STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495234	A. BUILDING _____ B. WING _____	C 08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS POINTE REHABILITATION AND NURSING	5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 08/02/2022 through 08/04/2022. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of	E 036		9/2/22

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

Electronically Signed | 09/06/2022

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E 036	Continued From page 1 this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.	E 036	1. The facility created a training test for EPP to be completed upon hire in orientation and annually to be completed by the Maintenance Director.	

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E 036	Continued From page 2 Facility staff failed to provide evidence of documentation that the facility has a written training and testing program and documentation that the training and testing program has been reviewed and updated on at least an annual basis. The findings include: On 08/04/2022 at approximately 1:00 p.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) #8, maintenance director. Review of the facility's emergency preparedness plan failed to evidence that the facility has a written training and testing program that meets the requirements of the regulation and documentation that the training and testing program has been reviewed and updated on, at least an annual basis. On 08/04/2022 at approximately 1:25 p.m., an interview was conducted with ASM (administrative staff member) # 1, administrator. When asked about the facility's written training and testing program ASM stated that they did not have a written training and testing program. On 08/04/2022 at approximately 11:40 a.m., ASM # 1, administrator ASM # 2, director of nursing, and ASM # 5, regional director of clinical services, were made aware of the above findings. No further information was presented prior to exit.	E 036	2. All residents have a potential to be effective by this practice. 3. Maintenance Director was educated on the implementation of a written training and testing program that meet the requirements of the regulation for the emergency operations plan. 4. Administrator will audit new employee orientation monthly X 3 months to ensure written testing and training program was conducted with new employees. Results will be shared during QAPI meeting.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/2/22 through 8/4/22.	F 000		

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F 000	Continued From page 3 Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Ten complaints were investigated during this survey (VA00055013-unsubstantiated, VA00050448-substantiated with no deficiency, VA00050065-substantiated with deficiency, VA00050647-substantiated with deficiency, VA00050101-substantiated with no deficiency, VA00053394-substantiated with deficiency, VA00054412-substantiated with deficiency, VA00048369-substantiated with no deficiency, VA00054714-substantiated with deficiency, and VA00055298-substantiated with no deficiency). The Life Safety Code survey/report will follow. The census in this 90 bed certified bed facility was 66 at the time of survey. The survey sample consisted of 34 current Resident reviews and 9 closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		9/2/22

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F 580	Continued From page 4 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and in the course of a complaint investigation, it was determined the facility staff failed to notify the physician and/or responsible party (RP) of missed medication and a change in	F 580	1. Resident # 427, was discharged from the facility on 01/17/22 and resident # 50 was discharged from the facility on 08/05/22, no adverse reactions were documented.	

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F 580	Continued From page 5 condition for 2 of 43 residents in the survey sample, Resident #427 and #50. The findings include: 1. The facility failed to notify the RP of Resident #427's thrush and abrasion on buttocks. Resident #427 was admitted to the facility on 11/11/21 with diagnosis that included but were not limited to: atrial fibrillation, stroke, hypertension, end stage renal disease and coronary artery disease. The most recent MDS (minimum data set) assessment, a 5 day Medicare assessment, with an ARD (assessment reference date) of 11/18/21, coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as being totally dependent for bed mobility, transfer, locomotion, dressing, eating, hygiene and bathing. A review of the comprehensive care plan dated 11/16/21, which revealed, "FOCUS: The resident has actual impairment MASD (moisture associated skin damage) to skin integrity of the right gluteal folds related to fragile skin, incontinence. INTERVENTIONS: Keep skin clean and dry. Use lotion on dry intact skin. Encourage good nutrition and hydration in order to promote healthier skin." A review of the physician orders dated 12/20/21, revealed, "Nystatin Suspension 100000 UNIT/Milliliter Give 5 milliliter by mouth four times	F 580	2. Residents who have had change in condition or medication have a potential to be affected by this practice. 3. Director of Nursing/Designee will audit 100% of current residents with physicians orders related to a change in condition to ensure notifications were completed and documented. Director of Nursing/Designee has re-educated licensed nursing staff on RP notification and documentation of changes in condition. 4. Director of Nursing/Designee will review clinical dashboard Monday-Friday, to include 24-hour report and order listing report to ensure all notifications are made. All new admissions will be reviewed Monday-Friday to ensure notifications are completed, these audits will be completed for 4 weeks, any variances will be corrected, and re-education offered. The results of these audits will be reporting by Director of Nursing to QAPI team to ensure on-going compliance.	

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a day for Thrush for 5 Days swish and swallow."

A review of the physician orders dated 12/29/21, revealed, "Right buttocks: Cleanse with wound cleanser, apply skin prep to surrounding area, place Ca+ alginate (cut to fit) to wound bed, apply bordered dressing q 3 days. One time a day every 3 day(s) for open area."

A review of Resident #427's MAR (medication administration record) revealed, Nystatin Suspension 100000 UNIT/Milliliter Give 5 milliliter by mouth four times a day for Thrush for 5 Days swish and swallow was administered December 21-December 25, 2021 at 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM.

A review of Resident #427's TAR (treatment administration record) revealed, Right buttocks cleansed and dressed per physician orders every three days, administered per physician orders on 12/31/21, 1/3/22, 1/6/22, 1/9/22, 1/12/22 and 1/15/22.

A review of the nursing progress note dated 12/28/21 at 10:59 PM, revealed, "Residents daughter called and made aware about the residents open area to her buttocks. Also the resident's daughter voiced concerns about her mothers' throat maybe irritated, sore and her being unable to voice the discomfort. Daughter requested to see if her mother can see a doctor to get her throat checked and this writer notified her that the doctor will be notified."

A review of the nursing progress note dated 12/29/21 at 4:04 PM, revealed, "Spoke with resident RP addressed concerns regarding her decreased oral intake, resident completed 6 days

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of Nystatin for oral thrush on 12/26/21 oral cavity assessed by nurse practitioner and free of thrush at this time new order received for chlorhexadine twice daily. Reviewed labs and educated on resident baseline results and also reviewed current treatment to impaired skin integrity to right buttock with new order in place for calmoseptine and hydrocolloid change every 3 days and prn. RP (responsible party) verbalized understanding and was thankful for the updates at this time."

An interview was conducted on 8/3/22 at 8:40 AM with LPN (licensed practical nurse) #4, the wound care nurse. When asked what the process is for notifying the family if an alteration in skin integrity is found, LPN #4 stated, the person that finds the wound, would call the doctor and the RP. "As the wound nurse I would call the RP to double check and the RP would know within a 24 hour period."

An interview was conducted on 8/4/22 at 7:29 AM with LPN #5, the unit manager. When asked the process for notifying a resident's RP or family regarding a change in condition or treatment, LPN #5 stated, they would call the family member and let them know there is an issue or change and you should do an incident report and put a progress note in the chart.

An interview was conducted on 8/4/22 at 7:40 AM, with RN (registered nurse) #2. When asked the process for notification if a resident has a change in condition or change in treatment, RN #2 stated, we would notify the RP and document it in the progress note. When asked to look at Resident #427's chart to find RP notification notes, RN #2 stated, we have the order to treat thrush on 12/20/2. I have looked at the nursing progress note for 12/16/21, 12/18/21 and

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12/20/21, there is not anything about family notification about this.

An interview was conducted on 8/4/22 at 8:05 AM, with ASM (administrative staff member) #1, the administrator. When asked if there was evidence of RP notification for Resident #427's thrush and abrasion, ASM #1 stated, "No, the proper documentation was not done for RP notification. The staff that were in place, were inefficient and there was not a lot of structure in place. We have replaced the staff and are putting structures in place."

On 8/4/22 at approximately 12:20 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of clinical services were made aware of the findings.

A review of the facilities' "Notification of Changes" policy dated 11/1/20, revealed the following: "The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification.
Circumstances requiring notification include:
1. Accidents: Resulting in injury. Potential to require physician intervention.
2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: Life-threatening conditions, or Clinical complications.
Circumstances that require a need to alter treatment. This may include: New treatment. Discontinuation of current treatment due to:

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Adverse consequences. Acute condition. Exacerbation of a chronic condition. A transfer or discharge of the resident from the facility. A change of room or roommate assignment. A change in resident rights. Documentation of Notification: Record of the date, time, name of individual who received the notification and any pertinent response to the notice will be made in the clinical record in the resident's clinical record.

No further information was provided prior to exit.

Complaint deficiency.

2. The facility staff failed to notify the physician and the responsible party of a medication not given to Resident #50 (R50) on 8/3/2022 as observed during the medication administration observation.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/4/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is cognitively intact for making daily decisions.

On 8/3/2022 at 8:26 a.m., an observation was made of LPN (licensed practical nurse) #7 administering medication to R50. LPN #7 prepared morning medication for R50 and stated that they did not have the scheduled 9:00 a.m. dose of Donepezil HCL 10 mg (milligram) to give to R50 because it was not on the cart. LPN #7 stated that the computer said that the medication was on order from the pharmacy. LPN #7 stated that they were going to call the pharmacy to check on the status of the medication after they

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finished the morning medications.

The eMAR (electronic medication administration record) dated 8/1/2022-8/31/2022 for R50 documented in part, "Donepezil HCl Tablet 10 MG, Give 1 tablet by mouth one time a day for dementia -Start Date- 06/28/2022 0900 (9:00 a.m.)" The record for 8/3/2022 at 9:00 a.m. documented a "9" with the eMAR chart codes documenting "...9=Other / See Nurse Notes..." The eMAR failed to evidence administration of the 9:00 a.m. dose of Donepezil 10 mg on 8/3/2022.

The progress notes for R50 documented in part, "8/3/2022 08:42 (8:42 a.m.) Donepezil HCl Tablet 10 MG, Give 1 tablet by mouth one time a day for dementia. Not available, will call pharmacy."

The physician orders for R50 documented in part, "Donepezil HCl Tablet 10 MG, Give 1 tablet by mouth one time a day for dementia. Order Date: 06/27/2022."

On 8/03/2022 at 3:58 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that if a residents medication was not available they checked their cubex medication system (automated medication dispensing system) to see if there was a stock of the medication they could pull. LPN #5 stated that if not, they would reach out to the pharmacy to see if the medication could be sent that day. LPN #5 stated that if the medication was not able to be sent by the pharmacy they would notify the physician to get an order to hold the medication until the medication arrived and notify the responsible party. LPN #5 stated that there should be documentation in the progress notes of

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F 580	Continued From page 11 notification of the pharmacy, physician and the responsible party. On 8/04/2022 at 7:52 a.m., an interview was conducted with LPN #4. LPN #4 stated that if a residents medication was not available staff were to contact the pharmacy to see if it was in route to them. LPN #4 stated that if the medication was due to be administered and not available they should notify the physician to get an order to hold the medication until it arrived and document the notification of the physician and the responsible party. LPN #4 stated that they also have a cubex medication system in house that stores some medications that staff could pull from if needed. Review of the clinical record on 8/4/2022 at 9:30 a.m. failed to evidence documentation of notification of the physician or the responsible party for the missed dose of Donepezil HCL on 8/3/2022, or communication with the pharmacy. On 8/4/2022 at 11:40 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.	F 580		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or	F 585		

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reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey

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Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as

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F 585	Continued From page 14 the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to maintain documentation of grievances. The facility staff failed to evidence documentation of grievances for 2020 and 2021. This was cited as past non-compliance. The findings include: A review of facility grievances failed to reveal documentation of grievances for 2020 and 2021. On 8/4/22 at 7:32 a.m., ASM (administrative staff member) #1 (the administrator) stated she did not have the facility grievances for 2020 and 2021. ASM #1 stated the former social services director was no longer employed at the facility and the current social services director completed an action plan. On 8/4/22 at 7:37 a.m., an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 stated that once she receives a grievance, she reviews it and provides it to the designated department head. OSM #1 stated an investigation is completed, a solution is developed, and then she follows up with the resident and/or family member who put forth the concern. OSM #1 stated all grievances	F 585	Past noncompliance: no plan of correction required.	

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F 585	Continued From page 15 are logged into a binder then at the end of each year, the binder will be purged into a file that will be kept for seven years. OSM #1 presented an action plan. The action plan with a completion date of 4/15/22 documented, "Root cause: Logging and filing system of Grievances unknown. Plan: to receive and review all grievances, provide the document to the responsible department head to investigate and provide a solution. Follow up with concerns and keep a log of all grievances from each month moving forward. Outcome- To ensure all resident and family concerns are acknowledged and addressed in a timely manner." No concerns regarding grievances for 2022 were identified during the survey. On 8/4/22 at 11:58 a.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Resident and Family Grievances" documented, "Grievance records will be maintained for three (3) years." No further information was presented prior to exit.	F 585		
F 606 SS=E	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State	F 606		9/2/22

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F 606	Continued From page 16 nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, employee record review, and in the course of a complaint investigation, it was determined the facility staff failed to complete criminal background checks on 7 out of 25 employee records reviewed. The findings include: Twenty five employee records were reviewed. Seven of the twenty five employee records failed to evidence the completion of a criminal background check, OSM (other staff member) #14, central supply clerk; OSM #15, physical therapist; LPN (licensed practical nurse) #9; OSM #17, dietary aide; LPN #12; CNA (certified nursing assistant) #10; and OSM #6, the business office manager/human resources staff member. Two of the seven employees were still employed at the facility, LPN #9 and OSM #6. An interview was conducted with OSM #6 on	F 606	1. A criminal background check was conducted on staff member #9 and #6. No concerning results were returned. 2. All residents have the potential to be affected by this practice 3. A complete audit of all current employee files was done to make sure they contain all forms needed to pass a State Survey Audit. The BOM and ABOM were educated on the need to obtain criminal background checks on all new employee hires. 4. The assistant and business office manage will audit 3 files per week of employees who were hired for the previous week to make sure that they are complete with a background check, sworn statement, license verification, and reference check	

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8/4/2022 at 7:58 a.m. When asked the process for a new hire, OSM #6 stated in the beginning after the new employee has their interview, we get their identification information, social security number, and vaccination card is submitted to us. Then we run the background check using their ID and social security number. When all information is back, we set them up for orientation. When asked why there are missing criminal background checks, OSM #6 stated she gave us all the documents she could find. OSM #6 stated, she couldn't run her own criminal background check. The previous human resources person had not completed it prior to her starting employment at the facility.

The facility policy, "Abuse, Neglect and Exploitation" documented in part, "The components of the facility abuse prohibition plan are discussed herein: 1. Screening: A. Potential employees will be screened for a history of abuse, neglect, exploitation or misappropriation of resident property; 1. Background, reference and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers and consultants...3. The facility will maintain documentation of proof that the screening occurred."

ASM (administrative staff member) # 1, the administrator, ASM #2, the director of nursing, and ASM #5, the director of clinical services, were made aware of the above concern on 8/4/2022 at 11:46 a.m.

No further information was obtained prior to exit.

Complaint deficiency.

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F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to implement their policies for the investigation of an allegation of abuse for one of 43 residents in the survey sample, Resident #26; and failed to implement their policies for the investigation of an injury of unknown origin for one of 43 residents in the survey sample, Resident #5 (R5); and failed to implement their policies for the completion of criminal background checks for 7 of 25 employee record reviews. The findings include: 1. The facility staff failed to implement their policies for the investigation of an allegation of abuse, at the time the allegation was made by the resident, for Resident #26 (R26). On the most recent MDS (minimum data set) assessment, with an ARD of 5/30/2022, the resident scored a 15 out of 15 on the BIMS score,	F 607	1. Resident # 5 and resident # 26 currently reside in the facility and no adverse effects have been observed. 2. All current residents have a potential to be effective by this practice. 3. Director of Nursing/Designee will re-educate staff in all departments regarding abuse policy and procedures to include timely reporting of allegations of abuse and injuries of unknown origins and escalation process for abuse notification. 100% audit was conducted on current employee files with no further missing background identified. Administrator will provide education to BOM/ABOM re: process for obtaining background checks on all new hires. 4. Administrator will audit all new hires x 4 weeks to ensure background check is completed. Director of Nursing/Designee	9/2/22

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F 607	Continued From page 19 indicating the resident was not cognitively impaired for making daily decisions. Diagnoses included but were not limited to: schizophrenia and dementia The "Facility Reported Incident (FRI)" dated, 11/4/2020, documented in part, "Report date: 11/4/2020. Residents involved: (Name of R26). Incident Type: Allegation of abuse/mistreat. Describe incident: (R26) report that a big black man had come into her room and threw her on the bed and they all jumped on her...Resident was fully assessed by nursing staff and bruises were all properly documented. Responsible party and physician were notified. Findings on investigation will be reported back in 5 working days." The "Facility Reported Incident (FRI)" dated, 11/11/2020, documented in part, "All staff on 3-11 and 11-7 were interviewed on whether they had witnessed or had knowledge of the incident in question. Statements were collected from all staff that did indicate that they had knowledge of the incident. A thorough head to toe assessment was completed on both residents, injuries and or bruises were all documented at that time. APS (adult protective services) worker (name of APS worker) and (name of detective) interviewed each resident and took pictures of all injuries/bruises... (R26) was unable to accurately recall detailed of the event as well as the names of the alleged employees involved. She stated that she is very confused and has difficulties remembering things. (Name of a male CNA) called top speak with HR (human resources) on 11/10/2020 and informed her that they were resigning effective immediately and that he never works with female residents	F 607	will review 24-hour report Monday-Friday, to ensure injuries of unknown origin are reviewed and investigated for 4 weeks the results of these audits will be reported by the Director of Nursing to the QAPI team for ongoing compliance.	

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and does not know who (R26) is. Statement from the 3-11 CNA (certified nursing assistant) indicated that (R26) was sitting at the nurse's station at the end of the shift free of any injuries and or bruises...The facility has unsubstantiated the allegation against the male CNA. MD (medical doctor) and RP (responsible party) were made aware of the outcome of the investigation."

The nurse's note dated, 11/1/2020 at 7:37 a.m., documented in part, "Note Text: @ (at) 0255 (2:55 a.m.) resident noted to have bleeding and bruising above right eyelid at nursing station. Resident noted to have 2 shallow lacerations above right eye lid. Injury unwitnessed. Resident very poor historian. Injury was not noted earlier in shift. Resident came from room. Resident's floor noted to have blood on it. Resident clothes scattered on floor. Attempt to clean lacerations and measure them. Resident refused. Walking away from nursing staff. Resident noted to be agitated. No change in behavior when normally agitated. Resident refused vital signs and neuro check to be taken. ADON (assistant director of nursing) notified of above. (Name of physician group) call at 0330 (3:30 a.m.) awaiting callback. 0520 (5:20 a.m.) Received callback from (Name of physician group) notified of the above. 0540 (5:40 a.m.) Received callback from (name of physician group) (name of NP - nurse practitioner) to send resident to ER (emergency room) via 911 for evaluation. 0540 (5:40 a.m.) 911 called. 0555 (5:55 a.m.) EMS (emergency medical services) arrived and assessed resident. Resident refused to go to ER. ADON notified. Called and left VM (voice mail) to notify (name of physician group) of above."

The "Skin Condition Observation Sheet," dated

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11/5/2020, five days after the initial reported incident, documented the following: 2 x 1 (in centimeters) bruising/black purple noted on right eye; two lacerations in the eyebrow area, scattered bruising on right forearm; swollen right hand; 0.3 x 0.1 area on left chest; 2x1.5 bruising on left antecubital area; 1 x 1.5 area on left arm below the elbow; 0.5 x 0.5 area on left wrist; 1.2 x 2 area noted on right abdomen.

None of the staff that were involved in this incident were employed at the facility at the time of survey. This included the administrator, director of nursing, the nurse that wrote the above note, the CNAs documented in the FRI and the ADON.

An interview was conducted with LPN (licensed practical nurse) # 5, on 8/3/2022 at 10:42 a.m. When asked the process for when a resident makes a statement that they have been abused, LPN #5 stated you have to initiate an investigation immediately. An incident report must be made. LPN #5 stated a full body assessment must be completed, notify the MD and RP (responsible party). Interview the people that cared for the resident, if the roommate is alert and verbal, would interview them. LPN #5 stated that if the resident named a staff member then that staff member would be placed on suspension. When asked if you have to report an allegation of abuse to the director of nursing (DON) or the administrator, LPN #5 stated that a nurse should report it to the DON or administrator as soon as you are aware of it.

An interview was conducted with ASM (administrative staff member) #1, the administrator, on 8/4/2022 at 11:19 a.m. When

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asked what steps are to be taken when a resident stated they have been abused, ASM #1 stated everyone stops what they are doing. First make sure the resident is safe, no injuries, no harm. Report a FRI. We have two hours to report abuse, start an investigation depending on what it is, if staff is involved, suspend the staff member. Question the resident and roommate. ASM #1 stated she takes a census sheet and the staff assignment sheet and start interviews with everyone on that group assignment. ASM #1 stated she would interview the whole hall of residents. Make sure the doctor and family is aware. Complete the investigation, if the allegation is founded, then we notify the police. When asked when she should be notified of an allegation of abuse, ASM #1 stated as soon as it happens.

