and presented clean, comfortable and homelike. Any areas found to be out of compliance were corrected. 3. Education was provided to the maintenance director on ensuring that showers rooms within the facility are in good repair and ready for patient use to ensure safety and a homelike environment. Education was provided to the housekeeping director and housekeeping staff on the policies and procedures on maintaning a clean and orderly shower room ready for patient use. 4. The maintenance director or designee will audit shower rooms 3x per week x 4 weeks and then monthly x 2 months to ensure the areas are properly maintained and do not require additional maintenance. The Housekeeping director or designee will audit all shower rooms 5x per week x 4 weeks and then monthly x 2 months to ensure that they are cleaned, orderly and ready for patient use. Results will be forwarded to the monthly QA meeting for review and comments. 5. Date of Compliance 9/24/2022	

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F 584	Continued From page 3 The Administrator was made aware of the concerns during the end of day meeting and no further information was provided.	F 584		
F 655 SS=D	Baseline Care Plan 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	F 655		9/24/22

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F 655	Continued From page 4 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 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 interview, clinical record review, facility documentation and in the course of an investigation, the facility staff failed to develop and implement a baseline care plan that includes the minimum healthcare information necessary to properly care for 1 Resident (#4) in a survey sample of 11 Residents. The findings included: For Resident #4 the facility staff failed to develop and implement a baseline care plan that included the required amount of oxygen and how it was to be provided. On 8/9/22 during a complaint investigation the clinical record was reviewed and it was discovered that in the baseline care plan there was a box checked for the Resident requiring "Oxygen." There was no amount of liters per minute specified, and no face mask or nasal cannula specified. On 8/10/22 an interview was conducted with LPN E who stated that the care plan is where you find out all of the things you need to do to care for your resident. When asked if Oxygen should be	F 655	1. Resident #4 is no longer at the center. 2. MDSC/designee will perform a quality review of current residents admitted in the last 30 days to ensure person centered base line care plans are developed and implemented completed within 48 hours of admission. 3. DCS/designee will educated nurses to initiate baseline care plans on new admissions. ED/designee will re-educate IDT team on patient centered base line care plans development and implementation completed within 48 hours of admission. MDSC and the IDT will review new admission in the clinical morning meeting to ensure the baseline care plan has been initiated on an ongoing basis. 4. MDSC/designee will conduct quality review of baseline care plans of new admits daily x 1 week, then q week x 4 weeks. The MDSC will report findings of the reviews to the QAPI Committee	

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F 655	Continued From page 5 addressed in the care plan she stated yes. She also stated it should be on the MAR and TAR too because it's considered a medication, and the tubing has to be changed and you have to know what kind of mask or nasal cannula to use. All of it should be in the care plan or the MAR and TAR. When asked where else she would look to find out about the oxygen requirements for a particular Resident she stated they should be in the orders. When asked if she remembered Resident #4 she stated that she remembered him quite well. When asked if he wore oxygen she stated that he did. When asked how much and was it mask or cannula she stated that she knew for sure it was nasal cannula but she would have to check for the amount of LPM. [Liters per Minute]. She reviewed his chart and could not find orders for oxygen. She could not find them in the care plan or the baseline care plan. The baseline care plan said he wore oxygen but not specifically how much or what type of mask. On 8/10/22 the DON was interviewed about Resident #4 and she stated that he wore oxygen but she wasn't sure of the amount. When asked where you would find that information she stated the orders, and the care plan as well as the MAR and TAR. On 8/10/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 655	monthly for 3 months for compliance and/or further revision. 5. Date of Compliance 9/24/2022	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		9/24/22

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F 657	Continued From page 6 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review, and in the course of complaint investigations, the facility staff failed to revise the care plan for 2 Residents (Resident #2, Resident #4) in a sample size of 11 Residents. The findings included: 1) For Resident #2, the facility staff failed to revise the care plan after a known incident of urinating on the floor.	F 657	1. Resident # 2 was affected and care plan was updated and #4 is no longer at the center. 2. MDSC/designee will perform a quality review of current residents care plans to ensure it has been revised to reflect the current care needs of the resident. 3. ED/designee will educate clinical and	

