STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495361	A. BUILDING _____ B. WING _____	C 07/21/2022

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ENVOY OF WOODBRIDGE, LLC	14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/19/22 through 7/21/22. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 035 SS=D	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. 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 communication plan. The facility	E 035	1. The facility provided a posting at the entrance and all other notice boards as method of sharing EP information with current residents, their families, or representatives and all new residents, their families, or representatives. 2. All residents, their families, or representatives are at risk for being impacted by the alleged deficient practice. 3. Information will be included in the Admission packet to ensure each new resident, their family, or representative is aware of the Emergency Preparedness plan and how this facility will ensure their safety during an emergency All staff will be educated regarding the emergency prepardness plan and how/where residents/families or RPs can receive information about it. 4. The ED/designee to conduct quality monitoring of 10 residents/RPs weekly x 6 weeks regarding understanding the EP plan information location The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	9/1/2022

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

Executive Director | 8/26/2022

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

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E 035	Continued From page 1 staff failed to provide evidence of a system in place to inform residents and staff about the facility's emergency plan. The findings include: On 7/19/22 at 11:26 a.m., ASM (administrative staff member) #1, the administrator, was asked to provide the facility's emergency plan, including evidence that the facility has a system in place to inform residents and staff about the facility's emergency plan. On 7/20/22 at 5:17 p.m., ASM #1 was again asked to provide evidence that facility's system to inform residents and staff about the facility's emergency plan. ASM #1 stated, "Normally we place the plan at the front desk or at the nurses' stations." He stated sometimes he leaves a note at the front elevator. When asked to provide evidence that any of these things had been done, ASM #1 stated: "I will work on that." He stated there is no facility policy regarding residents and families being informed about the facility's emergency plan. No further information was provided prior to exit.	E 035		
E 037 SS=D	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs	E 037		

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E 037	Continued From page 2 at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency	E 037	1. The facility recognizes that not all staff were fully trained in emergency preparedness policies/procedures. 2. All residents are at risk to be impacted by the alleged deficient practice. The facility initiated emergency preparedness training for its employees. 3. HR/Administrator will ensure Emergency Preparedness plan training is included in the orientation process for all new hires The HRC will review new hires in the AM meeting to ensure they have received their emergency preparedness training as indicated. 4. The Executive Director/Human Resource Coordinator will review all new hires weekly x 6 weeks to ensure they have received the proper emergency preparedness training. Additionally monthly the Human Resource Coordinator will provide a list of upcoming annual evaluations and the Executive Director/Human Resource Coordinator will ensure they receive emergency preparedness training along with their evaluation as indicated.	9/1/2022

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E 037	Continued From page 3	E 037		

preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

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E 037	Continued From page 4 (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.	E 037		

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E 037	Continued From page 5 (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.	E 037		

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E 037	Continued From page 6	E 037		

This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that facility staff have received annual emergency preparedness training.

The findings include:

On 7/19/22 at 11:26 a.m., ASM (administrative staff member) #1, the administrator, was asked to provide the facility's emergency plan, including evidence that the staff have received initial (at the time of hire) and annual emergency preparedness training.

On 7/19/22 at 4:59 p.m., OSM (other staff member) #5, the human resources director, was asked to provide evidence that the facility staff had received initial and annual emergency preparedness training.

On 7/20/22 at 5:17 p.m., ASM #1 was again asked to provide evidence that facility staff were being provided initial and annual emergency preparedness training. ASM #1 stated there was no such evidence.