The facility policy, "Abuse, Neglect and Exploitation," documented in part, V. Investigation of Alleged Abuse, and Exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in the handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent and cause and 6. Providing complete and thorough documentation of the investigation.

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ASM (administrative staff member) # 1, the administrator, ASM #2, the director of nursing, and ASM #5, the director of clinical services, were made aware of the above concern on 8/4/2022 at 11:46 a.m.

No further information was obtained prior to exit.

2. The facility staff failed to implement their policies for the investigation of an injury of unknown origin for Resident #5 (R5).

On the most recent MDS assessment, a quarterly assessment, with an ARD of 5/4/2022, the resident scored a 0 out of 15 on the BIMS score, indicating the resident is severely cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance to being totally dependent upon the staff for all of their activities of daily living.

The "Facility Reported Incident (FRI)" dated, 11/4/2020, documented in part, "Report date: 11/4/2020. Residents involved: (Name of R5). Incident Type: Allegation of abuse/mistreat; injury of unknown origin. Describe incident: (R5) injury of unknown origin. Resident unable to inform staff how bruise to her chest occurred...Resident was fully assessed by nursing staff and bruises were all properly documented. Responsible party and physician were notified. Findings on investigation will be reported back in 5 working days."

The "Facility Reported Incident (FRI)" dated, 11/11/2020, documented in part, "All staff on 3-11 and 11-7 were interviewed on whether they had witnessed or had knowledge of the incident in

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question. Statements were collected from all staff that did indicate that they had knowledge of the incident. A thorough head to toe assessment was completed on both residents, injuries and or bruises were all documented at that time. APS (adult protective services) worker (name of APS worker) and (name of detective) interviewed each resident and took pictures of all injuries/bruises... (R5). (R5) was unable to recall details of the event or how she got her bruises...(Name of a male CNA) called top speak with HR (human resources) on 11/10/2020 and informed her that they were resigning effective immediately and that he never works with female residents and does not know who (R26) is. Statement from the 3-11 CNA (certified nursing assistant) indicated that (R5) was sitting at the nurse's station at the end of the shift free of any injuries and or bruises...The facility has unsubstantiated the allegation against the male CNA. MD (medical doctor) and RP (responsible party) were made aware of the outcome of the investigation."

The nurse's note dated, 11/1/2022 at 8:10 a.m. documented, "Note Text: CNA giving care requested this nurse to assess resident, upon assessment noted bruised area to left clavicular area, purple in color, non-tender to touch, skin tear to right upper arm, approximately 1.5" in length, purple in color, cleansed with DWC (wound cleanser), pat dry, applied bacitracin, then covered with dry dressing. MD made aware/RP (name of RP) notified. Treatment initiated. Will continue to monitor status."

There were no skin assessments for around the date above in the clinical record.

There were no skin assessments documented in

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the FRI investigation folder. The only documentation, other than on the actual FRI of 11/4/2020, in the FRI investigation folder was related to the other resident documented on the FRI, not R5.

An interview was conducted with LPN (licensed practical nurse) #5, on 8/3/2022 at 10:42 a.m. When asked the process for when a nurse finds an injury of unknown origin on a resident, LPN #5 stated you have to initiate an investigation as to where the injury came from. An incident report must be made. LPN #5 stated a full body assessment must be completed, notify the MD and RP (responsible party). Interview the people that cared for the resident, if the roommate is alert and verbal, would interview them. When asked if you have to report an injury of unknown origin to the director of nursing (DON) or the administrator, LPN #5 stated that a nurse should report it to the DON or administrator as soon as you are aware of it.

An interview was conducted with ASM (administrative staff member) #1, the administrator, on 8/4/2022 at 11:19 a.m. When asked what steps are to be taken when a resident stated they have been abused, ASM #1 stated everyone stops what they are doing. First make sure the resident is safe, no injuries, no harm. Report a FRI. We have two hours to report abuse, start an investigation depending on what it is, if staff is involved, suspend the staff member. Question the resident and roommate. ASM #1 stated she takes a census sheet and the staff assignment sheet and start interviews with everyone on that group assignment. ASM #1 stated she would interview the whole hall of residents. Make sure the doctor and family is

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aware. Complete the investigation, if allegation is founded, then we notify the police. When asked when she should be notified of an allegation of abuse, ASM #1 stated as soon as it happens. When asked if this procedure is the same for an injury of unknown origin such as a bruise, ASM #1 stated, yes, because that could have been caused by abuse. ASM #1 stated she could not locate any further documentation related to the bruises found on R5.

The facility policy, "Abuse, Neglect and Exploitation" documented in part, " IV - Identification of Abuse, Neglect and Exploitation: B. Possible indicators of abuse include; but are not limited to: 2. Physical marks such as bruises or patterned appearances such as a hand print, belt or ring mark on a resident's body. 3. Physical injury of a resident, of unknown source.... V - Investigation of alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur...Vii. Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes; a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury."

ASM (administrative staff member) # 1, the administrator, ASM #2, the director of nursing,

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and ASM #5, the director of clinical services, were made aware of the above concern on 8/4/2022 at 11:46 a.m.

No further information was obtained prior to exit.

3. The facility staff failed to implement their policies for the completion of criminal background checks for 7 of 25 employee record reviews.

Twenty five employee records were reviewed. Seven of the twenty five employee records failed to evidence the completion of a criminal background check, OSM (other staff member) #14, central supply clerk; OSM #15, physical therapist; LPN (licensed practical nurse) #9; OSM #17, dietary aide; LPN #12; CNA (certified nursing assistant) #10; and OSM #6, the business office manager/human resources staff member.

Two of the seven employees were still employed at the facility, LPN #9 and OSM #6.

An interview was conducted with OSM #6 on 8/4/2022 at 7:58 a.m. When asked the process for a new hire, OSM #6 stated in the beginning after the new employee has their interview, we get their identification information, social security number, and vaccination card is submitted to us. Then we run the background check using their ID and social security number. When all information is back, we set them up for orientation. When asked why there are missing criminal background checks, OSM #6 stated she gave us all the documents she could find. OSM #6 stated, she couldn't run her own criminal background check. The previous human resources person had not completed it prior to her starting employment at the facility.

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F 607	Continued From page 28 The facility policy, "Abuse, Neglect and Exploitation" documented in part, "The components of the facility abuse prohibition plan are discussed herein: 1. Screening: A. Potential employees will be screened for a history of abuse, neglect, exploitation or misappropriation of resident property; 1. Background, reference and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers and consultants...3. The facility will maintain documentation of proof that the screening occurred." ASM (administrative staff member) # 1, the administrator, ASM #2, the director of nursing, and ASM #5, the director of clinical services, were made aware of the above concern on 8/4/2022 at 11:46 a.m. No further information was obtained prior to exit.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		9/2/22

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F 609	Continued From page 29 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint allegation, it was determined the facility staff failed to report to the state agency an allegation of abuse for one of 43 residents in the survey sample, Resident #26 (R26); and failed to report an injury of unknown origin for one of 43 residents in the survey sample, Resident #5 (R5). The findings include: 1. The facility staff failed to file a report, of an allegation of abuse, to the State Agency as required after the resident made the statement of alleged abuse, for Resident #26 (R26) On the most recent MDS (minimum data set) assessment, with an ARD of 5/30/2022, the resident scored a 15 out of 15 on the BIMS score, indicating the resident was not cognitively impaired for making daily decisions. Diagnoses included but were not limited to: schizophrenia	F 609	1. Resident # 5, currently reside in the facility and no adverse effects have been observed. Resident # 26 currently reside in the facility no adverse effects from this practice were observed. Facility reported incident was submitted on 11/4/20 for Resident #26. 2. All current residents have a potential to be effective by this practice. 3. Director of Nursing/Designee will re-educate staff in all departments regarding abuse policy and procedures to include timely reporting of allegations of abuse and injuries of unknown origins. Director of Nursing/Designee will re-educate staff in all departments on the escalation process for any allegations of abuse or injury of unknown origins to ensure timely responses.	

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F 609	Continued From page 30 and dementia The "Facility Reported Incident (FRI)" dated, 11/4/2020, documented in part, "Report date: 11/4/2020. Residents involved: Name of R26. Incident Type: Allegation of abuse/mistreat. Describe incident: (R26) report that a big black man had come into her room and threw her on the bed and they all jumped on her...Resident was fully assessed by nursing staff and bruises were all properly documented. Responsible party and physician were notified. Findings on investigation will be reported back in 5 working days. The "Facility Reported Incident (FRI)" dated, 11/11/2020, documented in part, " All staff on 3-11 and 11-7 were interviewed on whether they had witnessed or had knowledge of the incident in question. Statements were collected from all staff that did indicate that they had knowledge of the incident. A thorough head to toe assessment was completed on both residents, injuries and or bruises were all documented at that time. APS (adult protective services) worker (name of APS worker) and (name of detective) interviewed each resident and took pictures of all injuries/bruises... (R26) was unable to accurately recall detailed of the event as well as the names of the alleged employees involved. She stated that she is very confused and has difficulties remembering things. (Name of a male CNA) called top speak with HR (human resources) on 11/10/2020 and informed her that they were resigning effective immediately and that he never works with female residents and does not know who (R26) is. Statement from the 3-11 CNA (certified nursing assistant) indicated that (R26) was sitting at the nurse's station at the end of the shift free of any injuries	F 609	4. Administrator will audit all facility reportable incidents to ensure any abuse allegations or suspected abuse is reported within the required time frames for four weeks. Results will be reported to the QAPI team for ongoing compliance.	

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and or bruises...The facility has unsubstantiated the allegation against the male CNA. MD (medical doctor) and RP (responsible party) were made aware of the outcome of the investigation."

The nurse's note dated, 11/1/2020 at 7:37 a.m., documented in part, "Note Text: @ (at) 0255 (2:55 a.m.) resident noted to have bleeding and bruising above right eyelid at nursing station. Resident noted to have 2 shallow lacerations above right eye lid. Injury unwitnessed. Resident very poor historian. Injury was not noted earlier in shift. Resident came from room. Resident's floor noted to have blood on it. Resident clothes scattered on floor. Attempt to clean lacerations and measure them. Resident refused. Walking away from nursing staff. Resident noted to be agitated. No change in behavior when normally agitated. Resident refused vital signs and neuro check to be taken. ADON (assistant director of nursing) notified of above. (Name of physician group) call at 0330 (3:30 a.m.) awaiting callback. 0520 (5:20 a.m.) Received callback from (Name of physician group) notified of the above. 0540 (5:40 a.m.) Received callback from (name of physician group) (name of NP - nurse practitioner) to send resident to ER (emergency room) via 911 for evaluation. 0540 (5:40 a.m.) 911 called. 0555 (5:55 a.m.) EMS (emergency medical services) arrived and assessed resident. Resident refused to go to ER. ADON notified. Called and left VM (voice mail) to notify (name of physician group) of above."

The "Skin Condition Observation Sheet," dated 11/5/2020, five days after the initial reported incident, documented the following: 2 x 1 (in centimeters) bruising/black purple noted on right eye; two lacerations in the eyebrow area,

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scattered bruising on right forearm; swollen right hand; 0.3 x 0.1 area on left chest; 2x1.5 bruising on left antecubital area; 1 x 1.5 area on left arm below the elbow; 0.5 x 0.5 area on left wrist; 1.2 x 2 area noted on right abdomen.

None of the staff that were involved in this incident were employed at the facility at the time of survey. This included the administrator, director of nursing, the nurse that wrote the above note, the CNAs documented in the FRI and the ADON.

An interview was conducted with LPN (licensed practical nurse) #5, on 8/3/2022 at 10:42 a.m. When asked the process for when a resident makes a statement that they have been abused, LPN #5 stated you have to initiate an investigation immediately. An incident report must be made. LPN #5 stated a full body assessment must be completed, notify the MD and RP (responsible party). Interview the people that cared for the resident, if the roommate is alert and verbal, would interview them. LPN #5 stated that if the resident named a staff member then that staff member would be placed on suspension. When asked if you have to report an allegation of abuse to the director of nursing (DON) or the administrator, LPN #5 stated that a nurse should report it to the DON or administrator as soon as you are aware of it.

An interview was conducted with ASM (administrative staff member) #1, the administrator, on 8/4/2022 at 11:19 a.m. When asked what steps are to be taken when a resident stated they have been abused, ASM #1 stated everyone stops what they are doing. First make sure the resident is safe, no injuries, no harm.

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Report a FRI. We have two hours to report abuse, start an investigation depending on what it is, if staff is involved, suspend the staff member. Question the resident and roommate. ASM #1 stated she takes a census sheet and the staff assignment sheet and start interviews with everyone on that group assignment. ASM #1 stated she would interview the whole hall of residents. Make sure the doctor and family is aware. Complete the investigation, if the allegation is founded, then we notify the police. When asked when she should be notified of an allegation of abuse, ASM #1 stated as soon as it happens.

The facility policy, "Abuse, Neglect and Exploitation" documented in part, "VII. Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of an alleged violations to the Administrator, state agency, adult protective services and to all other required agencies(e.g., law enforcement when applicable) within specified timeframes; a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or results in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury...B. The Administrator will follow up government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.

ASM (administrative staff member) # 1, the administrator, ASM #2, the director of nursing, and ASM #5, the director of clinical services, were

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made aware of the above concern on 8/4/2022 at 11:46 a.m.

No further information was obtained prior to exit.

2. The facility staff failed to report to the State Agency, within 24 hours, an injury of unknown origin, a bruise, for Resident #5 (R5).

On the most recent MDS assessment, a quarterly assessment, with an ARD of 5/4/2022, the resident scored a 0 out of 15 on the BIMS score, indicating the resident is severely cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance to being totally dependent upon the staff for all of their activities of daily living.

The "Facility Reported Incident (FRI)" dated, 11/4/2020, documented in part, "Report date: 11/4/2020. Residents involved: (Name of R5). Incident Type: Allegation of abuse/mistreat; injury of unknown origin. Describe incident: (R5) injury of unknown origin. Resident unable to inform staff how bruise to her chest occurred...Resident was fully assessed by nursing staff and bruises were all properly documented. Responsible party and physician were notified. Findings on investigation will be reported back in 5 working days."

The "Facility Reported Incident (FRI)" dated, 11/11/2020, documented in part, "All staff on 3-11 and 11-7 were interviewed on whether they had witnessed or had knowledge of the incident in question. Statements were collected from all staff that did indicate that they had knowledge of the incident. A thorough head to toe assessment was completed on both residents, injuries and or

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bruises were all documented at that time. APS (adult protective services) worker (name of APS worker) and (name of detective) interviewed each resident and took pictures of all injuries/bruises... (R5). (R5) was unable to recall details of the event or how she got her bruises...(Name of a male CNA) called top speak with HR (human resources) on 11/10/2020 and informed her that they were resigning effective immediately and that he never works with female residents and does not know who (R26) is. Statement from the 3-11 CNA (certified nursing assistant) indicated that (R5) was sitting at the nurse's station at the end of the shift free of any injuries and or bruises...The facility has unsubstantiated the allegation against the male CNA. MD (medical doctor) and RP (responsible party) were made aware of the outcome of the investigation."

The nurse's note dated, 11/1/2022 at 8:10 a.m. documented, "Note Text: CNA giving care requested this nurse to assess resident, upon assessment noted bruised area to left clavicular area, purple in color, non-tender to touch, skin tear to right upper arm, approximately 1.5" in length, purple in color, cleansed with DWC (wound cleanser), pat dry, applied bacitracin, then covered with dry dressing. MD made aware/RP (name of RP) notified. Treatment initiated. Will continue to monitor status."

There were no skin assessments on or around the date above in the clinical record.

There were no skin assessments documented in the FRI investigation folder. The only documentation, other than on the actual FRI of 11/4/2020, in the FRI investigation folder was related to the other resident documented on the

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FRI, not R5.

An interview was conducted with LPN (licensed practical nurse) #5, on 8/3/2022 at 10:42 a.m. When asked the process for when a nurse finds an injury of unknown origin on a resident, LPN #5 stated you have to initiate an investigation as to where the injury came from. An incident report must be made. LPN #5 stated a full body assessment must be completed, notify the MD and RP (responsible party). Interview the people that cared for the resident, if the roommate is alert and verbal, would interview them. When asked if you have to report an injury of unknown origin to the director of nursing (DON) or the administrator, LPN #5 stated that a nurse should report it to the DON or administrator as soon as you are aware of it.

An interview was conducted with ASM (administrative staff member) #1, the administrator, on 8/4/2022 at 11:19 a.m. When asked what steps are to be taken when a resident stated they have been abused, ASM #1 stated everyone stops what they are doing. First make sure the resident is safe, no injuries, no harm. Report a FRI. We have two hours to report abuse, start an investigation depending on what it is, if staff is involved, suspend the staff member. Question the resident and roommate. ASM #1 stated she takes a census sheet and the staff assignment sheet and start interviews with everyone on that group assignment. ASM #1 stated she would interview the whole hall of residents. Make sure the doctor and family is aware. Complete the investigation, if r allegation is founded, then we notify the police. When asked when she should be notified of an allegation of abuse, ASM #1 stated as soon as it happens.

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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 609	Continued From page 37 When asked if this procedure is the same for an injury of unknown origin such as a bruise, ASM #1 stated, yes, because that could have been caused by abuse. ASM #1 stated she could not locate any further documentation related to the bruises found on R5. ASM (administrative staff member) # 1, the administrator, ASM #2, the director of nursing, and ASM #5, the director of clinical services, were made aware of the above concern on 8/4/2022 at 11:46 a.m. No further information was obtained prior to exit.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interivew, facility document	F 610	1. Resident # 5, currently reside in the	9/2/22

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review, clinical record review and in the course of a complaint investigation, it was detrmined the facility staff failed to investigate an injury of unknown origin for one of 43 residents in the survey sample, Resident #5 (R5).

The findings include:

On the most recent MDS assessment, a quarterly assessment, with an ARD of 5/4/2022, the resident scored a 0 out of 15 on the BIMS score, indicating the resident is severely cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance to being totally dependent upon the staff for all of their activities of daily living.

The "Facility Reported Incident (FRI)" dated, 11/4/2020, documented in part, "Report date: 11/4/2020. Residents involved: (Name of R5). Incident Type: Allegation of abuse/mistreat; injury of unknown origin. Describe incident: (R5) injury of unknown origin. Resident unable to inform staff how bruise to her chest occurred...Resident was fully assessed by nursing staff and bruises were all properly documented. Responsible party and physician were notified. Findings on investigation will be reported back in 5 working days."

The "Facility Reported Incident (FRI)" dated, 11/11/2020, documented in part, "All staff on 3-11 and 11-7 were interviewed on whether they had witnessed or had knowledge of the incident in question. Statements were collected from all staff that did indicate that they had knowledge of the incident. A thorough head to toe assessment was completed on both residents, injuries and or bruises were all documented at that time. APS

facility and no adverse effects have been observed.

2. All current residents have a potential to be effective by this practice.

3. Director of Nursing/Designee will re-educate staff in all departments regarding abuse policy and procedures to include timely reporting of allegations of abuse and injuries of unknown origins. Director of Nursing/Designee will re-educate staff in all departments on the escalation process for any allegations of abuse or injury of unknown origins to ensure timely responses.

4. Administrator will audit all facility reportable incidents to ensure any abuse allegations or suspected abuse is reported within the required time frames for four weeks. Results will be reported to the QAPI team for ongoing compliance.

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(adult protective services) worker (name of APS worker) and (name of detective) interviewed each resident and took pictures of all injuries/bruises... (R5). (R5) was unable to recall details of the event or how she got her bruises...(Name of a male CNA) called top speak with HR (human resources) on 11/10/2020 and informed her that they were resigning effective immediately and that he never works with female residents. Statement from the 3-11 CNA (certified nursing assistant) indicated that (R5) was sitting at the nurse's station at the end of the shift free of any injuries and or bruises...The facility has unsubstantiated the allegation against the male CNA. MD (medical doctor) and RP (responsible party) were made aware of the outcome of the investigation."

The nurse's note dated, 11/1/2022 at 8:10 a.m. documented, "Note Text: CNA giving care requested this nurse to assess resident, upon assessment noted bruised area to left clavicular area, purple in color, non-tender to touch, skin tear to right upper arm, approximately 1.5" in length, purple in color, cleansed with DWC (wound cleanser), pat dry, applied bacitracin, then covered with dry dressing. MD made aware/RP (name of RP) notified. Treatment initiated. Will continue to monitor status."