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F 657	Continued From page 7 On 08/09/2022 at 11:45 A.M., Resident #2 was observed in bed with a sweater on and blankets pulled up to their chin, and watching television. When asked if they had any concerns about the care they receive at the facility, Resident #2 indicated they had no concerns. When asked if staff assisted them to get to the bathroom, Resident #2 stated that they get themselves up to the bathroom and do not need assistance from the staff. On 08/09/2022, Resident #2's clinical record was reviewed. Resident #2's Minimum Data Set with an Assessment Reference Date of 06/23/2022 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of "15" indicative of intact cognition. Functional status for transfers and toileting were coded as requiring limited assistance from staff with one person physical assistance for support. Bowel and bladder continence were coded as frequently incontinent. Urinary toileting program was coded as "0" meaning "No." Resident #2's care plan was reviewed. A focus entitled, "[Resident #2] has an ADL [Activities of Daily Living] self-care performance deficit r/t [related to] muscle weakness, difficulty walking, Alzheimer's dementia ....refusal of care ...stuffing toilet paper/napkins in brief." Interventions associated with this focus included but were not limited to: "TOILET USE: The resident is able to with supervision. TRANSFER: The resident is able to transfer with setup." A focus entitled, "[Resident #2] has behaviors, rsd [resident] noted stuffing personal clothes in toilet, rsd places toilet paper on miniblinds in room, rsd	F 657	MDS staff on revising of care plans to ensure that it reflects the resident□s current POC. 4. MDSC/designee will perform quality audits on 15 random residents ensure revisions are made to residents care plans weekly for 4 weeks and monthly x 3 months. The MDSC will report Quality Improvement monitoring findings to QAPI Committee monthly for a period of 3 months for compliance and/or further revision. 5. Date of Compliance 9/24/2022	

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F 657	Continued From page 8	F 657		

places personal items under mattress, rsd wears multiple pull-ups at a time, stuffs toilet paper into briefs."

A focus entitled, "[Resident #2] has bladder incontinence r/t Alzheimer's disease, obstructive and reflux uropathy, presence of urogenital implants." Interventions associated with this focus included but was not limited to: "Monitor/document/report PRN [as needed] any possible causes of incontinence."

On 08/10/2022 at 9:15 A.M., Certified Nursing Assistant B (CNA B) was interviewed. When asked if Resident #2 had any behaviors, CNA B stated "Yes." When asked to describe behaviors, CNA B stated that if the Resident (#2) "has an accident" (meaning incontinent episode), Resident #2 will throw the linens on the floor. When asked if Resident #2 wears a brief, CNA B stated, "Yes." CNA B stated she has observed Resident #2 seated in her wheelchair with a brief on and urine on the floor around the wheelchair. CNA B stated that she has also seen Resident #2 standing at the bedside and urinating. CNA B stated that she would ask Resident #2 what happened and Resident #2 would state she couldn't make it to the bathroom in time. CNA B stated she would encourage Resident #2 to call for help but Resident #2 would not call for assistance and tries to do it herself. CNA B stated that about an hour after breakfast, she will assist Resident #2 to the bathroom in anticipation of her need to go to the bathroom.

On 08/10/2022 at approximately 2:00 P.M., the Director of Nursing (DON) was notified of findings of Resident #2's urinating on the floor in her room. When asked if that would be expected to

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F 657	Continued From page 9	F 657		

be addressed and included on the care plan, the DON stated, "Yes." At approximately 3:00 P.M., the administrator was also notified of findings.

Complaint defeicny

2. For Resident # 4 the facility staff failed to review and revise the care plan to include 2 actual falls with interventions for each.

On 8/9/22 during clinical record review, it was revealed that Resident # 4 had 2 falls. The first fall occurred on 2/26/22 and the second fall was on 2/28/22. A review of the clinical record revealed the following excerpts from progress notes:

"02/26/22 8:38 AM - Nursing Progress Note -Note Text: pt. found on floor at bedside.. pt states didn't fall just rolled out of bed trying to disconnect O 2 machine from CPAP.. vitals assessed skin observed no no [sic] skin injuries.. pt denies any pain or discomfort at this time.. pt denies hit head or injuries"

"2/28/2022 11:21 PM -Nursing Progress Note -Note Text: CNA staff noted resident sitting on the floor in front of his bed, she ask how did he fall he stated he was tranfer [sic] from the bed to the chair and he slid off the bed."

On 8/9/22 a review of the care plan revealed that the actual falls were not mentioned in the care plan and there were no interventions added in response to the first or second fall.