There were no skin assessments for around the date above in the clinical record.

There were no skin assessments documented in the FRI investigation folder. The only documentation, other than on the actual FRI of 11/4/2020, in the FRI investigation folder was related to the other resident documented on the FRI, not R5.

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An interview was conducted with LPN (licensed practical nurse) #5, on 8/3/2022 at 10:42 a.m. When asked the process for when a nurse finds an injury of unknown origin on a resident, LPN #5 stated you have to initiate an investigation as to where the injury came from. An incident report must be made. LPN #5 stated a full body assessment must be completed, notify the MD and RP (responsible party). Interview the people that cared for the resident, if the roommate is alert and verbal, would interview them. When asked if you have to report an injury of unknown origin to the director of nursing (DON) or the administrator, LPN #5 stated that a nurse should report it to the DON or administrator as soon as you are aware of it.

An interview was conducted with ASM (administrative staff member) #1, the administrator, on 8/4/2022 at 11:19 a.m. When asked what steps are to be taken when a resident stated they have been abused, ASM #1 stated everyone stops what they are doing. First make sure the resident is safe, no injuries, no harm. Report a FRI. We have two hours to report abuse, start an investigation depending on what it is, if staff is involved, suspend the staff member. Question the resident and roommate. ASM #1 stated she takes a census sheet and the staff assignment sheet and start interviews with everyone on that group assignment. ASM #1 stated she would interview the whole hall of residents. Make sure the doctor and family is aware. Complete the investigation, if allegation is founded, then we notify the police. When asked when she should be notified of an allegation of abuse, ASM #1 stated as soon as it happens. When asked if this procedure is the same for an

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injury of unknown origin such as a bruise, ASM #1 stated, yes, because that could have been caused by abuse. When asked if the FRI investigation in the facility FRI folder was a complete investigation, ASM #1 stated, it wasn't the way she would have done the investigation. ASM #1 stated she could not locate any further documentation related to the bruises found on R5.

The facility policy, "Abuse, Neglect and Exploitation" documented in part, " IV - Identification of Abuse, Neglect and Exploitation: B. Possible indicators of abuse include; but are not limited to: 2. Physical marks such as bruises or patterned appearances such as a hand print, belt or ring mark on a resident's body. 3. Physical injury of a resident, of unknown source.... V - Investigation of alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur...Vii. Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes; a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury."

ASM (administrative staff member) # 1, the administrator, ASM #2, the director of nursing, and ASM #5, the director of clinical services, were

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F 610	Continued From page 42 made aware of the above concern on 8/4/2022 at 11:46 a.m. No further information was obtained prior to exit.	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the	F 622		9/2/22

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resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:

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F 622	Continued From page 44 (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence that all required information was provided to the hospital staff for 2 out of 43 residents in the survey sample that were transferred to the hospital; Residents #27 and #26. The findings include: 1. For Resident #27, the facility staff failed to evidence provision of required resident information to a receiving facility at the time of transfer to the hospital on 7/24/22. Resident #27 was admitted to the facility on 7/20/21 with diagnosis that included but were not limited to: chronic respiratory failure, cerebrovascular accident and diabetes mellitus. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/29/22, coded the resident as scoring a 10 out of 15 on	F 622	1. Resident # 27, discharged on 07/24/22 and is currently not in the facility and resident # 26, currently resides in the facility and no harm was observed from this practice. 2. All current residents who require transfer to the hospital have a potential to be affected by this practice. A. 3. Director of Nursing/Designee will educate nursing staff on required notification and the implementation of transfer checklist for all residents who are transferred to the hospital and documentation of the transfer process in the medical record. 4. Director of Nursing/Designee will review all transfers to the hospital, during clinical meeting to ensure the checklist is completed and documentation is recorded in the medical records of the required information sent to the hospital, weekly for	

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F 622	Continued From page 45 the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, locomotion, dressing and hygiene; total dependence for bathing and supervision for eating. Section O-special procedures/treatments coded the resident as oxygen "yes". A review of the comprehensive care plan dated 12/5/20 and revised 3/8/21, revealed, "FOCUS: The resident is at risk for alteration in respiratory distress/shortness of breath related to COPD (chronic obstructive pulmonary disease) and sarcoidosis of the lungs. INTERVENTIONS: Observe for difficulty breathing (Dyspnea) on exertion. Remind resident not to push beyond endurance. Head of bed elevated while in bed." A review of the facilities "eINTERACT (Interventions To Reduce Acute Care Transfers) Change in Condition Evaluation V 5.1", "Neurological Status Evaluation: sudden change in level of consciousness." A review of the nursing progress note dated 7/24/22 at 9:10 AM, revealed, "Resident in bed, extremely confused, did not eat, normal cognitive level alert and oriented x 3. Resident does not know who she is or where she is at, cannot talk normal, babbling, pupil dilated. Physician notified requesting to send to emergency room." A review of the nursing progress note dated 7/24/22 at 10:03 AM, revealed, "Received nursing order to send to emergency room for evaluation and treatment per on-call NP (nurse practitioner) at 9:40 AM. 911 arrived at 9:50 AM, transported	F 622	4 weeks and any variance will be corrected, and re-education offered, the results of these audits will be reported by the Director of Nursing to the QAPI team for ongoing compliance.	

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resident to hospital."

A review of the nursing progress note dated 7/24/22 at 4:34 PM, revealed, "Resident admitted to hospital on 07/24/22 with an admitting diagnosis of: COPD exacerbation and Aspiration PNA (pneumonia)."

There was no evidence that any clinical documentation was sent with Resident #27 when transferred to the hospital on 7/24/22.

An interview was conducted on 8/3/22 at 8:50 AM with LPN (licensed practical nurse) #3. When asked what information is sent with a resident to the hospital, LPN #3 stated, the care plan, medication list, change of condition form, any labs or orders and advance directives. When asked who sends this information, LPN #3 stated, the nurse sends this information.

An interview was conducted on 8/4/22 at 8:05 AM with ASM (administrative staff member) #1, the administrator. ASM #1 stated, "When I came the proper documentation was not done, the staff that were in place were inefficient and there was not a lot of structure in place. We have worked to change that and to hire staff that will follow what is needed."

On 8/4/22 at 9:46 AM, there was an email from ASM #1, the administrator, confirming there is no evidence of clinical documentation sent with Resident #27 to the hospital on 7/24/22.

On 8/4/22 at approximately 12:20 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional

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director of clinical services were made aware of the findings.

A review of the facilities "Transfer and Discharge (Including AMA-against medical advice)" policy dated 10/2021, revealed the following: "Emergency Transfers/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified). Obtain physicians' orders for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis. Complete and send with the resident (or provide as soon as practicable) a Transfer Form which documents: Resident status, including baseline and current mental, behavioral and functional status and recent vital signs; Current diagnosis, allergies and for transfer/discharge; Contact information of the practitioner responsible for the care of the resident; Resident representative information including contact information; Current medications (including when last received), treatments, most recent relevant lab and/or radiological findings and recent immunizations; Special instructions or precautions for ongoing care to include precautions such as isolation or contact; Special risks such as risk for falls, elopement, bleeding or pressure injury and/or aspiration precautions; Comprehensive care plan goals, and Any other documentation, as applicable, to ensure a safe and effective transition of care. A copy of any Advance Directive, Durable Power of Attorney, DNR or Withholding or Withdrawing of Life-Sustaining Treatment forms should be sent with the resident. The original copies of the transfer form and Advance Directive accompany the resident.

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Copies are retained in the medical record."

No further information was provided prior to exit.
2. The facility staff failed to evidence the documentation of documents sent to the hospital for Resident #26 (R26) upon transfer to the hospital on 6/12/2022.

On the most recent MDS (minimum data set) assessment, with an ARD of 5/30/2022, the resident scored a 15 out of 15 on the BIMS score, indicating the resident was not cognitively impaired for making daily decisions.

The nurse's note dated 6/12/2022 at 5:07 a.m. documented in part, "Resident sent to the ER (emergency room) to be evaluated due to c/o (complaint of) SOB (shortness of breath) and anxiety. Received order to send resident out from NP (nurse practitioner). Spoke with resident's son, he also stated that he would like for his mother to be sent to the ER."

Review of the E-Interact form dated 6/12/2022 failed to evidence the care plan goals were sent with the resident upon transfer on 6/12/2022.

An interview was conducted with LPN (licensed practical nurse) #2 on 8/3/2022 at 1:21 p.m. When asked the process for sending a resident to the hospital, LPN #2 stated they send an envelope with the documentation that is listed on the front of the envelope. The envelope documents, Resident name, date of birth, unit. It further documents; Please include the following: face sheet, E-interact change in condition & transfer, resident dashboard printable view, order summary, baseline care plan, bed hold, nurse, date of transfer and comments. When asked

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CYPRESS POINTE REHABILITATION AND NURSING	5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 49 what happens to the white paper on the front of the envelope, LPN #2 stated she takes it off and keeps it here in the facility and stated that the nurse should also write a note in the chart as to what was sent. Clarified with LPN #2 the meaning of the baseline care plan, LPN #2 stated the nurse should print the care plan that is in the computer. An interview was conducted with LPN #5 on 8/3/2022 at 3:58 p.m. When asked when a resident goes to the hospital, what documents are sent with the resident upon transfer, LPN #5 stated they send the copy of the care plan, medication list, the change in condition transfer form, bed hold policy that is put in an envelope. On the front of the envelope is a paper to check off what is put in the envelope. LPN #5 stated they had the envelope to the EMTs (emergency medical technicians). When asked if the nurse documents the documents that were sent, LPN #5 stated she writes a note in the chart, theoretically there should be a note containing what you sent. ASM (administrative staff member) # 1, the administrator, ASM #2, the director of nursing, and ASM #5, the director of clinical services, were made aware of the above concern on 8/4/2022 at 11:46 a.m. No further information was obtained prior to exit.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 623		9/2/22

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(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written

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F 623	Continued From page 51	F 623		

notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information

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F 623	Continued From page 52 becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence that written RP (responsible party) and/or ombudsman notification was provided for 3 of 43 residents who were transferred to the hospital, Residents #27, #26 and #29. The findings include: 1. The facility staff failed to evidence provision of written RP notification was provided for Resident #27. Resident #27 was transferred to the hospital on 7/24/22. Resident #27 was admitted to the facility on 7/20/21 with diagnosis that included but were not limited to: chronic respiratory failure, cerebrovascular accident and diabetes mellitus. A closed record review was conducted. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/29/22, coded the resident as scoring a 10 out of 15 on	F 623	1. Resident # 27, discharged on 07/24/22 and is currently not in the facility. Resident # 26 currently resides in the facility and resident # 29 currently resides in the facility with no adverse effects from this practice. 2. All residents who require transfer to the hospital have a potential to be effective by this practice. 3. Director of Nursing/Designee will educate nursing staff on required notifications and the implementation of transfer checklist which includes the letter of written notification for the responsible party for all residents who are transferred to the hospital and documentation of the transfer process in the medical record. Director of Nursing will educate the social worker on the mailing the letter of written notification within the next business day. 4. Director of Nursing/Designee will review all transfers to the hospital, during	

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F 623	Continued From page 53 the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the facilities "eINTERACT (Interventions To Reduce Acute Care Transfers) Change in Condition Evaluation V 5.1", "Neurological Status Evaluation: sudden change in level of consciousness." A review of the nursing progress note dated 7/24/22 at 9:10 AM, revealed, "Resident in bed, extremely confused, did not eat, normal cognitive level alert and oriented x 3. Resident does not know who she is or where she is at, cannot talk normal, babbling, pupil dilated. Physician notified requesting to send to emergency room." A review of the nursing progress note dated 7/24/22 at 10:03 AM, revealed, "Received nursing order to send to emergency room for evaluation and treatment per on-call NP (nurse practitioner) at 9:40 AM. 911 arrived at 9:50 AM, transported resident to hospital." A review of the nursing progress note dated 7/24/22 at 4:34 PM, revealed, "Resident admitted to hospital on 07/24/22 with an admitting diagnosis of: COPD exacerbation and Aspiration PNA (pneumonia)." There was no evidence of any written RP notification when Resident #27 was transferred to the hospital on 7/24/22. An interview was conducted on 8/3/22 at 8:50 AM with LPN (licensed practical nurse) #3. When asked who contacts the RP and ombudsman when a resident to the hospital, LPN #3 stated,	F 623	clinical meeting to ensure the checklist is completed and documentation is recorded in the medical records of the required information sent to the hospital, weekly for 4 weeks and any variance will be corrected, and re-education offered, the results of these audits will be reported by the Director of Nursing to the QAPI team for ongoing compliance.	

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the nurses call the RP/family. "I do not know who informs the ombudsman." When asked who sends the written RP notification, LPN #3 stated, "Maybe social services, I do not know."

On 8/4/22 at 9:46 AM, email from ASM #1, the administrator, confirming evidence of ombudsman notification and the only evidence of RP notification is phone call to RP documented on the facilities "eINTERACT (Interventions To Reduce Acute Care Transfers) Change in Condition Evaluation V 5.1", dated 7/24/22.

On 8/4/22 at approximately 12:20 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of clinical services were made aware of the findings.

A review of the facilities "Transfer and Discharge (Including AMA-against medical advice)" policy dated 10/2021, revealed the following: "Emergency Transfers/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified). Obtain physicians' orders for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis. Provide transfer notice as soon as practicable to resident and representative. Social Services Director, or designee, shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via monthly list."

No further information was provided prior to exit.
2. The facility staff failed to provide a written

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notification to the resident and/or the responsible party upon transfer to the hospital on 6/11/2022 for Resident #26 (R26).

On the most recent MDS (minimum data set) assessment, with an ARD of 5/30/2022, the resident scored a 15 out of 15 on the BIMS score, indicating the resident was not cognitively impaired for making daily decisions.

The nurse's note dated 6/12/2022 at 5:07 a.m. documented in part, "Resident sent to the ER (emergency room) to be evaluated due to c/o (complaint of) SOB (shortness of breath) and anxiety. Received order to send resident out from NP (nurse practitioner). Spoke with resident's son, he also stated that he would like for his mother to be sent to the ER."

Review of the E-Interact form dated 6/12/2022 failed to evidence the care plan goals were sent with the resident upon transfer on 6/12/2022.

An interview was conducted with OSM (other staff member) #1, the director of social services, on 8/4/2022 at 10:08 a.m. When asked if she plays a role in sending a written notice to the resident and/or responsible party regarding what a resident has been transferred to the hospital, OSM #1 stated she did not. When asked who is responsible for this, OSM #1 stated she thought maybe admissions.

An interview was conducted with OSM #5, the admissions staff member, on 8/4 2022 at 10:13 a.m. When asked if she played a role in providing a written notification to the resident and/or family what a resident is transferred to the hospital, OSM #5 stated she believed it was in the

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package that is sent with them, she doesn't do that. OSM #5 stated she believes the nursing staff does that.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 8/4/2022 at 10:48 a.m. When asked who is responsible for providing the resident and/or the responsible party with a written notice why the resident went to the hospital, ASM #2 stated, the nurse usually document why they went to the hospital. When asked about the written notification, ASM #2 stated they just send the package. Nothing is given to the resident and/or responsible party in writing, we just call them.

ASM (administrative staff member) # 1, the administrator, ASM #2, and ASM #5, the director of clinical services, were made aware of the above concern on 8/4/2022 at 11:46 a.m.

No further information was obtained prior to exit.
3. The facility staff failed to evidence written notification was provided to (R29) and/or (R29's) responsible party for a facility-initiated transfer on 05/23/2022.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/06/2022, the resident scored 15 out of 14 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions.

The facility's progress noted for (R29) dated 05/23/2022 documented in part, "Note Text: Resident had small amount bloody drainage under wheelchair. Assisted resident to bed to assess where blood was coming from. Resident

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F 623	Continued From page 57 had large bloody bowel movement. Unit manager notified MD immediately. Vitals taken. Order to send 911 to hospital. 911 called ..." Review of the clinical record and the EHR (electronic health record) for (R29) failed to evidence written notification of discharge was provided to (R29) and (R29's) representative for the facility-initiated transfer on 05/23/2022. On 08/04/22 at approximately 10:48 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked if a written notification is sent to the resident and the resident's responsible party when a resident is transferred to the hospital ASM # 2 stated that nothing is given to the resident and or the responsible in writing. On 08/03/2022 at approximately 5:21 p.m., ASM # 1, administrator ASM # 2, director of nursing, and ASM # 5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to	F 625		9/2/22

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F 625	Continued From page 58 return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence that bed hold notification was provided to one out of 43 residents in the survey sample who was transferred to the hospital; Residents #27. The findings include: The facility staff failed to evidence provision of bed hold notification for Resident #27. Resident #27 was transferred to the hospital on 7/24/22. Resident #27 was admitted to the facility on 7/20/21 with diagnosis that included but were not limited to: chronic respiratory failure, cerebrovascular accident and diabetes mellitus. A closed record review was conducted.	F 625	1. Resident # 27, discharged on 07/24/22 and is currently not in the facility. 2. All current residents who transfer to the hospital have a potential to be affected by this practice. 3. Director of Nursing/Designee will educate nursing staff on required notification and the implementation of transfer checklist for all residents who are transferred to the hospital and documentation of the transfer process in the medical record, to include bed-hold policy. 4. Director of Nursing/Designee will review all transfers to the hospital, during clinical meeting to ensure the checklist is	

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F 625	Continued From page 59 The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/29/22, coded the resident as scoring a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the facilities "eINTERACT (Interventions To Reduce Acute Care Transfers) Change in Condition Evaluation V 5.1", "Neurological Status Evaluation: sudden change in level of consciousness." A review of the nursing progress note dated 7/24/22 at 9:10 AM, revealed, "Resident in bed, extremely confused, did not eat, normal cognitive level alert and oriented x 3. Resident does not know who she is or where she is at, cannot talk normal, babbling, pupil dilated. Physician notified requesting to send to emergency room." A review of the nursing progress note dated 7/24/22 at 10:03 AM, revealed, "Received nursing order to send to emergency room for evaluation and treatment per on-call NP (nurse practitioner) at 9:40 AM. 911 arrived at 9:50 AM, transported resident to hospital." A review of the nursing progress note dated 7/24/22 at 4:34 PM, revealed, "Resident admitted to hospital on 07/24/22 with an admitting diagnosis of: COPD exacerbation and Aspiration PNA (pneumonia)." There was no evidence of any bed hold documentation when Resident #27 was transferred to the hospital on 7/24/22.	F 625	completed and documentation is recorded in the medical records of the required information sent to the hospital, weekly for 4 weeks and any variance will be corrected, and re-education offered, the results of these audits will be reported by the Director of Nursing to the QAPI team for ongoing compliance.	

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F 625	Continued From page 60 An interview was conducted on 8/3/22 at 8:50 AM with LPN (licensed practical nurse) #3. When asked who provides the bed hold information, LPN #3 stated, nursing sends the bed hold with the resident. When asked if there is a copy of the bed hold provided, LPN #3 stated, we do not keep a copy of the bed hold. On 8/4/22 at 9:46 AM, email from ASM #1, the administrator, read, "behold policy was sent with discharge packet but was not documented." On 8/4/22 at approximately 12:20 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of clinical services were made aware of the findings. A review of the facilities "Transfer and Discharge (Including AMA-against medical advice)" policy dated 10/2021, revealed the following: "Emergency Transfers/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified). Obtain physicians' orders for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis. Provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer." No further information was provided prior to exit.	F 625		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		9/2/22

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F 656	Continued From page 61 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 62 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: 2. The facility staff failed to develop a comprehensive care plan for treatment and care of (R36's) pressure ulcer. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/10/2022, the resident scored 0 (zero) out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired of cognition for making daily decisions. The physician's order for (R36) DATED 08/06/2022 documented in part, "Sacral: Cleanse with wound cleanser, pat dry, apply hydrogel and foam dressing every other day, and prn." Review of the comprehensive care plan for (R36) dated 07/23/2022 failed to evidence documented for care and services for (R36's) sacral pressure ulcer. On 08/04/22 at approximately 11:24 a.m., an interview was conducted with LPN (licensed practical nurse) #5. When asked if there was a care plan that addressed (R36's) sacral pressure ulcer and the use of pressure reducing boots LPN #5 review (R36's) current comprehensive care plan and stated that there was no care plan for (R36's) pressure ulcer or the boots. When asked to describe the procedure for developing a care plan for (R36's) pressure ulcer LPN #5 stated that nursing or the MDS coordinator should have developed the care plan from the physician's orders.	F 656	The care plan for resident #38 was updated to include the use of oxygen on 8/3/22. Resident #36 was discharged from the center. Resident #73 care plan was updated to include care and treatment of the wound on 8/3/22. Resident #34 care plan intervention for anti-tippers was resolved. Resident #276 was discharged from the facility. Resident # 4 side rail were removed no update needed to the care plan. Resident #14 and #23 care plan was updated immediately (8/2/2022) to reflect the use of side rails. Resident #6 care plan was updated immediately (8/2/2022) to reflect hospice services in place. 2. No residents experienced harm but all resident have the potential to be affected by this practice. 3. Education will be provided to the IDT team on the importance of developing and implementing a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and will review the comprehensive care plan for all residents to ensure that their comprehensive care plan includes measurable objectives and timeframes to meet their needs 4. MDS Coordinator, DON, or designee will complete audits of resident care plans	

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F 656	Continued From page 63 On 08/04/2022 at approximately 11:24 a.m., LPN #5 provided page 16 of (R36's) comprehensive care plan that documented, "Focus: (R36) actual impairment of the skin integrity r/t left heel open area , open area to sacrum. Date Initiated: 07/23/2022. Revision on: 08/04/2022." On 08/0/2022 at approximately 11:40 a.m., ASM # 1, administrator ASM # 2, director of nursing, and ASM # 5, regional director of clinical services, were made aware of the above findings. No further information was presented prior to exit. 3. The facility staff failed to develop a comprehensive care plan for (R38's) use of oxygen. (R38) was admitted to the facility with diagnoses that included but were not limited to: lobar pneumonia (1). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/15/2022, the resident scored 6 (six) out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded (R38) for "Oxygen Therapy" while not a resident. On 08/02/22 at approximately 12:58 p.m., an observation of (R38) revealed they were sitting in their room in a wheelchair receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between two and two-and-a-half liters per minute.	F 656	for any change in condition, new safety interventions, current pressure ulcer care and treatment and oxygen use 2 x per week for 4 weeks. A summary of finding will be provided to the QAPI committee for additional oversight.	

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On 08/02/22 at approximately 2:58 p.m., an observation of (R38) revealed they were sitting in their room in a wheelchair receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between two and two-and-a-half liters per minute.

On 008/03/22 approximately 8:14 a.m., an observation of (R38) revealed they were lying in their bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between two and two-and-a-half liters per minute.

The physician's order for (R38) dated 07/26/2022 documented, "O2 @ 2lpm (oxygen at two liters per minute) via (by) n/c (nasal cannula), prn (as needed) for sats (saturation)."

Review of the (R38's) comprehensive care plan dated 06/09/2022 failed to evidence care and services for oxygen administration.

On 08/04/22 at approximately 8:03 a.m., an observation of (R38's) oxygen flow rate on the oxygen concentrator was conducted with LPN (licensed practical nurse) #5. When asked if there was a care plan for the use of oxygen for (R38) LPN # 5 review (R38's) current comprehensive care plan and stated that there was not care plan for (R38's) use of oxygen. When asked to describe the procedure for developing a care plan for (R38's) oxygen LPN #5 stated that nursing or the MDS coordinator should have developed the care plan from the physician's orders.

On 08/04/2022 at approximately 8:20 a.m., LPN #5 provided page 14 of (R38's) comprehensive

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care plan that documented, "Focus: The resident has oxygen therapy r/t (related to) Ineffective gas exchange. Date Initiated: 08/04/2022." Under "interventions" it documented, "Monitor for s/sx (signs and symptoms) of respiratory distress and report to MD (medical doctor) PRN (as needed): Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. Date Initiated: 08/04/2022; OXYGEN SETTINGS: O2 via nasal cannula @ 2L as needed. Date Initiated: 08/04/2022. Revision on: 08/04/2022; Promote lung expansion and improve air exchange by positioning with proper body alignment. If tolerated, head of bed elevated to 30 degrees. Date Initiated: 08/04/2022. Revision on: 08/04/2022"

On 08/0/2022 at approximately 11:40 a.m., ASM # 1, administrator ASM # 2, director of nursing, and ASM # 5, regional director of clinical services, were made aware of the above findings.

No further information was presented prior to exit.

4. The facility staff failed to follow Resident 73's (R73's) care plan for the administration of oxygen.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/13/22, R73 was coded as being moderately impaired for making daily decisions, having scored 11 out of 15 on the BIMS (brief interview for mental status). R73 was coded as having received oxygen at the facility during the look back period. R73's diagnoses

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included COPD (chronic obstructive pulmonary disease) and COVID-19.

On the following dates and times, R73 was observed lying in bed, with oxygen being delivered at 3 lpm (liters per minute) via nasal cannula per oxygen concentrator: 8/2/22 at 12:35 p.m. and 3:00 p.m.; 8/3/22 at 8:02 a.m. and 10:37 a.m.

A review of R73's care plan dated 1/14/22 and revised on 7/14/22 revealed, in part: "[R73] has orders for oxygen therapy - on 2L/NC (two liters per minute via nasal cannula)."

A review of R73's clinical record revealed no evidence of a provider's order for oxygen administration.

On 8/3/22 at 10:21 a.m., LPN (licensed practical nurse) #2 was interviewed. When asked how a nurse knows at what rate to administer oxygen to a resident, she stated she checks the provider's order for the rate. When asked why oxygen administration requires a provider's order, she stated: "Because it is a drug."

On 8/3/22 at 1:54 p.m., LPN #5, a unit manager, was asked to verify the rate at which R73 should be receiving oxygen. She stated she needed to check the physician's orders. LPN #5 stated she did not see an order, and would need to check with R73's nurse.

On 8/3/22 at 1:55 p.m., LPN #2, who was caring for R73 on that shift, was asked to verify the rate at which R73 should be receiving oxygen. LPN #2 checked R73's orders, and stated: "I don't see any orders for oxygen. But I'm sure it's two liters

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[per minute]." LPN #2 re-checked the orders, but found none for the administration of oxygen for R73. LPN #2 checked R73's oxygen rate, and turned the rate on the concentrator from three lpms to two lpms. LPN #2 stated the purpose of a resident's care plan is to tell the staff how best to take care of a resident. She stated everyone is responsible for implementing each resident's care plan. She stated the facility staff had not been following R73's care plan for oxygen administration.

On 8/3/22 at 5:22 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director for clinical services, were informed of these concerns.

No further information was provided prior to exit.

5. The facility failed to follow R6's care plan to evidence coordination of hospice services with the hospice provider.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/29/22, R6 was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). R6 was coded as receiving hospice services during the look-back period.

A review of R6's clinical record revealed the following provider's order dated 4/22/22: "Admit to [name of hospice company]."

A review of R6's care plan dated 5/17/22 revealed, in part: "Resident admitted to hospice

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services...Encourage support system of family and friends...Work with [hospice] nursing staff to provide maximum comfort for the resident."

Further review of R6's clinical record failed to reveal a care plan, progress notes, or any other documentation by R6's hospice services provider.

On 8/3/22 at 1:54 p.m., LPN (licensed practical nurse) #5, a unit manager, was asked to provide notes and/or other evidence of coordination with R6's hospice provider. LPN #5 stated there was no such documentation. She stated this particular hospice company "does not provide notes" to the facility. She stated she would need to call the company and asked the company to send the notes by fax. She stated she was aware of the facility's requirement to coordinate care with R6's hospice provider, but stated the company did not comply with that requirement regarding paperwork.

On 8/3/22 at 1:55 p.m., LPN (licensed practical nurse) #2 was interviewed. LPN #2 stated the purpose of a resident's care plan is to tell the staff how best to take care of a resident. She stated everyone is responsible for implementing each resident's care plan.

On 8/3/22 at 5:22 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director for clinical services, were informed of these concerns.

No further information was provided prior to exit.

6. For Resident #34 (R34), the facility staff failed

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to follow the care plan for anti-tippers to be placed on R34's wheelchair. No anti-tippers were observed on multiple occasions during the survey while R34 was in the wheelchair.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/9/22, R34 was coded as being severely impaired for making daily decisions, having scored 4 out of 15 on the BIMS (brief interview for mental status). R34 was coded as requiring a wheelchair for moving around the room and the unit.

On the following dates and times, R34 was observed sitting in a wheelchair: 8/2/22 at 12:47 p.m. and 1:59 p.m.; 8/3/22 at 8:00 a.m. At no time did R34's wheelchair have anti-tip devices on the back to prevent R34's wheelchair from tipping over backwards.

A review of R34's care plan dated 10/11/20 and revised 10/17/21 revealed, in part: "The resident is at risk for fall R/T (related to): poor balance, unsteady gait, confusion, unaware of safety needs...dementia...antiroll back system to w/c (wheelchair).

On 8/3/22 at 1:55 p.m., LPN (licensed practical nurse) #2 was interviewed. LPN #2 stated the purpose of a resident's care plan is to tell the staff how best to take care of a resident. She stated everyone is responsible for implementing each resident's care plan.

On 8/4/22 at 8:08 a.m., OSM (other staff member) #3, an occupational therapist and the director of rehab, was interviewed. She stated she was familiar with R34. When asked if R34's

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wheelchair needed any specialized adaptations, she stated R34 had sustained multiple falls. She stated she had worked extensively with R34, and R34 had no ability to control their own impulses to stand and try to walk. She stated R34 was unsafe to walk independently. She stated R34 needed anti-tippers on the wheelchair to prevent the wheelchair from falling backwards if the resident tried to stand independently. OSM #3 observed R34 in the wheelchair. OSM #3 stated: "No, she does not have anything on the wheelchair for extra safety. No anti-tippers." She stated if R34's care plan contained anti-tippers on the wheelchair, then the care plan was not being followed.

On 8/4/22 at 12:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director for clinical services, were informed of these concerns.

No further information was provided prior to exit.

Complaint deficiency.
7. The facility staff failed to develop the comprehensive care plan for the use of bed rails for Resident #4 (R4).

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/29/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions.

On 8/2/2022 at 2:10 p.m., an interview was conducted with R4 in their room. R4 was

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observed in bed lying on top of the made bed. Bilateral upper quarter bed rails were observed to be in the up position on the bed. R4 stated that they did not really use the rails but sometimes pulled up on them. When asked if staff had discussed the bed rails with them, R4 stated that they may have when they first came in but they did not remember because they had changed rooms.

The comprehensive care plan for R4 failed to evidence documentation of bed rail use.

The "Admission/Re-admission screening" dated 4/22/2022 for R4 documented in part, "...Side rails, Sides: Neither, Not indicated at this time..."

The "Bed Rail Safety Review" dated 4/22/2022 for R4 documented in part, "...Have alternative to bed rails been attempted? Yes...Continue current alternative measures..."

On 8/3/2022 at 3:58 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that the care plan was updated by the nurse, the unit manager or the MDS staff. LPN #5 stated that the care plan purpose was for the staff to treat the patient according to the plan of care. LPN #5 stated that bed rails should be addressed on the care plan so the staff know that they were a part of their plan of care.

On 8/3/2022 at 5:22 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the regional director of clinical services and LPN (licensed practical nurse) #4, the director of clinical education/wound care were made aware of the findings.

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No further information was provided prior to exit.

8. The facility staff failed to develop the comprehensive care plan for the use of bed rails for Resident #23 (R23).

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/26/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is cognitively intact for making daily decisions.

On 8/2/2022 at 1:16 p.m., an interview was conducted with R23 in their room. R23 was observed in bed. The left upper bed rail was observed to be up on the bed. R23 stated that they used the bed rail to hold onto for positioning. When asked if staff had discussed the bed rails with them, R23 stated that they were not sure if anyone had asked, but they used them.

The comprehensive care plan for R23 failed to evidence documentation of bed rail use.

The "Bed Rail Safety Review" dated 6/16/2022 for R23 documented in part, "...Have alternative to bed rails been attempted? Yes...Implement new bed rail(s) as indicated to promote independence and safety (Obtain informed consent). List bed rail(s) to be implemented: Quarter rail. List side(s): Both..."

On 8/3/2022 at 3:58 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that the care plan was updated by the nurse, the unit manager or the MDS staff. LPN #5 stated that the care plan purpose was for

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the staff to treat the patient according to the plan of care. LPN #5 stated that bed rails should be addressed on the care plan so the staff know that they were a part of their plan of care.

On 8/3/2022 at 5:22 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the regional director of clinical services and LPN (licensed practical nurse) #4, the director of clinical education/wound care were made aware of the findings.

No further information was provided prior to exit.

9. The facility staff failed to develop a comprehensive care plan to include (1) the use of bed rails and (2) address activities of daily living for Resident #14 (R14).

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/19/2022, the resident scored 13 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section G documented R14 requiring extensive assistance of one person for dressing, bathing, personal hygiene and toileting.

On 8/2/2022 at 3:45 p.m., an interview was conducted with R14 in their room. R14 was observed lying on top of their bed with bilateral upper bed rails up on the bed. R14 stated that they used the bed rails to grab on to when turning. R14 stated that the facility staff were very helpful and assisted them with bathing and personal hygiene.

The comprehensive care plan for R14 failed to

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evidence documentation of bed rail use or address ADL requirements.

The "Bed Rail Safety Review" dated 3/22/2021 for R14 documented in part, "...Have alternative to bed rails been attempted? Yes...Implement new bed rail(s) as indicated to promote independence and safety (Obtain informed consent). List bed rail(s) to be implemented: Half rail. List side(s): Both..."

On 8/3/2022 at 3:58 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that the care plan was updated by the nurse, the unit manager or the MDS staff. LPN #5 stated that the care plan purpose was for the staff to treat the patient according to the plan of care. LPN #5 stated that all residents should have a care plan regarding their ADL's (activities of daily living). LPN #5 reviewed R14's care plan and stated that they did not see a care plan regarding the bed rails or the ADL's and that these areas should be addressed.

On 8/3/2022 at 5:22 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the regional director of clinical services and LPN (licensed practical nurse) #4, the director of clinical education/wound care were made aware of the findings.

No further information was provided prior to exit.

Based on observation, resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to develop and/or implement the comprehensive care plan

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for 9 of 43 residents in the survey sample, Residents #276, #36, #38, #73, #6, #34, #4, #23 and #14.

The findings include:

1. The facility staff failed to implement Resident #276's (R276) comprehensive care plan for wound care treatments per physician's orders.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/12/21, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions.

R276's comprehensive care plan dated 6/11/21 documented, "(Name) has Venous Ulcer r/t (related to) PVD (peripheral vascular disease) to Left medial bunion. Administer treatment/medication as per MD (medical doctor) order. (Name) has Venous Ulcer r/t PVD to Right medial foot. Administer treatment/medication as per MD order."

A review of R276's clinical record revealed a note signed by the wound care nurse practitioner on 1/26/22 that documented, "Treatment Recommendations: #2 Venous ulcer Hallux left medial- Instructions: Clean with wound cleaner. collagen (1), silver alginate (1), dry dressing and Ace wrap QD (every day) and prn (as needed). #1 Venous ulcer Foot right medial- Freq (Frequency): Daily (QD) & prn. Instructions: Clean with dakins (wound cleansing solution). Santyl (1) (medihoney (1) until avail [available]), calcium alginate (1), skin prep to peri, dry dressing and wrap with Ace, QD/prn)."

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A review of R276's January 2022 and February 2022 physician's orders and TARs (treatment administration records) revealed the following orders:
"1/26/22-Clean (L) (left) bunion (venous ulcer hallux left medial) with wound cleaner, apply silver alginate/collagen, skin prep around the wound and cover with dry dressing, and wrap with ace wrapping up to below knees QD and PRN every night shift every other day for wound care."
"1/27/22-Clean (R) (right) bunion (venous ulcer foot right medial) with Dakins, apply medihoney and calcium alginate to wound bed, skin prep around the wound and cover with dry dressing, and wrap with ace wrapping up to below knee QD and PRN every night shift every other day for venous ulcer every day."
The treatment to the left bunion was only initialed as completed every other day on 1/26/22, 1/28/22, 1/30/22 and 2/1/22 (the other days were blocked off with an "X"). The treatment to the right bunion was only initialed as completed every other day on 1/27/22, 1/29/22 and 1/31/22 (the other days were blocked off with an "X"). R276 discharged from the facility on 2/2/22.

On 8/4/22 at 8:06 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the wound care doctors and nurse practitioners email their notes to the nurses and the nurses create orders that are based on the notes in the facility computer system. LPN #4 stated the orders carry over to the TARs and nurses complete treatments based on the TARs. LPN #4 stated there is a specific tab in the computer system to block off days on the TARs to instruct nurses to not complete treatments on those days. LPN #4 reviewed the above wound

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care nurse practitioner note and the above TARs. LPN #4 stated the nurse who entered the order into the computer system set the frequency for treatment as every other day and that is why every other day was blocked off on the TARs. LPN #4 stated that according to the wound care note and the orders, the treatments should have been completed every day but were not.

On 8/4/22 at 9:32 a.m., another interview was conducted with LPN #4. LPN #4 stated the comprehensive care plan is the plan of care for the resident and interventions are documented so that all clinicians or anyone working with the resident knows what care the resident needs. LPN #4 stated care plans are implemented on admission and can be reviewed.

On 8/4/22 at 11:58 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Care Planning-Resident and/or Resident Representative participation" documented, "6. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care." The policy failed to document specific information regarding care plan implementation.

No further information was presented prior to exit.

Complaint deficiency.

Reference:

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F 656	Continued From page 78 (1) Collagen, silver alginate, Santyl, medihoney and calcium alginate are all products used to treat wounds.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §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 staff interview, facility document review and clinical record review, it was determined the facility staff failed to review and revise the	F 657	1. The care plan for resident #26 was revised to include use of oxygen on 8/3/22.	9/2/22

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F 657	Continued From page 79 comprehensive care plan for the use of oxygen for Resident #26 (R26). The findings include: On the most recent MDS (minimum data set) assessment, with an ARD of 5/30/2022, the resident scored a 15 out of 15 on the BIMS score, indicating the resident was not cognitively impaired for making daily decisions. The physician order dated, 6/2/2022, documented, "Oxygen at 2 L (liters per minute) for nocturnal dyspnea." The comprehensive care plan, dated, 3/22/2022, failed to evidence any documentation related to the use of oxygen. Observation was made on 8/3/2022 at 8:04 a.m. of R26 resting on their bed. An oxygen concentrator was located across from the foot of the bed. The oxygen tubing was laying over the concentrator with the nasal prongs touching the floor. When asked if she uses the oxygen, R26 stated they have been having shortness of breath and used it last night. An interview was conducted with LPN (licensed practical nurse) #5 on 8/3/2022 at 3:58 p.m. When asked who updates the care plan, LPN #5 stated it could be a nurse, the unit manager or MDS. When asked if oxygen should be on the care plan, LPN #5 stated, it should be. When asked the purpose of the care plan, LPN #5 stated it's so we can treat the patient according to their plan of care. The facility policy, "Oxygen Administration"	F 657	2. Any residents with a change in their plan of care have the potential to be affected. 3. MDS Coordinator or designee will educate IDT team in the timely revision of resident care plans. 4. MDS Coordinator, DON, or designee will audit 24 hour, incident, and change of condition reports Monday-Friday two times per week for 4 weeks to ensure any revisions to the resident care plan are updated in a timely manner. A summary of finding will be provided to the QAPI committee for additional oversight.	

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F 657	Continued From page 80 documented in part, "The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: a. The type of oxygen delivery system. b. When to administer, such as continuous or intermittent and/or when to discontinue. c. Equipment setting for the prescribed flow rates. d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. e. Monitoring for complications associated with the use of oxygen." ASM (administrative staff member) # 1, the administrator, ASM #2, the director of nursing, and ASM #5, the director of clinical services, were made aware of the above concern on 8/3/2022 at 5:28 p.m. No further information was obtained prior to exit.	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the	F 660		9/2/22

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discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality

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F 660	Continued From page 82 measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. 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, it was determined that the facility staff failed to develop, with the resident or the resident representative, a discharge plan for one of 43 residents in the survey sample, Resident #428. Resident #428's RP (responsible party), was not provided education on insulin administration or wound care. DME (durable medical equipment) was not at resident's home upon her discharge from the facility. The findings included: Resident #428 was admitted to the facility on 1/5/22 with diagnosis that included but were not limited to: osteomyelitis, cardiomyopathy, atrial fibrillation, hypertension, diabetes mellitus and	F 660	1. Resident #428 was discharged from the facility 2. All residents who are being discharged from the facility have the potential to be affected by this practice. 3. The IDT team will be educated regarding the resident discharge process to include education for resident family members and care giver and ensuring resident medical equipment is received. 4. Social Worker will audit all resident discharges weekly X four weeks to ensure that all required discharge components have been met. Results of the audits will be shared and reviewed with the QAPI team.	