On 8/10/22 at approximately 12:15 PM an interview was conducted with LPN D who stated that when a Resident has a fall the care plan

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F 657	Continued From page 10 should be updated to include any new interventions for preventing further falls. On 8/10/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, facility documentation and in the course of an investigation the facility staff failed to provide care in keeping with professional standards of care for 1 Resident in a survey sample of 11 Residents. The findings included: For Resident #4 the facility staff failed to accurately verify and transcribe orders for oxygen on admission. Resident #4 was admitted to the facility on 2/23/22 after a hospital stay for COVID related pneumonia, including time spent in ICU on a ventilator. According to the hospital records the Resident had been on oxygen at 4 LPM (liters per minute) home for CHF (congestive heart failure) prior to the hospital stay. [Please note: Resident #4 had oxygen on in his admission photo, showing that he came to the	F 658	1. Residents #4 is no longer at this facility. 2. Residents on oxygen have the potential to be affected. An audit of residents currently using oxygen will be conducted to ensure orders are in place and accurate. 3. The DCS/Designee will educate licensed staff on ensuring obtaining, clarifying, inputting orders in PCC when residents are placed on oxygen. New admissions on oxygen and residents newly placed on oxygen will be reviewed in clinical morning meetings to verify oxygen orders are in place and accurate. 4. The DCS/Designee will conduct audits to verify that oxygen orders are in place and reviewed with the MD for accuracy on 15 random residents□ weekly x 4 weeks	9/24/22

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F 658	Continued From page 11 facility with oxygen in place.] On 8/10/22 a review of the clinical record revealed the following progress note: "2/23/2022 7:01 PM -Nursing Progress Note - Note Text: [Resident #4 name redacted] was admitted today 02/23/22. Current vital signs are: Temperature: 97.7 oral Pulse: 80 reg Respirations: [left blank] Blood pressure:135/75 denies any report of pain.. pt to have therapy on 2 oxygen via NS [sic] and CPAP no skin assessed. pt oriented to surroundings pt verbalized understanding will continue to monitor and provide pt care." "2/25/2022 at 8:53 AM -Physician Progress Note please see scanned document for full H&P. Briefly: admitted with AMS [Altered Mental Status], AHRF [Acute Hypoxemic Respiratory Failure] required ICU stay, intubated/ etubated [SIC] all due to post covid GNR [Gram Negative] PNA [Pneumonia] causing severe sepsis, all resolved. He has completed abx [antibiotic] course. noted further to have afib rvr [Rapid Ventricular Response] - rate now controlled. further with AKI [Acute Kidney Injury] on CKD [Chronic Kidney Disease] - now stabilizing but complicates treatment for his HF [Heart Failure] PEF [Preserved Ejection Fraction] whereby he needs diuretics. his DM [Diabetes] 2 currently under improved control. he will require short SNF [Skilled Nursing Facility] stay to return to baseline level of function which was independent with ADL [Activities of Daily Living] living with family in his home. he uses 4 L [liters] O2 all times. [Physician name redacted]" A Review of the physician's orders revealed there	F 658	and then monthly x 3 months. DCS will report in QAPI x 3months. 5. Date of Compliance 9/24/2022	

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F 658	Continued From page 12	F 658		

were no orders put in the computer for Oxygen rate, oxygen mask, or nasal cannula.

On 8/10/22 at approximately 3 PM an interview was conducted with LPN [licensed Practical Nurse] D who stated the admitting nurse is supposed to verify the orders with the MD or on Call [MD] and then place the orders in the computer, fax to pharmacy so the Resident does not miss his medications or treatments. When asked if this applied to oxygen orders she stated that it did apply to oxygen. She also stated it should be on the MAR [Medication Administration Record}]and TAR [Treatment Administration Record] too because it's considered a medication, and the tubing has to be changed and you have to know what kind of mask or nasal cannula to use.

On the afternoon of 8/10/22 the clinical record was reviewed with the DON who stated that oxygen should have been on the orders and it should have been clarified as to the rate of oxygen.