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pneumonia. Resident #428 was discharged from the facility on 2/21/22.

The most recent MDS (minimum data set) assessment, a 5 day Medicare assessment, with an ARD (assessment reference date) of 2/2/22, coded the resident as scoring a 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, bathing and hygiene; supervision for eating. Walking and locomotion did not occur. Section H-bowel and bladder status coded as always incontinent.

A review of the comprehensive care plan dated 2/8/22, which revealed, "FOCUS: The resident has Diabetes Mellitus with hyperglycemia, foot ulcer also with neuropathy. INTERVENTIONS: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Monitor/document/report as needed any signs/symptoms of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait. Monitor/document/report as needed any signs/symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity), stupor and coma.

A review of the physician orders dated 1/6/22, revealed, "Humalog KwikPen Solution Pen-injector 100 UNIT/milliliter (Insulin Lispro (1 Unit Dial)) Inject 8 unit subcutaneously before

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meals for diabetes." Order revised on 1/27/22, revealed, "Humalog KwikPen Solution Pen-injector 100 UNIT/milliliter (Insulin Lispro (1 Unit Dial)) Inject 5 unit subcutaneously before meals for diabetes."

A review of the physician orders dated 1/6/22, revealed, "Insulin Glargine 100 UNIT/milliliter Solution pen injector-Inject 40 unit subcutaneously at bedtime related to TYPE 2 DIABETES MELLITUS." Order revised 1/27/22, revealed, "Insulin Glargine 100 UNIT/milliliters Solution pen injector Inject 20 unit subcutaneously every evening shift related to TYPE 2 DIABETES MELLITUS."

A review of the physician orders dated 2/7/22, revealed, "Clean area to lower back with wound cleanser, pat dry, apply medihoney and calcium alginate, then dry dressing daily and as needed every day shift for wound care."

A review of the nurse practitioner orders dated 2/14/22, revealed, "Please evaluate and treat patient for the following services, home health, occupational therapy and physical therapy."

A review of the physician orders dated 2/16/22, revealed, "Cleanse open area to left medial foot with wound cleanser, apply collagen foam, add calcium alginate, cover with dry dressing, every day and as needed for soil age every day shift. Cleanse open area to lumbar back with wound cleanser, apply medihoney, cover with dry dressing, daily and as needed for soil age every day shift."

A review of the nurse practitioner orders dated 2/17/22, revealed, "Standard manual wheelchair

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with elevated leg rests; walker with wheels, folding, adjustable or fixed height and commode chair."

A review of the discharge planning progress note dated 2/17/22 at 4:39 PM, revealed "Summary of Stay Most Recent Admission: 01/26/2022 4:30 PM Recapitulation of Stay:: Resident admitted to SNF (skilled nursing facility) for IV ABT (intravenous antibiotic), wound care, PT/OT/ST (physical therapy/occupational therapy/speech therapy), medication management. IV ABT was completed, she remains on PO ABT (oral antibiotic) for the infection. She has had follow up with both infectious and ankle foot specialist. Follow up appointments has been scheduled. Transitional Services and Referrals Home Health Agency. DME (durable medical equipment) Ordered: Wheelchair, Walker, Bedside Commode. Social Services Summary: Mental and psychosocial Status: is independent with making her wants and needs met. Resident is to return to her private residence with supports from her family and Home Care to help maintain her overall health. Cognitive Status: Resident has modified independence when making decisions regarding tasks of daily life. Communication Deficits: not applicable. Physical Functional Status: Bed Mobility self-performance is Limited Assistance. Transfer self-performance is Extensive Assistance. Locomotion on unit self-performance is Total Dependence. Locomotion off unit was not assessed. Walk in Corridor was not assessed. Resident is always continent of urine. Resident is always continent of bowel. Sensory and Physical Impairments (i.e. vision, hearing, etc.): not applicable. Dental Condition: good.
Special treatments and procedures: not

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applicable. Skin Condition/Wound Care: Left lateral foot-Cleanse with normal saline, apply collagen sheet/calcium alginate, and cover with dry dressing, daily. Lower back- cleanse open area with normal saline, apply medihoney, calcium alginate, and cover with dry dressing, daily.
Summary of Nursing Services: Resident admitted to SNF for IV ABT, wound care, PT/OT/ST, medication management. IV ABT was completed, she remains on PO ABT for the infection. She has had follow up with both infectious and ankle foot specialist. Follow up appointments has been scheduled. Medication Reconciliation: A medication reconciliation has been completed. The post-discharge medication list has been discussed with the resident's family. The post-discharge medication list has been provided to the resident's family. The following received the post-discharge medication list: The responsible party will be provided with medication list on 02/20/2022. Medication list was also discussed on 02/19/2022. Therapy Referrals: A referral was made for Physical Therapy (PT). A referral was made for Occupational Therapy (OT). A referral was made for Speech Therapy (ST). Summary of Service Provided by SNF: Pt received OT services to address BUE (bilateral upper extremity) strengthening, ADL retraining and adaptive equipment/DME use. PT focused on balance training, bed mobility, and transfers. ST interventions for cognition, short term memory and orientation. Final Disposition: Resident Discharged to Home. Resident left facility via wheelchair. Resident was accompanied by family. Resident will have a caregiver after discharge: Husband. Resident has home health. Reason for Discharge: Condition Improvement. Comments: IV ABT completed."

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A review of the discharge note by social services dated 2/18/22 at 10:51 AM, revealed, "Resident is scheduled to discharge from the facility on Sunday February 20, 2022 around 10am. She will be picked up by her husband and will received home health supports. Nurse Practitioner provided medication orders and DME (wheelchair and or walker, and bedside commode) ordered."

A review of the nursing progress note dated 2/21/22 at 11:30 AM, revealed, "Resident was discharged home via stretcher with medical staff, all paperwork and scripts sent with here. Also discharge summary was signed by the resident; all belongs were taken with her. Residents' skin noted to have no new open areas, bruising or redness noted, she just had two open areas she had, one to her foot and the one to her lower back. RP called when transportation arrived to make aware she was on her way."

An interview was conducted on 8/2/22 at 4:02 PM with OSM (other staff member) #1, the social services director. When asked when she had started in the facility, OSM #1 stated, it was on February 9, 2022. There was another social worker before her and they are no longer employed. When asked to describe the discharge planning process for Resident #428, OSM #1 stated, she was to be discharged home with home health in place. The RP was in the loop with things. I documented that he was provided transportation time. I do not recall that the husband was unable to support his wife with medications. I ordered the DME: wheelchair, walker and bedside commode and sent the referral for home health/OT/PT. When asked what home health process was, OSM #1 stated,

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they come out and do an evaluation of services needed. When asked if the resident has wounds what is the process, OSM #1 stated, some of the nurse practitioners leave the order open for home health to decide. There was no specifics on wound care for this resident in the home health orders.

An interview was conducted on 8/3/22 at 8:40 AM with LPN (licensed practical nurse) #4, the wound care nurse. When asked when she started in the facility, LPN #4 stated, it was February 2022 and she not know this resident. When asked the process for transitioning a resident home with wound care, LPN #4 stated, if they are going with home health, home health would get the orders for the wound care. When asked if education would be provided to the RP, if the orders were as needed, LPN #4 stated, "We would educate the RP in that situation and document it in the progress note or discharge plan."

An interview was conducted on 8/3/22 at 8:50 AM with LPN #3. When asked if she remembered Resident #428, LPN #3 stated, there is no memory of her or discharge planning with this resident. When asked if she had a resident on insulin discharging home with the RP as primary caregiver, what steps would be taken for a safe discharge, LPN #3 stated, education on insulin administration would be provide to the RP.

An interview was conducted on 8/3/22 at 9:20 AM with ASM (administrative staff member) #3, the nurse practitioner. When asked if she remembered resident #428, ASM #3 stated, "Yes, she had osteomyelitis on foot that would not heal and was receiving intravenous antibiotics." When asked if she was aware of the RP's concern

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regarding a safe discharge, ASM #3 stated, "No I did not hear that the husband had any issues. I had never spoken with her husband. The facility said she was ready to discharge she had run out of money or was requesting a discharge, I am not sure which. I give the order to the social worker. The resident was on oral antibiotics and did not need wound care orders, just skilled nursing and they would evaluate through the physician they have for wound care orders."

An interview was conducted on 8/4/22 at 7:29 AM, with LPN #5, the unit manager. When asked how long she had been employed and if she knew Resident #248, LPN #5 stated, since February 2022 and I do not know this resident. When asked what education would be provided to a RP who would be a resident's caregiver upon discharge, LPN #5 stated, if it is medication distribution then we would do education. They could come in for a training and we would do a tutorial. When asked where this would be documented, LPN #5 stated, "In the past I would just do a progress note, here we have a discharge summary we can document on."

An interview was conducted on 8/4/22 at 7:40 AM with RN (registered nurse) #2. When asked if he remembered Resident #248, RN #2 stated, "A little bit. Let me look up her chart." When asked if there was documentation regarding education being provided to Resident #248's RP, RN #2 stated, "There is a multidisciplinary discharge summary on 2/17/22, section 5 is vague regarding medication. There is no additional detail, is not explicit on how to administer insulin. I do not see any note but have not looked at notes past the week of 2/16/22."

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An interview was conducted on 8/4/22 at 10:29 AM with the home health agency Resident #248 was referred to. Home health agency confirmed that Resident #248 was not provided home health services from them until 5/25/22 and that no DME was at the resident's home during the initial assessment on 2/21/22.

On 8/4/22 at approximately 12:20 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of clinical services were made aware of the findings.

A review of the facilities' "Discharge Planning Process" policy dated 11/1/20, revealed the following: "It is the policy of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. 'Discharge planning' is a process that generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge. If discharge to community is a goal, an active discharge care plan will be implemented and will involve the interdisciplinary team, including the resident and/or resident representative. The plan shall be documented on the resident medical records and comprehensive care plan. An active individualized discharge care plan will address, at a minimum: a. Discharge destination, with assurances the destination meets the resident's

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F 660	Continued From page 91 health/safety needs and preferences. b. Identified needs, such as medical, nursing, equipment, educational, or psychosocial needs. c. Caregiver/support person availability and the resident's or caregiver's/support person's capacity and capability to perform required care. d. Resident's goals of care and treatment preferences. The evaluation of the resident's discharge needs and discharge plan will be completely documented on a timely basis in the clinical record. Education needs, as identified in the discharge plan, will be provided to the resident and/or family member prior to discharge." No further information was provided prior to exit.	F 660		
F 684 SS=E	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: 2. The facility failed to evidence coordination of hospice services with the hospice provider for Resident #6 (R6). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/29/22, R6 was coded as being moderately impaired for making daily	F 684	1. Resident # 6, hospice documentation was obtained during the day of concern. Resident # 8, has recovered from COVID still currently residing in the facility. Resident # 50, discharged on 08/05/22 and nurse educated on day of observation of proper process to notify physician and pull meds from Cubex. Resident # 276,	9/2/22

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F 684	Continued From page 92 decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). R6 was coded as receiving hospice services during the look-back period. A review of R6's clinical record revealed the following provider's order dated 4/22/22: "Admit to [name of hospice company]." A review of R6's care plan dated 5/17/22 revealed, in part: "Resident admitted to hospice services...Encourage support system of family and friends...Work with [hospice] nursing staff to provide maximum comfort for the resident." Further review of R6's clinical record failed to reveal a care plan, progress notes, or any other documentation by R6's hospice services provider. On 8/3/22 at 1:54 p.m., LPN (licensed practical nurse) #5, a unit manager, was asked to provide notes and/or other evidence of coordination with R6's hospice provider. LPN #5 stated there was no such documentation. She stated this particular hospice company "does not provide notes" to the facility. She stated she would need to call the company and asked the company to send the notes by fax. She stated she was aware of the facility's requirement to coordinate care with R6's hospice provider, but stated the company did not comply with that requirement regarding paperwork. On 8/3/22 at 5:22 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director for clinical services, were informed of these concerns.	F 684	discharged on 02/02/22 with no adverse effects observed. 2. All residents have a potential of being affected. 3. Director of Nursing/Designee will educate nursing staff on the rights of medication administration, obtaining resident medication and completing respiratory assessments on COVID positive residents as indicated. Director of Nursing/Designee educated social worker and MDS to ensure collaboration with hospice care provider and care plans are obtained for those residents who receive hospice services. 100% of current residents receiving hospice services was conducted to ensure care plan was present. 4. Director of Nursing/Designee will complete audits on treatment records, medication administration record and respiratory assessments as indicated 3 x week for 4 weeks. Social worker will audit any residents enrolled in Hospice services x four weeks to ensure care plan is provided. Any variance will be corrected and re-education provided, the results of these audits will be reported by the Director of Nursing and Social Worker to the QAPI team for ongoing compliance.	

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A review of the facility policy, "Hospice Services Facility Agreement," revealed, in part: "It is the policy of this facility to provide and/or arrange for hospice services...A written agreement with the hospice....sets out the following...a communication process, including how the communication will be documented between the facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day...ensure documentation from hospice that addresses...the most recent hospice plan of care specific to each resident...hospice election form...physician certification and recertification of the terminal illness specific to each resident."

No further information was provided prior to exit.

3. The facility staff failed to consistently assess and monitor Resident #8 (R8) after they tested positive for COVID-19 and during their COVID-19 isolation period.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/5/2022, the resident scored 7 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions.

The progress notes for R8 documented in part, "6/10/2022 19:15 (7:15 p.m.) Note Text: This writer spoke with the RP (responsible party), [name of responsible party] regarding res (resident) COVID test results were positive and that the res was being moved to the COVID unit at this time."

The physician orders for R8 documented in part,
- "Isolation in private room related to Covid

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positive (+) diagnosis every shift, every shift for Covid positive diagnosis for 10 Days. Order Date: 06/10/2022."
- "Respiratory Interview: ask Do you have a cough? Do you have a sore throat? Do you have SOB (shortness of breath)? Are you experiencing aches/weakness? every shift for 14 Days Respiratory Interview: ask Do you have a cough? Do you have a sore throat? Do you have SOB? Are you experiencing aches/weakness? If yes, initiate a respiratory UDA (user defined assessment) (assessment completed in electronic medical record). Order Date: 06/11/2022."
- "VITAL SIGNS Q 6 (every six) HOURS four times a day for COVID + for 10 Days. Order Date: 06/14/2022."

The eMAR (electronic medication administration record) for R8 documented in part,
- "Respiratory Interview: ask Do you have a cough? Do you have a sore throat? Do you have SOB? Are you experiencing aches/weakness? every shift for 14 Days Respiratory Interview: ask Do you have a cough? Do you have a sore throat? Do you have SOB? Are you experiencing aches/weakness? If yes, initiate a respiratory UDA. -Start Date- 06/11/2022 0700." The eMAR documented staff answering yes to the interview questions on 6/11/2022 night shift, 6/12/2022 day and evening shift, 6/13/2022 day and evening shift, 6/14/2022 night shift and 6/17/2022 evening and night shift.

The clinical record for R8 documented a UDA respiratory assessment completed on 6/12/2022 at 1:58 a.m. The record failed to evidence UDA respiratory assessments completed on 6/11/2022 night shift, 6/12/2022 day and evening shift,

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6/13/2022 day and evening shift, 6/14/2022 night shift and 6/17/2022 evening and night shift.

On 8/03/2022 at 3:58 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that any resident who tested positive for COVID had vital signs completed twice a shift. LPN #5 stated that they also completed respiratory assessments during the quarantine period. LPN #5 stated that they did the respiratory assessments to make sure the resident did not have any symptoms and to treat any symptoms that came up. LPN #5 stated that the respiratory assessments were full assessments, were completed at least once a day and were documented in the electronic medical record.

The facility policy "Coronavirus Prevention and Response" dated 7/18/2022 documented in part, "Policy: This facility will respond promptly upon suspicion of illness associated with a novel coronavirus in efforts to identify, treat, and prevent the spread of the virus..."

According to The Centers for Disease Control "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, Nursing Homes & Long-Term Care Facilities, Updated Feb. 2, 2022" it documented in part, "Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection...Increase monitoring of residents with suspected or confirmed SARS-CoV-2 infection, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to identify and quickly manage serious infection. This information was obtained from the website:

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https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631030962190

On 8/3/2022 at 5:22 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the regional director of clinical services and LPN (licensed practical nurse) #4, the director of clinical education/wound care were made aware of the findings.

No further information was provided prior to exit.

4. The facility staff failed to administer Donepezil to Resident #50 (R50) during the medication administration observation on 8/3/2022 that was available in the cubex medication system (automated medication dispensing system) in the facility.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/4/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions.

On 8/3/2022 at 8:26 a.m., an observation was made of LPN (licensed practical nurse) #7 administering medication to R50. LPN #7 prepared morning medication for R50 and stated that they did not have the scheduled 9:00 a.m. dose of Donepezil HCL 10 mg (milligram) to give to R50 because it was not on the cart. LPN #7 stated that the computer said that the medication was on order from the pharmacy. LPN #7 stated that they were going to call the pharmacy to check on the status of the medication after they finished the morning medications.

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The eMAR (electronic medication administration record) dated 8/1/2022-8/31/2022 for R50 documented in part, "Donepezil HCl Tablet 10 MG, Give 1 tablet by mouth one time a day for dementia -Start Date- 06/28/2022 0900 (9:00 a.m.)" The record for 8/3/2022 at 9:00 a.m. documented a "9" with the eMAR chart codes documenting "...9=Other / See Nurse Notes..." The eMAR failed to evidence administration of the 9:00 a.m. dose of Donepezil 10 mg on 8/3/2022.

The progress notes for R50 documented in part, "8/3/2022 08:42 (8:42 a.m.) Donepezil HCl Tablet 10 MG, Give 1 tablet by mouth one time a day for dementia. Not available, will call pharmacy."

The physician orders for R50 documented in part, "Donepezil HCl Tablet 10 MG, Give 1 tablet by mouth one time a day for dementia. Order Date: 06/27/2022."

On 8/03/2022 at 3:58 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that if a residents medication was not available they checked their cubex medication system to see if there was a stock of the medication they could pull. LPN #5 stated that if not, they would reach out to the pharmacy to see if the medication could be sent that day. LPN #5 stated that if the medication was not able to be sent by the pharmacy they would notify the physician to get an order to hold the medication until the medication arrived and notify the responsible party. LPN #5 stated that there should be documentation in the progress notes of notification of the pharmacy, physician and the responsible party.

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On 8/04/2022 at 7:52 a.m., an interview was conducted with LPN #4. LPN #4 stated that if a residents medication was not available staff were to contact the pharmacy to see if it was in route to them. LPN #4 stated that if the medication was due to be administered and not available they should notify the physician to get an order to hold the medication until it arrived and document the notification of the physician and the responsible party. LPN #4 stated that they also have a cubex medication system in house that stores some medications that staff could pull from if needed. LPN #4 stated that they were not sure if Donepezil was kept in the cubex system but staff could pull medication from it if needed.

On 8/4/2022 at 1:45 p.m., ASM (administrative staff member) #1, the administrator, provided a listing of the medications that were available to staff in the cubex automated medication system which documented in part, "...Item Description: Donepezil Tab (tablet) 5 mg..." It documented 7 tablets on hand.

On 8/4/2022 at 11:40 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

Based on observation, staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility

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staff failed to provide services to maintain residents' highest level of well-being for 4 of 43 residents in the survey sample, Residents #276, #6, #8 and #50.

The findings include:

1. The facility staff failed to provide Resident #276's (R276) wound care treatments every day per physician's orders from 1/26/22 through 2/2/22.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/12/21, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions.

A review of R276's clinical record revealed a note signed by the wound care nurse practitioner on 1/26/22 that documented, "Treatment Recommendations: #2 Venous ulcer Hallux left medial- Instructions: Clean with wound cleaner. collagen (1), silver alginate (1), dry dressing and Ace wrap QD (every day) and prn (as needed). #1 Venous ulcer Foot right medial- Freq (Frequency): Daily (QD) & prn. Instructions: Clean with dakins (wound cleansing solution). Santyl (1) (medihoney (1) until avail [available]), calcium alginate (1), skin prep to peri, dry dressing and wrap with Ace, QD/prn)."

A review of R276's January 2022 and February 2022 physician's orders and TARs (treatment administration records) revealed the following orders:

"1/26/22-Clean (L) (left) bunion (venous ulcer

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hallux left medial) with wound cleaner, apply silver alginate/collagen, skin prep around the wound and cover with dry dressing, and wrap with ace wrapping up to below knees QD and PRN every night shift every other day for wound care." "1/27/22-Clean (R) (right) bunion (venous ulcer foot right medial) with Dakins, apply medihoney and calcium alginate to wound bed, skin prep around the wound and cover with dry dressing, and wrap with ace wrapping up to below knee QD and PRN every night shift every other day for venous ulcer every day."

The treatment to the left bunion was only initialed as completed every other day on 1/26/22, 1/28/22, 1/30/22 and 2/1/22 (the other days were blocked off with an "X"). The treatment to the right bunion was only initialed as completed every other day on 1/27/22, 1/29/22 and 1/31/22 (the other days were blocked off with an "X"). R276 discharged from the facility on 2/2/22.

R276's comprehensive care plan dated 6/11/21 documented, "(Name) has Venous Ulcer r/t (related to) PVD (peripheral vascular disease) to Left medial bunion. Administer treatment/medication as per MD (medical doctor) order. (Name) has Venous Ulcer r/t PVD to Right medial foot. Administer treatment/medication as per MD order."

On 8/4/22 at 8:06 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the wound care doctors and nurse practitioners email their notes to the nurses and the nurses create orders that are based on the notes in the facility computer system. LPN #4 stated the orders carry over to the TARs and nurses complete treatments based on the TARs.

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F 684	Continued From page 101 LPN #4 stated there is a specific tab in the computer system to block off days on the TARs to instruct nurses to not complete treatments on those days. LPN #4 reviewed the above wound care nurse practitioner note and the above TARs. LPN #4 stated the nurse who entered the order into the computer system set the frequency for treatment as every other day and that is why every other day was blocked off on the TARs. LPN #4 stated that according to the wound care note and the orders, the treatments should have been completed every day but were not. On 8/4/22 at 11:58 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Wound Treatment Management" documented, "1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change." No further information was presented prior to exit. Complaint deficiency. Reference: (1) Collagen, silver alginate, Santyl, medihoney and calcium alginate are all products used to treat wounds.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		9/2/22

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F 689	Continued From page 102 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to implement interventions to keep a resident safe for one of 43 residents in the survey sample, Resident #34 (R34). R34's care plan called for anti-roll back system to be placed on R34's wheelchair. No anti roll devices were observed on multiple occasions during the survey while R34 was in the wheelchair. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/9/22, R34 was coded as being severely impaired for making daily decisions, having scored four out of 15 on the BIMS (brief interview for mental status). R34 was coded as requiring a wheelchair for moving around the room and the unit. On the following dates and times, R34 was observed sitting in a wheelchair: 8/2/22 at 12:47 p.m. and 1:59 p.m.; 8/3/22 at 8:00 a.m. At no time did R34's wheelchair have anti roll/tip devices on the back to prevent R34's wheelchair from rolling or tipping over backwards.	F 689	1. Resident #34 was assessed by therapy and determined anti rollbacks were not required, Care plans was updated and the intervention for anti rollback device was resolved. 2. All residents have a potential to be affected when identified safety interventions are not followed. 3. Director of Nursing/Designee will re-educate licensed nurses and Unit Managers regarding fall prevention and safety to include following interventions related to resident incidents and updating the care plan as indicated. 4. Director of Nursing/Designee will review all incidents with Interdisciplinary team to ensure identified interventions are implemented and care updated, for 3 x a week for 4 weeks, any variance will be corrected, re-educate with be provided, the results of these audits will be reported by the Director of Nursing to the QAPI team for ongoing compliance.	

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A review of R34's care plan dated 10/11/20 and revised 10/17/21 revealed, in part: "The resident is at risk for fall R/T (related to): poor balance, unsteady gait, confusion, unaware of safety needs...dementia...antiroll back system to w/c (wheelchair).

On 8/4/22 at 8:08 a.m., OSM (other staff member) #3, an occupational therapist and the director of rehab, was interviewed. She stated she was familiar with R34. When asked if R34's wheelchair needed any specialized adaptations, she stated R34 had sustained multiple falls. She stated she had worked extensively with R34, and R34 had no ability to control their own impulses to stand and try to walk. She stated R34 was unsafe to walk independently. She stated R34 needed anti-tippers on the wheelchair to prevent the wheelchair from falling backwards if the resident tried to stand independently. OSM #3 observed R34 in the wheelchair. OSM #3 stated: "No, she does not have anything on the wheelchair for extra safety. No anti-tippers."

On 8/4/22 at 12:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director for clinical services, were informed of these concerns.

On 8/4/22 at 1:42 p.m., ASM #1 stated the facility did not have a policy related to wheelchair safety/safety equipment.

No further information was provided prior to exit.

Complaint deficiency.

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F 695	Continued From page 104	F 695		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to administer oxygen in a safe, sanitary manner for 4 of 43 residents in the survey sample, Residents #73, #69, #26, and #38. The findings include: 1. For Resident #73 (R73), the facility staff failed to obtain an order to administer oxygen, and failed to change the oxygen tubing in a timely manner. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/13/22, R73 was coded as being moderately impaired for making daily decisions, having scored 11 out of 15 on the BIMS (brief interview for mental status). R73 was coded as having received oxygen at the facility during the look back period. R73's diagnoses included COPD (chronic obstructive pulmonary disease) and COVID-19.	F 695	1. Resident #73, was discharged from the facility on 08/06/22. Resident #69, nebulizer immediately placed in sanitary bag. Resident #26, oxygen tube was immediately changed upon notification. Resident #38, oxygen level was corrected to appropriate oxygen flow rate. 2. All residents receiving respiratory care have a potential to be effective by this practice. 3. Director of Nursing/Designee re-educated licensed staff on respiratory care to include storage of nebulizer mouthpieces, oxygen tubing not touching the floor and not following physician order for oxygen administration. 4. Unit managers will audit oxygen tubing, nebulizer mouth pieces and oxygen concentrators 3x a week for 4 weeks, any variance will be corrected, re-educate with be provided, the results of these audits will be reported by the	9/2/22

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F 695	Continued From page 105 On the following dates and times, R73 was observed lying in bed, with oxygen being delivered at 3 lpm (liters per minute) via nasal cannula per oxygen concentrator: 8/2/22 at 12:35 p.m. and 3:00 p.m.; 8/3/22 at 8:02 a.m. and 10:37 a.m. At each observation, a sticker was located close to the concentrator. The sticker stated: "CHANGE SUNDAY 7/31." A review of R73's clinical record revealed no evidence of a provider's order for oxygen administration. A review of R73's care plan dated 1/14/22 and revised on 7/14/22 revealed, in part: "[R73] has orders for oxygen therapy - on 2L/NC (two liters per minute via nasal cannula)." On 8/3/22 at 10:21 a.m., LPN (licensed practical nurse) #2 was interviewed. When asked how a nurse knows at what rate to administer oxygen to a resident, she stated she checks the provider's order for the rate. When asked why oxygen administration requires a provider's order, she stated: "Because it is a drug." She stated oxygen tubing should be changed regularly, and stated she believed the tubing needed to be changed at least weekly, and more frequently if needed. She stated oxygen is being delivered into the lungs, and the tubing should be as clean as possible to prevent infection. On 8/3/22 at 1:54 p.m., LPN #5, a unit manager, was asked to verify the rate at which R73 should be receiving oxygen. She stated she needed to check the physician's orders. LPN #5 stated she did not see an order, and would need to check with R73's nurse.	F 695	Director of Nursing to the QAPI team for ongoing compliance.	

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F 695	Continued From page 106 On 8/3/22 at 1:55 p.m., LPN #2, who was caring for R73 on that shift, was asked to verify the rate at which R73 should be receiving oxygen. LPN #2 checked R73's orders, and stated: "I don't see any orders for oxygen. But I'm sure it's two liters [per minute]." LPN #2 re-checked the orders, but found none for the administration of oxygen for R73. LPN #2 checked R73's oxygen rate, and turned the rate on the concentrator from three lpms to two lpms. LPN #2 checked the sticker on R73's oxygen tubing. She stated: "Well, this should have been changed on Sunday. I'll take care of it." She located new tubing, and replaced R73's expired tubing with the new tubing. On 8/3/22 at 5:22 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director for clinical services, were informed of these concerns. A review of the facility policy, "Oxygen Administration," revealed, in part: "Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences...Oxygen is administered under orders of a physician, except in the case of an emergency...Other infection control measures include:...Change oxygen tubing and mask/cannula weekly and as needed if it becomes contaminated." No further information was provided prior to exit. 2. The facility staff failed to store a nebulizer mask in a sanitary manner for Resident #69 (R69).	F 695		

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On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/14/2022, the resident scored a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately, cognitively impaired for making daily decision.

Observation was made on 8/2/2022 at approximately 12:00 p.m. of R69 in bed. A nebulizer mask was observed to be sitting on the night stand not within a bag or covered. A second observation was made on 8/2/2022 at 3:41 p.m., the nebulizer mask was noted to be sitting on the night stand, uncovered.

The physician order dated, 6/16/2021, documented, "Pratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML (milligram per milliliter)3 ml inhale orally via nebulizer two times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE" The medication was scheduled for 9:00 a.m. and 5:00 p.m. The review of the August MAR (medication administration record) documented the administration of the medication above for the month of August.

The comprehensive care plan dated 2/2/2020 documented in part, "Focus: At risk for respiratory distress r/t (related to) COPD (Chronic obstructive pulmonary disease)." The "Interventions" documented in part, "Give medications as ordered. Observe/document any side effects and effectiveness."

An interview was conducted with LPN (licensed practical nurse) #5, on 8/3/2022 at 10:42 a.m. When asked how a nebulizer masks is to be stored when not in use, LPN #5 stated it should

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be stored in a plastic bag and labels with the resident's name and date.

The facility policy, "Nebulizer Therapy" documented in part, "g. Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag."

ASM (administrative staff member) # 1, the administrator, ASM #2, the director of nursing, and ASM #5, the director of clinical services, were made aware of the above concern on 8/3/2022 at 5:28 p.m.

No further information was obtained prior to exit.

3. The facility staff failed to store oxygen tubing in a sanitary manner for Resident #26 (R26).

On the most recent MDS (minimum data set) assessment, with an ARD of 5/30/2022, the resident scored a 15 out of 15 on the BIMS score, indicating the resident was not cognitively impaired for making daily decisions.

Observation was made on 8/3/2022 at 8:04 a.m. of R26 resting on their bed. An oxygen concentrator was located across from the foot of the bed. The oxygen tubing was laying over the concentrator with the nasal prongs touching the floor. When asked if she uses the oxygen, R26 stated they have been having shortness of breath and used it last night. R26 stated the staff moved the concentrator to where it is at.

The physician order dated, 6/2/2022, documented, "Oxygen at 2 L (liters per minute) for nocturnal dyspnea."

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The comprehensive care plan, dated, 3/22/2022, failed to evidence any documentation related to the use of oxygen.

An interview was conducted with LPN #5 on 8/3/2022 at 10:42 a.m. When asked where oxygen tubing should be stored when not in use, LPN #5 stated, not on the floor, but should be contained in a bag that is labeled with a date.

The facility policy, "Oxygen Administration," documented in part, "7. Cleaning and care of equipment shall be in accordance with facility policies for such equipment." The policy failed to document the storage of the tubing when not in use.

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment."

ASM (administrative staff member) # 1, the administrator, ASM #2, the director of nursing, and ASM #5, the director of clinical services, were made aware of the above concern on 8/3/2022 at 5:28 p.m.

No further information was obtained prior to exit.
3. Facility staff failed to maintain Resident #38's (R38's) oxygen flow rate at two liters per minute according to the physician's orders.

(R38) was admitted to the facility with diagnoses that included but were not limited to: lobar pneumonia (1).

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On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/15/2022, the resident scored 6 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded (R38) for "Oxygen Therapy" while not a resident.

On 08/02/22 at approximately 12:58 p.m., an observation of (R38) revealed they were sitting in their room in a wheelchair receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between two and two-and-a-half liters per minute.

On 08/02/22 at approximately 2:58 p.m., an observation of (R38) revealed they were sitting in their room in a wheelchair receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between two and two-and-a-half liters per minute.

On 08/03/22 approximately 8:14 a.m., an observation of (R38) revealed they were lying in their bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between two and two-and-a-half liters per minute.

The physician's order for (R38) dated 07/26/2022 documented, "O2 @ 2lpm (oxygen at two liters per minute) via (by) n/c (nasal cannula), prn (as needed) for sats (saturation)."

Review of the (R38's) comprehensive care plan dated 06/09/2022 failed to evidence care and services for oxygen administration.

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F 695	Continued From page 111 On 08/04/22 at approximately 8:03 a.m., an observation of (R38's) oxygen flow rate on the oxygen concentrator was conducted with LPN (licensed practical nurse) #5. After reading the flow meter LPN #5 stated that it was two-and-a-half liters per minute. When asked what the flow rate should be LPN #5 stated that they needed to check the physician's orders. After looking up the physician's order in (R38's) EHR (electronic health record) LPN #5 stated that the flow rate was ordered for two liters per minute. When asked to describe how to read the oxygen flow rate on an oxygen concentrator and how often a resident's oxygen flow rate should be checked LPN #5 stated that the liter line should pass through the middle of the float ball inside the flow meter and the flow rate should be checked at the beginning of each shift and whenever the nurse goes into the room. When informed of the observations stated above LPN #5 stated that (R38's) oxygen flow rate was not being checked. On 08/03/2022 at approximately 5:21 p.m., ASM #1, administrator ASM #2, director of nursing, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: (1) Affects one or more sections (lobes) of the lungs. This information was obtained from the website: https://www.urmc.rochester.edu/encyclopedia/content.aspx?contenttypeid=85&contentid=P01321.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4)	F 700		9/2/22

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F 700	Continued From page 112 §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to implement bed rail requirements for 3 of 43 residents in the survey sample, Residents #73, #4, and #23. The findings include: 1. The facility staff failed to assess Resident #73 (R73) for the necessity of bed rails, and failed to evidence education of the resident regarding risks and benefits of implementing bed rails.	F 700	1. Resident #73, currently discharged from the facility on 08/06/22. Resident #4, was assessed found that siderails to not be in needed and removed. Resident #23, consent obtained for siderails. 2. All residents have a potential to be effective by this practice. 3. 100% audit for all residents have been completed to assess need and obtain consents for siderails. Director of nursing/Designee will re-educate licensed staff regarding assessing for side rails and	

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F 700	Continued From page 113 On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/13/22, R73 was coded as being moderately impaired for making daily decisions, having scored 11 out of 15 on the BIMS (brief interview for mental status). On the following dates and times, R73 was observed lying in bed with the top quarter side rails up on both sides of the bed: 8/2/22 at 12:35 p.m. and 3:00 p.m.; 8/3/22 at 8:02 a.m. and 10:37 a.m. A review of R73's clinical record, including facility assessments, failed to reveal a bed rail assessment or any evidence the resident/RP (responsible party) received education regarding the risks and benefits of utilizing bed rails. A review of R73's care plan dated 1/14/22 revealed, in part: "The resident needs a safe environment with...rails for mobility." On 8/3/2022 at 3:58 p.m., LPN (licensed practical nurse) #5, a unit manager, was interviewed. LPN #5 stated that residents were assessed for the use of bed rails to make sure that the rail would not be a restraint. LPN #5 stated the facility staff assessed the resident to determine the resident's ability to lift the rail or to remove it. Additionally, the resident should be assessed to determine whether the bed rails are needed for mobility or repositioning. On 8/3/22 at 5:22 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director for clinical services, were informed of these concerns.	F 700	obtaining consents as indicated. 4. Unit managers will review all new admissions to ensure siderail assessments are completed and consents signed as indicated 3x a week for 4 weeks, any variance will be corrected, re-educate with be provided, the results of these audits will be reported by the Director of Nursing to the QAPI team for ongoing compliance.	

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A review of the facility policy, "Proper Use of Side Rails," revealed, in part: "It is the policy of this facility to utilize a person-centered approach when determining the use of side rails...1. As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of side/bed rails meets those needs:
a. Medical diagnosis, conditions, symptoms, and/or behavioral symptoms
b. Size and weight
c. Sleep habits
d. Medication(s)
e. Acute medical or surgical interventions
f. Underlying medical conditions
g. Existence of delirium
h. Ability to toilet self safely
i. Cognition
j. Communication
k. Mobility (in and out of bed)
l. Risk of falling
3. If after an attempted alternative to side/bed rails has been made, and the alternatives do not meet the resident's needs, the facility shall:
a. Evaluate the alternatives and document how these alternatives failed to meet the resident's assessed needs. If there is no appropriate alternative, document reason.
b. Assess the resident for risks of entrapment, and other risks associated with the use of side/bed rails. The following are examples of potential risks:
i. Accident hazards (i.e., falls, entrapment, injuries sustained from attempts to climb over, around, between, or through the rails)
ii. Barrier from safely getting out of bed
iii. Physical restraint (i.e., hinders from

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independently getting out of bed or performing routine activities)
iv. Decline in function, such as muscle functioning/balance
v. Skin integrity issues
vi. Decline in other areas of daily living, such as using the bathroom, continence, eating, hydration, walking, and mobility
vii. Negative psychosocial outcomes, such as altered self-esteem, feelings of isolation, or agitation/anxiety
c. Obtain informed consent from the resident, or the resident representative for the use of bed rails, prior to installation/use...5. The use of side rails will be specified in the resident's plan of care.
a. Side rails that are permanently installed on the bed frame shall not be used, even incidentally, without proper assessment, informed consent, and physician orders.
b. Once side/bed rails are installed, the facility will ensure side rail/bed rail usage does not prohibit necessary treatments and resident care. Care and treatments will continue to be provided in accordance with professional standards of practice and resident choices.
c. Parameters for use shall be clearly defined, such as half rails or at certain times."

No further information was provided prior to exit.

2. The facility staff failed to obtain consent for and assess for the use of bed rails for Resident #4 (R4).

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/29/2022, the resident scored 15 out of 15 on the BIMS (brief interview for

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mental status) assessment, indicating the resident was cognitively intact for making daily decisions.

On 8/2/2022 at 2:10 p.m., an interview was conducted with R4 in their room. R4 was observed in bed lying on top of the made bed. Bilateral upper quarter bed rails were observed to be in the up position on the bed. R4 stated that they did not really use the rails but sometimes pulled up on them. When asked if staff had discussed the bed rails with them, R4 stated that they may have when they first came in but they did not remember because they had changed rooms.

The comprehensive care plan for R4 failed to evidence documentation of bed rail use.

The "Admission/Re-admission screening" dated 4/22/2022 for R4 documented in part, "...Side rails, Sides: Neither, Not indicated at this time..."

The "Bed Rail Safety Review" dated 4/22/2022 for R4 documented in part, "...Have alternative to bed rails been attempted? Yes...Continue current alternative measures..." The bed rail safety review failed to evidence an indication for bed rail use or consent obtained.

On 8/3/2022 at 3:58 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that residents were assessed for the use of bed rails to make sure that the rail would not be a restraint. LPN #5 stated that they assessed the resident to see if they were able to lift the rail or remove it and whether they needed the rail for mobility or repositioning. LPN #5 stated that if the bed rail was appropriate there

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should be a consent from the resident or the responsible party. LPN #5 stated that the consent could be a verbal consent but there should be documentation of the consent in the progress notes.

On 8/3/2022 at 5:22 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the regional director of clinical services and LPN (licensed practical nurse) #4, the director of clinical education/wound care were made aware of the findings.

No further information was provided prior to exit.

3. The facility staff failed to obtain consent for the use of bed rails for Resident #23 (R23).

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/26/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions.

On 8/2/2022 at 1:16 p.m., an interview was conducted with R23 in their room. R23 was observed in bed. The left upper bed rail was observed to be up on the bed. R23 stated that they used the bed rail to hold onto for positioning. When asked if staff had discussed the bed rails with them, R23 stated that they were not sure if anyone had asked, but they used them.

The comprehensive care plan for R23 failed to evidence documentation of bed rail use.

The "Admission/Re-admission screening" dated

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4/20/2022 for R23 documented in part, "...Side rails, Sides: Both, Indicated to promote independence with bed mobility..." The document failed to evidence a consent for bed rail use obtained.

The "Bed Rail Safety Review" dated 5/16/2022 for R23 documented in part, "...Have alternative to bed rails been attempted? Yes...Continue current alternative measures..." The bed rail safety review failed to evidence a consent obtained for bed rail use.

The "Bed Rail Safety Review" dated 6/16/2022 for R23 documented in part, "...Have alternative to bed rails been attempted? Yes...Implement new bed rail(s) as indicated to promote independence and safety (Obtain informed consent)..." The bed rail safety review failed to evidence a consent obtained for bed rail use.