According to the National Institutes of Health website (https://www.ncbi.nlm.nih.gov/books/NBK2648/)

"Medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. It should be done at every transition of care in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting, service, practitioner, or level of care. This process

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F 658	Continued From page 13 comprises five steps: (1) Develop a list of current medications (2) Develop a list of medications to be prescribed (3) Compare the medications on the two lists (4) Make clinical decisions based on the comparison; and (5) Communicate the new list to appropriate caregivers and to the patient" [Please note: A careful comparison of the hospital discharge summary and the current physician orders would have highlighted the fact that oxygen had not been ordered.] On 8/10/22 during the end of day meeting the Administrator was made aware of the concern and no further information was provided.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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; This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide consistent Activities of Daily Living (ADL) assistance for one Resident (Resident #11) in a sample size of 11 Residents. For Resident #11, the facility staff failed to provide consistent bathing assistance for July and August 2022. The findings included: On 08/10/2022 at 9:00 A.M., Resident #11 was	F 677	1. Resident #11 was affected and received a shower on that day. 2. Residents requiring ADL assistance have the potential to be affected. The DCS/Designee will educate staff on completing showers/baths as scheduled and ADL documentation is completed for assigned residents. 3. CNAs will provide showers/baths as scheduled. The residents shower sheets	9/24/22

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F 677	Continued From page 14 interviewed. When asked if staff assisted them with Activities of Daily Living such as bathing and personal hygiene, Resident #11 stated, "Not really." When asked if they received showers and bed baths, Resident #11 stated, "Not often." Resident #11 confirmed they would like showers/baths more often. On 08/10/2022, Resident #11's clinical record was reviewed. Resident #11's Minimum Data Set with an Assessment Reference Date of 07/26/2022 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of "15" indicative of intact cognition. Bathing was coded as requiring physical help in part of bathing activity. Resident #11's care plan was reviewed. A focus dated 08/02/2021 entitled, "[Resident #11] has an ADL self-care performance deficit ..." included but was not limited to the following interventions: "The resident requires assistance by staff with bathing/showering. The ADL flowsheet for July and August 2022 were reviewed. According to the July 2022 flowsheet, Resident #11 did not receive a shower in the month of July and only one bed bath (07/27/2022). According to the August ADL flowsheet, Resident #11 did not receive a shower or bath from 08/01/2022 through the day of survey on 08/10/2022. On 08/10/2022 at 2:45 P.M., a copy of the facility's policy for ADL's was requested and the administrator confirmed that the facility does not have an ADL policy. The administrator was notified of findings.	F 677	will be reviewed daily and signed off by the charge nurse daily. ADL documentation will be reviewed daily to ensure that showers/baths were completed a licensed nurse. 4. The DCS/Designee will conduct audits to verify showers/baths were completed and ADL documentation and showers/baths were completed on 15 random residents□ weekly x4 weeks and then monthly x 3months. DCS will report in QAPI x3. 5. Date of Compliance 9/24/2022	

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F 689	Continued From page 15	F 689		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility documentation the facility staff failed to provide and environment free from accident hazards for 1 of 3 shower rooms. This has the potential to affect multiple residents. The findings included: For the Residents using the shower room located on the 3rd floor across from room 324, the facility staff failed to repair the flooring which creates a trip hazard for Residents and staff pushing wheel chairs, shower chairs and or shower stretchers. On 8/10/22 at approximately 10:00 AM the following observation was made of the shower room on the 3rd floor across from room 324. Shower room floor has 1 ft. X 2 ft. area where the flooring has torn off and sub-floor is exposed, creating an uneven surface. This creates a trip hazard as well as a hazard for wheelchairs, shower chairs and shower stretchers. On 8/10/22 at approximately 10:30 AM an interview was conducted with the Maintenance	F 689	1. The Flooring in the shower room was repaired to ensure the subflooring was not exposed, the floor was level so not to create a trip hazzard. 2. And Audit of Shower rooms was conducted to ensure proper maintenance was in place to ensure the areas were free of accident hazards. Any areas found to be out of compliance were repaired. 3. Education was provided to the maintenance director on ensuring that showers rooms within the facility are in good repair and ready for patient use to ensure safety and a homelike environment. 4. The maintenance director or designee will audit shower rooms 3x per week x 4 weeks and then monthly x 2 months to ensure the areas are properly maintained and do not require additional maintenance. Results will be forwarded to the monthly QA meeting for review and	9/24/22