On 8/3/2022 at 3:58 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that residents were assessed for the use of bed rails to make sure that the rail would not be a restraint. LPN #5 stated that they assessed the resident to see if they were able to lift the rail or remove it and whether they needed the rail for mobility or repositioning. LPN #5 stated that if the bed rail was appropriate there should be a consent from the resident or the responsible party. LPN #5 stated that the consent could be a verbal consent but there should be documentation of the consent in the progress notes.

On 8/3/2022 at 5:22 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the regional director

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F 700	Continued From page 119 of clinical services and LPN (licensed practical nurse) #4, the director of clinical education/wound care were made aware of the findings. No further information was provided prior to exit.	F 700		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732		9/2/22

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F 732	Continued From page 120 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to complete and post daily nurse staffing information before the shift. On 08/02/2022 and 08/03/2022 the facility staff failed to post the nurse staffing prior to the beginning of the shift and failed to document the facility's census on 17 of 31 days of July 2022. The findings include: On 08/02/22 at approximately 11:52 a.m., an observation of the facility's staff posting located in the facility's lobby on the receptionist desk was observed to be dated 08/01/2022. On 08/03/22 at approximately 7:15 a.m., an observation of the facility's staff posting located in the facility's lobby on the receptionist desk was observed to be dated 08/02/2022. Review of the facility's "Daily Staffing Sheets" dated 07/02/2022, 07/03/2022, 07/04/2022, 07/05/2022, 07/09/2022, 07/10/2022, 07/11/2022, 07/12/2022, 07/15/2022, 07/16/2022, 07/24/2022, 07/25/2022, 07/27/2022, 07/28/2022, 07/29/2022, 07/30/2022 and 07/31/2022 failed to evidence the facility's census. On 08/03/2022 at approximately 10:08 a.m., an	F 732	1. An updated nurse staff posting was completed upon notification. 2. Residents and families have the right to be aware of facility staffing. 3. Staffing Coordinator, Business Office Manager, and Assistant Business Office Manager was in serviced 8/4 on the requirements for facility to post nurses staffing before the beginning of the shift and that it is completed in its entirety to ensure we are maintaining public access to posted nurse staffing data. 4. Business Office Manager or designee will 2 x per week for 4 weeks to ensure staffing postings are updated and visible. A summary of findings will be provided to the QAPI committee for additional oversight.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS POINTE REHABILITATION AND NURSING	5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462

(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 732	Continued From page 121 interview was conducted with OSM (other staff member) # 13, staffing coordinator. When asked to describe the procedure for the daily staff posting OSM # 13 stated that the staff posting is posted each day after the morning meeting at 9:00 a.m. with the facility department heads and the administrator. When asked if the daily staffing should be posted prior to the 7:00 a.m. shift OSM # 13 stated yes. After reviewing the daily staffing sheets listed above OSM # 13 was asked about the missing information regarding the facility's census. OSM # 13 stated the facility's census should be written on each staffing sheet for that day. On 08/03/2022 at approximately 5:21 p.m., ASM # 1, administrator ASM # 2, director of nursing, and ASM # 5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit.	F 732		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		9/2/22

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F 761	Continued From page 122 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to store medications in a safe manner on 1 of 2 nursing units, Rose Garden Unit. 1. RN #1 left medications on top of a medication cart, unsupervised, on the Rose Garden unit. 2. LPN #2 left the medication cart unlocked during medication administration, while it was unsupervised, on the Rose Garden unit. The findings include: 1. RN #1 left medications on top of a medication cart, unsupervised, on the Rose Garden unit. Resident #42 was admitted to the facility on 11/17/21. On the most recent MDS (Minimum Data Set), a quarterly assessment dated 6/20/22, the resident was coded as being cognitively intact in ability to make daily life decisions. Resident #19 was admitted to the facility on 12/25/21. On the most recent MDS (Minimum	F 761	1. RN #1 and LPN #2, both were educated on not leaving medications on top of the carts unsupervised and leaving medication carts unlocked and unsupervised. 2. No residents were harmed but all residents have a potential to be effective by this practice. 3. Director of Nursing/Designee will reeducate licensed nurses on proper medication storage and locking the cart when unsupervised. 4. Unit managers will complete medication pass observation 2x a week for 4 weeks, for proper storing and supervision of medications any variance will be corrected, re-educate with be provided, the results of these audits will be reported by the Director of Nursing to the QAPI team for ongoing compliance.	

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F 761	Continued From page 123	F 761		

Data Set), a quarterly assessment dated 5/20/22, Resident #19 was coded as being severely cognitively impaired in ability to make daily life decisions.

On 8/3/22 at 7:43 AM, while waiting for Medication Administration observations, LPN #1 (Licensed Practical Nurse) was preparing to begin medications and had to briefly leave her cart. While she was away from her cart, at 7:45 AM, RN #1 (Registered Nurse) came to the cart and left 2 medication cards of new medications that were delivered, under the computer on top of the medication cart. These medications were Lipitor (1) for Resident #42 and Crestor (2) for Resident #19. At 7:47 AM, LPN #1 returned to her cart, identified that medications were left on top of her cart unsupervised and took the medications and went to speak to RN #1 about leaving the medications on top of the cart unsupervised.

On 8/3/22 at 8:48 AM, an interview was conducted with LPN #1. She stated that RN #1 was the night shift nurse and had left for the day. She stated that they should not have left the medications on top of her cart unsupervised when she was away from the cart, and that she addressed it with them immediately. She stated she was upset that they had done that.

A review of the facility policy "Medication Storage" was conducted. This policy documented, "A. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls....C. During a medication pass, medications must be under the direct observation of the person administering

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F 761	Continued From page 124	F 761		

medications or locked in the medication storage area/cart."

On 8/3/22 at approximately 6:00 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #4, the Regional Director of Clinical Services, were made aware of the findings. No further information was provided by the end of the survey.

(1) Lipitor is used to reduce cholesterol. Information obtained from https://medlineplus.gov/druginfo/meds/a600045.html

(2) Crestor is used to reduce cholesterol. Information obtained from https://medlineplus.gov/druginfo/meds/a603033.html

2. LPN #2 left the medication cart unlocked during medication administration, while it was unsupervised, on the Rose Garden unit.

Resident #38 was admitted to the facility on 6/8/22. On the most recent MDS (Minimum Data Set), an admission assessment dated 6/15/22, the resident was coded as being severely cognitively impaired in ability to make daily life decisions.

On 8/3/22 at 8:36 AM, LPN #2 was preparing medications for Resident #38. She had to leave the medication cart to attend to a resident in another room. At 8:37 AM, LPN #2 left the medication cart in front of Resident #38's room, with the cart facing to the inside of the doorway to

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F 761	Continued From page 125	F 761		

the room. She left the cart unlocked when she stepped away from the cart to attend to the other resident in another room. Two staff members passed by the cart, and a staff member entered the room with the breakfast tray At 8:38 AM, LPN #2 returned to the cart.

On 8/3/22 at 8:43 AM after preparing medications for Resident #38, LPN #2 entered the room to administer the medications. The resident's bed was the one furthest from the doorway (by the window) and the curtain was pulled around the bed. LPN #2 was behind the curtain to administer the medications, leaving the medication cart unlocked and out of line of sight while she was behind the pulled curtain. Other staff were in the room tending to the resident in the bed closest to the doorway and the cart, which was unlocked and unsupervised by LPN #2. At 8:45 AM, LPN #2 returned to the cart.

On 8/3/22 at 8:45 AM an interview was conducted with LPN #2. She stated that when staff leave a medication cart, they should leave the cart locked and computer screen closed. When asked if she locked it every time she walked away from it, she stated that she thought she had, that she tried to. When told of the observations of the cart unlocked she stated, "I need to push it (the lock) in more."

A review of the facility policy "Medication Storage" was conducted. This policy documented, "A. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls....C. During a medication pass, medications must be under the direct observation of the person administering

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F 761	Continued From page 126 medications or locked in the medication storage area/cart." On 8/3/22 at approximately 6:00 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #4, the Regional Director of Clinical Services, were made aware of the findings. No further information was provided by the end of the survey.	F 761		
F 772 SS=D	Lab Services Not Provided On-Site CFR(s): 483.50(a)(1)(iv) §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to obtain laboratory tests per physician's order for one of 43 residents in the survey sample, Resident #276. The facility staff failed to obtain multiple lab tests per Resident #276's (R276) nephrologist's (kidney doctor) orders. The findings include: On the most recent MDS (minimum data set), a	F 772	1. Resident #276, discharged on 02/02/22, no adverse effects to resident were documented. 2. All residents needing lab work have a potential to be affected by this practice. 3. Director of Nursing/Designee re-educated licensed nursing staff regarding following physician orders for obtaining labs in a timely manner. 4. Unit managers will audit residents who attend off site medical appointments	9/2/22

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F 772	Continued From page 127	F 772		

quarterly assessment with an ARD (assessment reference date) of 11/12/21, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. R276's diagnoses included acute renal failure and cystic kidney disease.

A review of R276's clinical record revealed a note from the nephrologist (kidney doctor) dated 4/6/21 that documented, "Follow-up in 6 months. H&H (hemoglobin and hematocrit), protein creatinine ratio, renal panel, vitamin D25, PTH." The note documented future lab orders for:
10/01/2021: SPOT URINE CREATININE (1).
10/01/2021: VITAMIN D 25 LEVEL (2).
10/01/2021: HCT (HEMATOCRIT) (3).
10/01/2021: HBG (HEMOGLOBIN) (4).
10/01/2021: PTH INTACT (5). 10/01/2021: RENAL FUNCTION PANEL (6). 10/01/2021 SPOT PROTEIN URINE (7).

Further review of R276's clinical record failed to reveal any lab results for October 2021 until after the resident's follow-up nephrology appointment on 10/5/21.

On 8/4/22 at 8:06 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that when lab orders are received from a consulting physician, the orders are placed into the facility computer system to make sure the labs get done then the requisitions are placed into the electronic lab system so someone from the laboratory will come in and obtain the labs. LPN #4 reviewed R276's lab orders. LPN #4 stated she would enter the lab orders into the facility computer system and electronic lab system and set the labs up to be done about a month before

3x per week for four weeks to to ensure all labs are entered in lab book and are drawn in a timely manner and results reported appropriately, any variance will be corrected, re-educate with be provided, the results of these audits will be reported by the Director of Nursing to the QAPI team for ongoing compliance.

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F 772	Continued From page 128	F 772		

the scheduled follow-up appointment.

On 8/4/22 at 11:58 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Laboratory Services and Reporting" documented, "1. The facility must provide or obtain laboratory services to meet the needs of its residents. 2. The facility is responsible for the timeliness of the services."

No further information was presented prior to exit.

Complaint deficiency.

References:

(1) A spot creatinine test, "Measures creatinine levels in blood and/or urine. Creatinine is a waste product made by your muscles as part of regular, everyday activity. Normally, your kidneys filter creatinine from your blood and send it out of the body in your urine. If there is a problem with your kidneys, creatinine can build up in the blood and less will be released in urine." This information was obtained from the website: https://medlineplus.gov/lab-tests/creatinine-test/

(2) A Vitamin D 25 level measures how much vitamin D is in your body. This information was obtained from the website: https://medlineplus.gov/ency/article/003569.htm

(3) "A hematocrit test is a blood test that measures how much of your blood is made up of red blood cells. Red blood cells carry oxygen from your lungs to the rest of your body." This

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F 772	Continued From page 129 information was obtained from the website: https://medlineplus.gov/lab-tests/hematocrit-test/ (4) "A hemoglobin test measures the levels of hemoglobin in your blood. Hemoglobin is a protein in your red blood cells that carries oxygen from your lungs to the rest of your body." This information was obtained from the website: https://medlineplus.gov/lab-tests/hemoglobin-test/ (5) A PTH (parathyroid hormone) test, "Measures the level of parathyroid hormone in the blood. PTH, also known as parathormone, is made by your parathyroid glands. These are four pea-sized glands in your neck. PTH controls the level of calcium in the blood." This information was obtained from the website: https://medlineplus.gov/lab-tests/parathyroid-hormone-pth-test/ (6) A renal function panel is a series of tests that measures the function of your kidneys. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3afile=viv_xncpDV&server=pvlb7srch13&v%3astate=root%7croot&url=https%3a%2f%2fmedlineplus.gov%2fkidneytests.html&rid=Ndoc0&v%3aframe=redirect&v%3aredirect-hash=93448cb06446aa2e60807d26615c5671& (7) A spot protein urine test measures the amount of protein in your urine. This information was obtained from the website: https://pubmed.ncbi.nlm.nih.gov/32058809/#:~:text=A%20spot%20urine%20P%2FC,%2Fmg)%20confirms%20nephrotic%20proteinuria.	F 772		
F 776 SS=D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii)	F 776		9/2/22

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F 776	Continued From page 130 §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to obtain a diagnostic test per physician's request for one of 43 residents in the survey sample, Resident #276. The facility staff failed to obtain a renal ultrasound (1) per Resident #276's (R276) nephrologist's (kidney doctor) request. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/12/21, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. R276's diagnoses included acute renal failure and	F 776	1. Resident #276, discharged on 02/02/22, no adverse effects were documented. 2. All residents with orders for diagnostic services have the potential to be affected by this practice. 3. Director of Nursing/Designee re-educated license nursing staff on following physician orders in obtaining radiology services and the process for obtaining radiology services in a timely manner. 4. Unit managers will audit residents off site medical appointments and consultation reports 3X per week for 4 weeks to ensure the results are obtained and followed up in timely and results	

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F 776	Continued From page 131 cystic kidney disease. A review of R276's clinical record revealed a note from the nephrologist (kidney doctor) dated 4/6/21 that documented, "Follow-up in 6 months...Renal ultrasound prior to the next visit...Future Procedures: 4/12/20/21: RENAL ULTRASOUND..." Further review of R276's clinical record failed to reveal any renal ultrasound results. On 8/4/22 at 8:06 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that when diagnostic requests are received from a consulting physician, the nurses should place the request into the facility computer system as an order to make sure the test is done and call an outside company to come in and complete the test. On 8/4/22 at 11:58 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Diagnostic Testing Services" documented, "This facility will provide the appropriate diagnostic services (laboratory and radiology) required to maintain the overall health of its residents and in accordance with State and Federal guidelines." No further information was presented prior to exit. Complaint deficiency. Reference:	F 776	reported appropriately, any variance will be corrected, re-educated with be provided, the results of these audits will be reported by the Director of Nursing to the QAPI team for ongoing compliance.	

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F 776	Continued From page 132 (1) "A renal ultrasound uses sound waves to make images of the kidneys, ureters, and bladder." This information was obtained from the website: https://kidshealth.org/en/parents/renal-ultrasound.html	F 776		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined facility staff failed to maintain a clean deli slicer and store dishware in a clean and sanitary manner in one of one kitchen; and failed to label and date resident food stored in the refrigerator in one of two nourishment rooms in accordance with professional standards for food service safety.	F 812	1. The meat slicer was removed from the kitchen on 8/2/22. Nourishment room refrigerators were cleaned out on 8/2/22 and all non labeled food was discarded. No specific resident was identified as being affected by this citation. The wet items and the items containing visible debris were corrected immediately prior to	9/2/22

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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 812	Continued From page 133 The findings include: 1. The facility failed to maintain a clean blade on the deli slicer that was available for use; and failed to fully dry dishware in the kitchen prior to stacking. On 8/2/2022 at 11:57 a.m., an observation was made of the kitchen in the facility with OSM (other staff member) #2, the dietary manager. Observation of the deli slicer on the counter top in the kitchen revealed it covered with a plastic bag. OSM #2 stated that it was available for use and removed the bag. Observation of the blade on the deli slicer revealed debris that could be scraped off of the edge. When asked about the blade, OSM #2 stated that the blade needed to be cleaned. OSM #2 stated that the deli slicer blade was washed after every use and dried prior to being put back on the slicer. OSM #2 stated that the blade should not have any debris on it. Observation of the kitchen revealed a stack of six small bowls. OSM #2 stated that the bowls were clean and available for use. Two of the bowls were observed to have visible debris stuck onto them and six of the bowls were observed to have visible water droplets on them. The bowls were observed to be stacked on top of each other with the water droplets between the bowls. OSM #2 stated that the bowls should be dried completely before they were stacked on top of each other. Beside the bowls were two stacks of small saucers. One stack of 18 saucers were observed to be visibly wet with water droplets on them. The second stack of 21 saucers was observed to be visibly wet with water droplets on them and two of the saucers were observed to have dried debris on them. OSM #2 stated that they should be	F 812	survey team exiting the building 2. All residents have the potential to be impacted when kitchen equipment is not cleaned and sanitized and food is not properly labeled. 3. Dietary and Nursing staff will be educated on food handling and safety. 4. Dietary Manager or designee will audit nourishment room refrigerators 2X per week for four weeks to ensure that food is stored, prepared, and distributed in accordance with professional standards for food service safety.	

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dried before they were stacked on top of each other and the bowls and saucers with the debris needed to be washed again.

The facility policy "Food Safety Requirements" dated 10/1/2021 documented in part, "Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared and served in accordance with professional standards for food service safety...All equipment used in the handling of food shall be cleaned and sanitized, and handled in a manner to prevent contamination. a. Staff shall follow facility procedures for dishwashing and cleaning fixed cooking equipment. b. Clean dishes shall be kept separate from dirty dishes.

On 8/3/2022 at 5:22 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the regional director of clinical services and LPN (licensed practical nurse) #4, the director of clinical education/wound care were made aware of the findings.

No further information was provided prior to exit.

2. The facility staff failed to label and date resident food stored in the refrigerator in the nourishment room on the Rose Garden unit.

On 8/3/2022 at approximately 12:30 p.m., an observation was made of the nourishment room on the Rose Garden unit. Observation of the refrigerator in the nourishment room revealed a canvas lunch box containing a peanut butter and jelly sandwich and prepackaged pickles. No name or date was observed on the lunchbox. A plastic shopping bag was observed with a half of

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a sandwich inside with no name or date on the bag.

On 8/3/2022 at approximately 12:35 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that everything in the refrigerator belonged to residents on the unit. LPN #1 observed the lunchbox with the peanut butter and jelly sandwich and prepackaged pickles and stated that they did not know who it belonged to. LPN #1 observed the plastic shopping bag with a half of a sandwich inside and stated that there was no name or date on it but they knew which resident it belonged to. LPN #1 stated that the staff member who put the food in the refrigerator for the resident was responsible for dating and labeling the food with the residents name. LPN #1 stated that food was kept for three days and then thrown away. LPN #1 stated that they would try to find out who the lunchbox belonged to.

On 8/03/2022 at 12:44 p.m., an interview was conducted with OSM (other staff member) #2, dietary manager. OSM #2 stated that dietary stocked the nourishment rooms with puddings, sandwiches, ice cream, juices, milk and filled the snack bins. OSM #2 stated that the nursing staff handled the resident food stored in the refrigerator. OSM #2 stated that any food should be labeled and have a date so they knew who it belonged to and when to discard it.

The facility policy "Use and storage of food brought in by family or visitors" dated 10/1/2021 documented in part, "Policy: It is the right of the residents of this facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the

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F 812	Continued From page 136 resident...2. All food items that are already prepared by the family or visitor borough in must be labeled with content and dated..." On 8/3/2022 at 5:22 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the regional director of clinical services and LPN (licensed practical nurse) #4, the director of clinical education/wound care were made aware of the findings. No further information was provided prior to exit.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		9/2/22

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F 880	Continued From page 137 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 138 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to maintain a complete infection control surveillance program. The facility staff failed to maintain a complete surveillance system with enough data collection to properly track infections. The findings include: A review of the facility infection control surveillance program for January 2022 through June 2022 revealed the following: -Folders for January 2022 through April 2022 only contained a list of residents that were prescribed an antibiotic and information regarding the antibiotic prescription, lab tests results related to various infections for various residents and a color coded facility floor plan that tracked infections by categories of urinary infections, respiratory infections, gastrointestinal infections skin infections and other infections. -A folder for May 2022 only contained a log that tracked infection type, a list of residents that were prescribed an antibiotic and information regarding the antibiotic prescription. -No documentation for June 2022. On 8/3/22 at 4:14 p.m., an interview was conducted with LPN (licensed practical nurse) #4 (the infection control nurse who had been employed in that position for two weeks). LPN #4 stated each day she pulls a list of residents receiving antibiotics, including residents who are	F 880	1. No immediate correction could be completed on past months infection control logs. 2. All residents have a potential to be effective by this practice. 3. The infection preventionist has received required CDC training to include maintaining a monthly surveillance log of infections. 4. Director of Nursing will review log twice a week for 4 weeks, any variance will be corrected, re-educated with be provided, the results of these audits will be reported by the Director of Nursing to the QAPI team for ongoing compliance.	