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F 689	Continued From page 16 Director who stated that he has been here since January 2022 and the hole in the floor was there when he arrived, however he claimed he patched floor with silicone. At that time patched area was smaller than it was now. When asked how long the floor has been the size it is now with the sub floor showing, he stated a few months. He further stated that he got an estimate for a replacement of the floor in July. The Maintenance Director provided a statement from a local flooring company however the estimate was not signed at the bottom where it read "Accepted by (and the space for signature & date was not filled in). On 8/10/22 at approximately 2:00 PM the Administrator was asked if she had seen the shower room on the third floor and she indicated that she had not been in there recently. Surveyor accompanied the Administrator to the shower room. The Administrator was shown the floor and she agreed it was a trip hazard. Surveyor B demonstrated to the Administrator what could happened by pushing an empty shower chair over the area where the flooring was missing. The shower chair got caught on the uneven edge. The administrator agreed this could pose a potential hazard for a resident. The Administrator was made aware of the concerns during the end of day meeting and no further information was provided.	F 689	comments. 5. Date of Compliance 9/24/2022	
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	F 695		9/24/22

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F 695	Continued From page 17 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 staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide respiratory services for 2 Residents (Resident #1, Resident #4) in a sample size of 11 Residents. The findings included: 1. For Resident #1 (with a known severe obstructive sleep apnea condition), the facility staff failed to re-evaluate Resident #1's functional status to determine if Resident #1 could safely resume wearing their CPAP (continuous positive airway pressure) mask. On 08/10/2022, Resident #1's closed clinical record was reviewed. An excerpt of the Discharge Summary from the hospital dated 07/01/2021 documented, "OSA [Obstructive Sleep Apnea]: Recent sleep study at [an unidentified hospital] showed sever [sic] OSA. - Recommend CPAP 11cmH20 [11 centimeters of water] at night and w/ naps [with naps]." Resident #1's physician's orders were reviewed. There were no orders for CPAP. Resident #1's care plan was reviewed. Resident #1's diagnosis of Obstructive Sleep Apnea was not addressed on the care plan.	F 695	1. Residents #1 and #4 are no longer at this facility. 2. Residents on oxygen and using CPAPs and BiPAPs have the potential to be affected. All residents using oxygen orders will be reviewed daily during the clinical meeting to ensure they are in place and accurate. All residents utilizing CPAPs and Bipaps will be evaluated by therapy. 3. The DCS/Designee will educate licensed staff on ensuring that all oxygen orders are in place, and is accurate this will be reviewed daily. License staff will ensure that CPAP/BiPAP are in place as ordered daily. Admissions and residents new placed on oxygen will be reviewed in clinical meeting to verify order is in place and accurate. Rehab staff will evaluate admissions and residents newly ordered CPAP/BiPAP to ensure the resident is safely able to wear it. 4. The DCS/Designee will conduct audits to verify that oxygen orders are in place and reviewed with the MD for accuracy on 15 random residents□ weekly x 4 weeks and then monthly x 3 months. DCS will report in QAPI x 3months.	

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F 695	Continued From page 18 Excerpts of a progress note written by Employee H, the Nurse Practitioner, dated 07/02/2021 at 12:18 P.M. documented, "Presented 6/21/2021 to [hospital] with bilateral shoulder dislocation following a mechanical fall from a WC [wheelchair]." "NWB bilateral UE [non-weight bearing both upper extremities] with strict activity restrictions ..." "OSA: Stable, recent confirmed diagnosis and recommend CPAP 11cmH2O but can't wear until able to remove herself." Excerpts of the Nurse Practitioner (Employee H) note dated 07/19/2021 at 3:42 P.M. documented: "OSA: Stable; recent confirmed diagnosis and recommended CPAP 11cmH2O but can't wear until able to remove herself." "[Resident #1] was seen this morning lying in bed. Her splints [sic] is present on the left shoulder and she is eating breakfast with her right hand." On 08/10/2022 at 10:00 A.M., the Director of Rehab was interviewed. When asked about the progression of functional abilities for Resident #1, the Director of Rehab referred to the clinical notes and stated that when Resident #1 first arrived to the facility, Resident #1 was non-weight bearing for both arms and required to wear bilateral slings at all times. The Director of Rehab then stated that on 07/12/2021, there was an orthopedic physician's order for Resident #1 to remain non-weight bearing for both upper extremities but that a sling for the right arm was no longer required. The Director of Rehab stated that Resident #1's strength and range of motion had improved to where she could feed herself and had started dressing herself. When asked about Resident #1's ability to remove a CPAP mask, the Director of Rehab stated that since [Resident #1]	F 695	5. Date of Compliance 9/24/2022	

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had the strength to reach for her food with a utensil and feed herself, she may have had the ability to remove a CPAP mask but she was not evaluated for that specifically.

On 08/10/2022 at 1:00 P.M., the Nurse Practitioner, Employee H, was interviewed. When asked about considering a therapy evaluation for Resident #1 to safely remove a CPAP mask, the Nurse Practitioner referred to her own progress notes in the clinical record and stated that Resident #1 probably had enough strength to pull the CPAP off if she was feeding herself. The Nurse Practitioner then stated that according to her progress note dated 08/04/2021, Resident #1 was encouraged to use the CPAP and "she didn't care to use it." When asked how it was determined Resident #1 didn't care to use it, the Nurse Practitioner stated that she would ask Resident #1 if she used it, and Resident #1 would say, "No." The Nurse Practitioner stated she doesn't remember if Resident #1 had the CPAP machine/mask at the bedside but it may have been there which would have prompted her to ask Resident #1 about it. When asked about why there was no physician's order for the CPAP, the Nurse Practitioner stated that "We don't necessarily put in an order for CPAP ...unless Residents are forgetful or non-compliant." The Nurse Practitioner went on to say that most Residents just put their own CPAP on themselves. When asked about Resident #1 needing assistance to put a CPAP on due to having her left arm in a sling and restrictions to her upper extremities, the Nurse Practitioner indicated Resident #1 would have needed assistance putting the CPAP mask on.

An excerpt of the nurse practitioner note dated

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08/04/2021 documented, "Encourage use of CPAP as prescribed. Non-adherent."

On 08/10/2022, the facility staff provided a copy of their policy entitled, "General Administration of CPAP or BiPAP." An excerpt under the Section entitled, "Policy", it was documented, " ...CPAP is set up and monitored by a licensed nurse or respiratory therapist with a physician's order."

On 08/10/2022, the Administrator and Director of Nursing were notified of findings.

2. For Resident # 4 the facility staff failed accurately verify oxygen orders with the physician and clarify any discrepancies.

Resident #4 was admitted to the facility on 2/23/22 after a hospital stay for COVID related pneumonia, including time spent in ICU on a ventilator. The Resident had been on oxygen at 4 LPM (liters per minute) home for CHF (congestive heart failure) prior to the hospital stay.

Upon admission to the facility the Resident was wearing oxygen as he was discharged from the hospital with oxygen orders.
On 8/10/22 a review of the clinical record revealed the following progress note:

"2/23/2022 7:01 PM -Nursing Progress Note - Note Text: [Resident #4 name redacted] was admitted today 02/23/22. Current vital signs are: Temperature: 97.7 oral Pulse: 80 reg Respirations: [left blank] Blood pressure:135/75 denies any report of pain.. pt to have therapy on 2 oxygen via NS [sic] and CPAP no skin assessed.

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pt oriented to surroundings pt verbalized understanding will continue to monitor and provide pt care."

"2/25/2022 at 8:53 AM -Physician Progress Note please see scanned document for full H&P. Briefly: admitted with AMS, AHRF required ICU stay, intubated/ etubated all due to post covid GNR PNA causing severe sepsis, all resolved. he has completed abx course. noted further to have afib rvr - rate now controlled. further with AKI on CKD - now stabilizing but complicates treatment for his HF pEF whereby he needs diuretics. his DM 2 currently under improved control. he will require short SNF stay to return to baseline level of function which was independent with ADL's living with family in his home. he uses 4 L O 2 all times. [Physician name redacted]"

A Review of the physician's orders revealed there were no orders put in the computer for Oxygen, oxygen mask or nasal cannula.

On 8/10/22 at approximately 3 PM an interview was conducted with LPN D who stated that admitting nurse is supposed to verify the orders with the MD or on Call and then place the orders in the computer, fax to pharmacy so the Resident does not miss his medications or treatments. When asked if this applied to oxygen orders she stated that it did apply to oxygen. She also stated it should be on the MAR and TAR too because it's considered a medication, and the tubing has to be changed and you have to know what kind of mask or nasal cannula to use.

On the afternoon of 8/10/22 the clinical record was reviewed with the DON who stated that this should have been on the orders and it should

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F 695	Continued From page 22 have been clarified as to the rate of oxygen. On 8/10/22 during the end of day meeting the Administrator was made aware of the concern and no further information was provided.	F 695		