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newly prescribed antibiotics. LPN #4 stated she also pulls any related lab test results related to the infection the antibiotic is prescribed for. LPN #4 stated she then tracks the types of infections based on the color coded floor plan.

On 8/4/22 at 10:58 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated that every morning the team looks at residents who are newly prescribed antibiotics. ASM #2 stated the surveillance program should include a list of residents who have an infection, what infection the resident is diagnosed with, labs, diagnostics, whether the infection is hospital acquired or facility acquired, a facility tracking map and a formula to calculate the percentage of facility acquired infections. ASM #2 stated the purpose of infection surveillance is to see if there is a trend of infections so interventions can be implemented to prevent outbreaks.

On 8/3/22 at 5:39 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern.

The facility policy titled, "Infection Surveillance" documented, "A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections. Definitions: 'Infection surveillance' refers to an ongoing systematic collection, analysis, interpretation, and dissemination of infection-related data...6. Monthly time periods will be used for capturing and reporting data. Line charts will be used to

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F 880	Continued From page 140 show data comparisons over time and will be monitored for trends. 10. Formulas used in calculating infection rates will remain constant for a minimum of one calendar year..." No further information was presented prior to exit.	F 880		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.	F 886		9/2/22

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F 886	Continued From page 141 §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to conduct COVID-19 testing in a manner consistent with professional standards of practice. The facility staff failed to conduct complete COVID-19 testing during a facility outbreak that	F 886	1. The facility has discontinued outbreak testing as 08/06/22. 2. All residents have the potential to be affected by this practice. Infection preventionist check the CDC tracker weekly and testing is based upon	

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F 886	Continued From page 142 began on 6/10/22. The findings include: A review of facility documentation revealed the facility began COVID-19 outbreak status on 6/10/22 because a resident tested positive. A review of facility testing documentation revealed the following: On 6/10/22, all residents were tested and eight residents were positive for COVID-19. No staff were tested. On 6/13/22, only residents who were symptomatic or exposed were tested. Ten residents were positive. On 6/14/22, one staff member was tested and the results of the test were not documented. On 6/17/22, seven staff were tested and one was positive. On 6/20/22, eight staff were tested and all were negative. On 6/29/22, seven staff were tested and all were negative. On 7/1/22, one resident was symptomatic, tested and was positive. The resident's roommate was also tested and was negative. On 7/7/22, four staff were tested. Three were negative and one staff member's results were not documented. On 7/8/22 one staff was tested and was negative. On 7/10/22, five residents were symptomatic, tested and were positive. On 7/11/22, seven staff were tested and one was positive. On 7/18/22, four staff were tested and were negative. On 7/20/22, one resident was symptomatic, tested and was positive. One staff was tested and was negative. Two other residents were exposed, tested and were negative. On 7/24/22, one resident was symptomatic, tested and was positive. On 7/25/22, seven staff were tested. Six were negative and one staff member's results were not documented.	F 886	community transmission rate, test results in binder and uploaded into a data spreadsheet. 3. Director of Nursing/Designee will educate staff in all departments re: testing per CDC guidelines and community transmission rates. 4. Director of nursing to review data spreadsheet weekly x 4 weeks to validate staff is being tested, any variance will be corrected, re-educated with be provided, the results of these audits will be reported by the Director of Nursing to the QAPI team for ongoing compliance.	

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On 8/3/22 at 1:49 p.m., an interview was conducted with LPN (licensed practical nurse) #4 (the infection control nurse who was employed in that positon for two weeks). LPN #4 stated she was informed to conduct COVID-19 testing once a week for staff who were not vaccinated or had not received a booster vaccine. LPN #4 stated that only residents who were symptomatic were being tested and no outbreak testing had been completed.

On 8/3/22 at 2:18 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 stated that symptomatic residents and staff, anyone who had been at risk of being exposed, and staff who were exempted from the COVID-19 vaccine were being tested during the facility outbreak.

On 8/3/22 at 3:23 p.m., an interview was conducted with ASM #2 (the director of nursing). ASM #2 stated the outbreak began on 6/10/22, when a resident was tested and was positive. ASM #2 stated the resident's family member was positive and had been all over the building so broad based testing was completed on 6/10/22.

On 8/3/22 at 4:29 p.m., a telephone interview was conducted with OSM (other staff member) #9 (the local health department representative), in regards to COVID-19 outbreak testing. OSM #9 stated a facility can do either contact tracing or broad based testing but if a facility begins with broad based testing then they have to continue with broad based testing. OSM #9 stated that with broad based testing, all residents and staff should initially be tested at the beginning of the outbreak, then all staff and residents should be

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tested at least every seven days until there is a 14 day period with no new positive cases. OSM #9 stated the facility administrator had contacted her regarding positive cases but she requested additional information and did not receive a response.

On 8/3/22 at 5:39 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

On 8/4/22 at 11:23 a.m., an interview was conducted with ASM #5 (the regional director of clinical services). ASM #5 stated that if a facility begins with broad based testing during an outbreak then all residents should initially be tested, then all residents who have not been positive in the last 90 days should be tested every five to seven days until there are no positive cases for two weeks. ASM #5 stated staff should be tested based on the community based cadence unless someone is symptomatic. ASM #5 stated the facility should also follow the local health department recommendations.

The CDC (Centers for Disease Control) website documents the following:
"New Infection in Healthcare Personnel or Residents
When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority...Alternative, broad-based approach:
If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-level or group-level (e.g., unit, floor, or

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other specific area(s) of the facility).
Broader approaches might also be required if the facility is directed to do so by the jurisdiction's public health authority, or in situations where all potential contacts are unable to be identified, are too numerous to manage, or when contact tracing fails to halt transmission. Perform testing for all residents and HCP (health care personnel) on the affected unit(s), regardless of vaccination status, immediately (but generally not earlier than 24 hours after the exposure, if known) and, if negative, again 5-7 days later." This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Fnursing-homes-facility-wide-testing.html#anchor_1631031062858

The facility policy titled, "Coronavirus Prevention and Response" documented, "5. When COVID-19 is suspected or confirmed the facility will: e. Implement procedures, including, but not limited to, contact testing and tracing, to identify and monitor others who may have been exposed if COVID-19 is confirmed...9.a. Any staff or resident with symptoms of COVID-19, regardless of vaccination status, should receive a viral test immediately. b. Asymptomatic HCP (health care personnel) with a higher-risk exposure and residents with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 5-7 days after the exposure..."

No further information was presented prior to exit.

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F 887	Continued From page 146	F 887		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and	F 887		9/2/22

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F 887	Continued From page 147 (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to provide education and offer the COVID-19 immunization for 4 of 5 residents reviewed during the immunization record reviews, Residents #3 (R3), #73 (R73), #18 (R18) and #42 (R42). The facility staff failed to provide Residents R3, R73, R18 and R42 (or their representatives) education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine, or offer the vaccine.	F 887	1. Resident # 3, currently resides in the facility and immediately upon notification received education on COVID-19 vaccine regarding the benefits and risks and potential side effects associated with COVID-19 was offered and a second dose was immediately offered. Resident #73, discharged from the facility on 08/06/22. Resident # 18, currently resides in the facility, and immediately upon notification received education on COVID-19 vaccine regarding the benefits and risks and potential side effects	

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F 887	Continued From page 148 The findings include: 1. For R3, on the most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 4/29/22, R3 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. A review of the immunization tab in R3's clinical record revealed the resident had received one dose of the Pfizer COVID-19 vaccine on 4/19/22. Further review of R3's clinical record failed to reveal evidence that R3 was provided education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine or was offered the second dose of the vaccine. On 8/3/22 at 10:26 a.m., an interview was conducted with R3. R3 stated the resident received one dose of the COVID-19 vaccine at the hospital. R3 stated the resident had repeatedly asked facility staff for the second dose of the vaccine but had not received it. R3 stated this upset the resident because the resident contracted COVID-19 while at the facility. 2. For R73, on the most recent MDS, a quarterly assessment with an ARD (assessment reference date) of 7/13/22, R73 scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately cognitively impaired for making daily decisions. A review of the immunization tab in R73's clinical record failed to reveal documentation regarding the resident's COVID-19 immunization status. Further review of R73's clinical record failed to reveal evidence that R73 or the resident's representative was provided education regarding the benefits and risks and potential side effects associated with the	F 887	associated with COVID-19 was offered. Resident # 42, currently resides in the facility, and immediately upon notification received education on COVID-19 vaccine regarding the benefits and risks and potential side effects associated with COVID-19 was offered. 2. All residents have the potential to be effective by this practice. 3. Director of Nursing/Designee re-educated licensed staff that they have to offer COVID vaccines if they are not up to date and provide education to residents on the risk versus benefits and documenting in the immunization record in PCC that it was offered. The infection preventionist will review the immunization section and documentation in PCC daily to ensure COVID-19 vaccination information is up to date and that all residents are offered COVID-19 vaccine and educated on the risk versus benefits of the vaccine and documenting in the immunization record in PCC as indicated that it was offered. 4. Director of Nursing/Designee to review 3x a week for 4 weeks all new admits and current residents to verify that COVID-19 vaccine was offered, and education was provided on the risk versus benefits of receiving COVID-19 vaccine, any variance will be corrected, re-educated with be provided, the results of these audits will be reported by the Director of Nursing to the QAPI team for ongoing compliance.	

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COVID-19 vaccine or was offered the vaccine.

3. For R18, on the most recent MDS, a quarterly assessment with an ARD (assessment reference date) of 5/20/22, R18 scored 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. A review of the immunization tab in R18's clinical record failed to reveal documentation regarding the resident's COVID-19 immunization status. Further review of R18's clinical record failed to reveal evidence that R18 or the resident's representative was provided education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine or was offered the vaccine.

4. For R42, on the most recent MDS, a quarterly assessment with an ARD (assessment reference date) of 6/20/22, R42 scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. A review of the immunization tab in R42's clinical record failed to reveal documentation regarding the resident's COVID-19 immunization status. Further review of R42's clinical record failed to reveal evidence that R42 was provided education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine or was offered the vaccine. On 8/3/22 at approximately 10:30 a.m., an interview was attempted with R42 but the resident was unavailable.

On 8/3/22 at 1:49 p.m., an interview was conducted with LPN (licensed practical nurse) #4 (the infection control nurse). LPN #4 stated the admissions department is supposed to notify all department heads (including her), the unit

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F 887	Continued From page 150 managers and the admitting nurses of residents' COVID-19 vaccination status. LPN #4 stated the admitting floor nurses and any managers that follow up on the admission can ascertain a residents' COVID-19 vaccine status, provide education regarding the vaccine and offer the vaccine. LPN #4 stated the former infection control nurse was supposed to follow up to make sure this was being done and did not do so. On 8/3/22 at 5:39 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Coronavirus Prevention and Response" documented, "11. Vaccination Planning" a. All facility staff and residents will be encouraged to get vaccinated against SARS-CoV-2." The policy failed to document any further information regarding the process for education and offering the vaccine. No further information was presented prior to exit.	F 887		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 919	1. The call bells for Residents #29, #46,	9/2/22

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F 919	Continued From page 151 interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain an operational call bell system for four of 43 residents in the survey sample, Residents #29 (R29), #46 (R46), #60 (R60), and #36 (R36), The findings include: 1. The facility staff failed to ensure (R29's) call bell was operational on 08/02/2022. (R29) was admitted to the facility with diagnoses that included but were not limited to: muscle weakness. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/06/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 08/02/22 at 1:11 p.m., an observation of (R29) revealed they were in their room sitting in a wheelchair. When asked to activate their call bell, (R29) pressed the call bell button and an observation revealed that the light in the hallway outside of (R29's) room did not light up. On 08/02/22 at 1:09 p.m., an interview was conducted with (R29) regarding their call bell. (R29) stated that their call bell was not working. When asked if they notified any of the facility staff about their call bell (R29) stated that they told a nurse, CNA (certified nursing assistant). On 08/02/22 at 3:00 p.m., an observation of (R29) revealed they were in their room sitting in a wheelchair. When asked to activate their call	F 919	#60, and #36 were repaired on 8/3/22 2. All residents who are capable of using the call bell system to request assistant have the potential to be affected. 3. A 100% audit was completed on 8/3/222 and no other call bells that were not operational were identified. Staff in all departments were educated on the process for submitting a repair order for broken call bells. Facility staff who conduct rounds were educated to check call bell functionality during facility room rounds. 4. IDT team will conduct audits Monday through Friday of all resident rooms x 4 weeks to ensure call bells are operational. Maintenance Director or designee will complete audits Monday through Friday x 4 weeks of facility work orders to ensure call bell repairs are prioritized. A summary of findings will be provided to the QAPI committee for additional oversight.	

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bell, (R29) pressed the call bell button and an observation revealed that the light in the hallway outside of (R29's) room did not light up.

On 08 03/2022 at approximately 3:40 a.m., an interview was conducted with OSM (other staff member) #13, maintenance director. When asked about call bell inspections OSM #13 stated that they test all the resident's call bells monthly. When asked what the testing consisted of OSM #13 stated that they activate the resident's call bell in the their room, make sure the panel above the resident's bed lights up, the light in the hallway outside the resident's room is illuminated and that the call bell panel at the nurse's station also is illuminated. When informed of the above observation OSM #13 stated that they were not aware that the call bell was not working.

On 08/03/2022 at approximately 5:21 p.m., ASM # 1, administrator ASM #2, director of nursing, and ASM #5, regional director of clinical services, were made aware of the above findings.

No further information was provided prior to exit.

2. The facility staff failed to ensure (R46's) call bell was operational on 08/02/2022 and on 08/03/2022.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/29/2022, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

On 08/02/22 at 4:46 p.m., an observation of (R46) revealed they were in their room lying on their

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bed. When asked to activate their call bell, (R46) pressed the call bell button and an observation revealed that the light in the hallway outside of (R46's) room did not light up.

On 08/03/22 at 8:17 a.m., an observation of (R46) revealed they were in their room lying on their bed. When asked to activate their call bell, (R46) pressed the call bell button and an observation revealed that the light in the hallway outside of (R46's) room did not light up.

On 08/03/2022 at approximately 3:40 a.m., an interview was conducted with OSM (other staff member) #13, maintenance director. When asked about call bell inspections OSM #13 stated that they test all the resident's call bells monthly. When asked what the testing consisted of OSM #13 stated that they activate the resident's call bell in the their room, make sure the panel above the resident's bed lights up, the light in the hallway outside the resident's room is illuminated and that the call bell panel at the nurse's station also is illuminated. When informed of the above observation OSM #13 stated that they were not aware that the call bell was not working.
On 08/03/2022 at approximately 5:21 p.m., ASM #1, administrator ASM #2, director of nursing, and ASM #5, regional director of clinical services, were made aware of the above findings.

No further information was provided prior to exit.

3. The facility staff failed to ensure (R60's) call bell was operational on 08/02/2022.

(R60) was admitted to the facility with diagnoses that included but were not limited to: dementia (1).

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On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/07/2022, the resident scored 3 (three) out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired of cognition for making daily decisions.

On 08/02/22 at approximately 1:15 p.m., an observation of (R60) was observed lying in their bed. When asked to activate their call bell (R60) was confused and could not follow the request. The surveyor pressed (R60's) call bell next to the bed and observation of the call light in the hallway next to (60's) room failed to light up. Observation of (R60's) room failed to evidence a hand bell or any other device to notify staff.

On 08/02/22 at approximately 3:10 p.m., (R60's) call bell was tested by the surveyor. The surveyor pressed (R60's) call bell next to the bed and observation of the call light in the hallway next to (60's) room failed to light up. Observation of (R60's) room failed to evidence a hand bell or any other device to notify staff.

On 08/03/2022 at approximately 3:40 a.m., an interview was conducted with OSM (other staff member) # 13, maintenance director. When asked about call bell inspections OSM # 13 stated that they test all the resident's call bells monthly. When asked what the testing consisted of OSM # 13 stated that they activate the resident's call bell in the their room, make sure the panel above the resident's bed lights up, the light in the hallway outside the resident's room is illuminated and that the call bell panel at the nurse's station also is illuminated. When

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informed of the above observation OSM # 13 stated that they were not aware that the call bell was not working.

On 08/03/2022 at approximately 5:21 p.m., ASM # 1, administrator ASM # 2, director of nursing, and ASM # 5, regional director of clinical services, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

4. The facility staff failed to ensure (R36's) call bell was operational on 08/02/2022 and on 08/03/2022.

(R36) was admitted to the facility with diagnoses that included but were not limited to: dementia (1).

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/10/2022, the resident scored 0 (zero) out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired of cognition for making daily decisions.

On 08/02/22 at approximately 1:02 p.m., an observation of (R36) was observed lying in their bed. When asked to activate their call bell (R36) was confused and could not follow the request. The surveyor pressed (R60's) call bell next to the

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bed and observation of the call light in the hallway next to (36's) room failed to light up. Observation of (R36's) room failed to evidence a hand bell or any other device to notify staff.

On 08/03/22 at approximately 9:00 a.m., (R36's) call bell was tested by the surveyor. The surveyor pressed (R36's) call bell next to the bed and observation of the call light in the hallway next to (36's) room failed to light up. Observation of (R36's) room failed to evidence a hand bell or any other device to notify staff.

On 08/03/2022 at approximately 3:40 a.m., an interview was conducted with OSM (other staff member) #13, maintenance director. When asked about call bell inspections OSM #13 stated that they test all the resident's call bells monthly. When asked what the testing consisted of OSM #13 stated that they activate the resident's call bell in the their room, make sure the panel above the resident's bed lights up, the light in the hallway outside the resident's room is illuminated and that the call bell panel at the nurse's station also is illuminated. When informed of the above observation OSM #13 stated that they were not aware that the call bell was not working.

On 08/03/2022 at approximately 5:21 p.m., ASM #1, administrator ASM #2, director of nursing, and ASM #5, regional director of clinical services, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was

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CYPRESS POINTE REHABILITATION AND NURSING	5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462

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F 919	Continued From page 157 obtained from the website: https://medlineplus.gov/ency/article/000739.htm.	F 919		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview, employee record review and facility documentation review, it was determined that the facility staff failed to ensure that 5 of 5 certified nursing assistants (CNAs) during annual performance reviews received dementia training (CNAs #2, #3, #4, #5 and #6). The findings include: On 08/04/2022 at approximately 8:45 a.m., a review of the annual competency trainings for	F 947	1. CNAs #2, #3, #4, #5 and #6, all received upon notification Dementia training on 8/4/22. 2. All residents have the potential to be impacted when staff do not receive required inservices. 3. Director of Nursing/Designee will re-educate the Assistant Director of	9/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495234	A. BUILDING _____ B. WING _____	C 08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 947	Continued From page 158 CNA (certified nursing assistant) #2 with a hire date of 05/13/2005, CNA #3 with a hire date of 07/22/2020, CNA #4 with a hire date of 07/05/2017, CNA #5 with a hire date of 07/06/2016 and CNA #6 with a hire date of 11/20/1990 was conducted. The review failed to evidence dementia training for CNA # 2 from 05/13/2021 through 05/13/2022, , CNA #3 from 07/22/2021 through 07/22/2022, CNA #4 from 07/05/2021 through 07/05/2022, CNA# 5 from 07/06/2021 through 07/06/2022 and CNA #6 from 11/20/2020 through 11/20/2021. On 08/04/22 at approximately 9:19 a.m., an interview was conducted with ASM (administrative staff member) #2 , director of nursing and ADON regarding the annual competency training for the CNAs listed above. When asked who was responsible for tracking the CNA's annual competency training ASM #2 stated that it was the ADON. When informed that there was no evidence of dementia training for the CNAs listed above ASM #2 stated that when they were reviewing the competency trainings for the CNAs listed above they did not find evidence of dementia training. ADON stated that the dementia training is part of the CNA's annual competency training and also agreed that it was not evidenced for the CNAs listed above. The facility's policy "Competency Evaluation" documented in part, "It is the policy of this facility to evaluate each employee to assure appropriate competencies and skills for performing his or her job and to meet the needs of facility residents." On 08/04/2022 at approximately 11:40 a.m., ASM #1, administrator ASM #2, director of nursing, and	F 947	Nursing on required In-Service training for C.N.A's. A 100% audit of current C.N.A's will be conducted to identify any staff that have not received required in-service training. 4. Director of Nursing will review all certified nursing assistants training folder weekly to verify that all education is up to date and current for 4 weeks, any variance will be corrected, re-educated with be provided, the results of these audits will be reported by the Director of Nursing to the QAPI team for ongoing compliance.	

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F 947	Continued From page 159 ASM #5, regional director of clinical services, were made aware of the above findings. No further information was presented prior to exit.	F 947		