A review of the facility policy, "Disaster Training," revealed, in part: "The facility has established training and education programs that provide specific guidance and instruction on the proper handling of a crisis or disaster situation...Staff members, contract employees, and volunteers are trained upon hire and at least annually on the community's emergency preparedness and

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E 037	Continued From page 7 response plan and procedures...Disaster training is organized and conducted by qualified persons within the organization or from other credible resources, such as local emergency responders, qualified vendors, and consultants." No further information was provided prior to exit.	E 037		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/19/22 through 7/21/22/22. Two complaints (VA00055351-substantiated with a related deficiency and VA00054154-substantiated with deficiency) were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 96 at the time of the survey. The survey sample consisted of 25 current resident reviews and 8 closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		

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F 550	Continued From page 8 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to preserve resident dignity when serving meals in one of one facility kitchen. The facility staff served the 7/19/22 lunch meal on disposable Styrofoam containers for all residents, and gave disposable eating utensils to the final seven residents served from the tray line.	F 550	1.The facility recognizes that Styrofoam was used for a meal during the survey visit. 2.All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Dietary Manager and ED to ensure adequate dishware is available for use for meals as indicated. Meals will be served on dishware. 3.All dietary staff will be re-educated by the Social Service Director/Assistant related to Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required. In the AM meeting, the Dietary Manger will report to the ED any situations that may impact dishware availability.	9/1/2022

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F 550	Continued From page 9 The findings include: On 7/19/22 at 1:29 p.m., OSM (other staff member) #1, the dietary manager, was observed as he served all resident lunches from the tray line in the facility's only kitchen. OSM #1 served each and every meal on a disposable Styrofoam container. The food was placed on one side of the container, and the other side of the container was folded over to create a cover. Two stacks of facility dishware were observed in a dish cart adjacent to the tray line. Additionally, the last seven Styrofoam containers served were paired with disposable plastic eating utensils. OSM #1 stated: "I don't know where the [stainless steel] forks are going. We just don't have enough for everybody." On 7/19/22 at 1:46 p.m., OSM #2, the dietary manager at a sister facility, who had also observed the lunch tray line service, was interviewed. She stated OSM #1 was serving on Styrofoam "because they are short staffed." She stated if the facility staff did not serve on disposable dishware, there is no way they would ever be able to turn the dishware around on time to get the dinner meal "out at a decent time." She stated there was not enough staff at the facility to wash the dishware. When asked if serving the residents on disposable dishware for staff convenience promoted a sense of resident dignity, she said it did not. On 7/20/22 at 5:17 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns.	F 550	4.The Executive Director/Assistant to conduct quality monitoring of 10 meals weekly x 6 weeks to ensure proper dishware is utilized. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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F 550	Continued From page 10 A review of the facility policy, "Resident Rights," revealed, in part: "A resident shall be treated with dignity and respect." No further information was provided prior to exit.	F 550		
F 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or	F 574		

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F 574	Continued From page 11 federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide the email address of the State Long-Term Care Ombudsman, in the posted	F 574	1.The Ombudsman email was posted prior to the end of the survey. 2.All residents are at risk for being impacted by the alleged deficient practice. A quality review was conducted by the Executive Director/designee of all notification postings to ensure complete Ombudsman information present. 3.The SSD will be re-educated by the ED/designee related to ensuring complete Ombudsman information is posted where posters and information is shared. 4.The ED (Executive Director)/DCS/designee to conduct quality monitoring of the Ombudsman postings to ensure complete information is present weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	9/1/2022

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F 574	Continued From page 12 information on the wall by the elevators on the ground, first and second floors. The findings include: On 7/19/22 at 2:30 PM, this surveyor reviewed the information posted on the wall by the elevators on the ground, first and second floors. It was observed that the information included the mailing address and phone number of the State Long-Term Care Ombudsman but was missing the email address. On 7/20/22 at 7:00 AM, RN (registered nurse) #1 confirmed the email address was not included in the information posted on the wall. On 7/20/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.	F 574		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583		

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F 583	Continued From page 13 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to maintain confidentiality of residents' medical records for 4 of 33 residents in the survey sample, Residents #7, #88, #25 and #96. The findings include: 1. The facility staff failed to maintain confidentiality of Resident #7's (R7) durable DNR (do not resuscitate) order. The order was posted on the wall in R7's room. On the most recent MDS (minimum data set), a	F 583	1.Residents' #7, #25, #88, and #96 with DNRs posted on the wall in their rooms were immediately removed. 2.All residents are at risk for being impacted by the alleged deficient practice. A quality monitoring audit of rooms on both the first and second floor was completed on 07/20/2022 to ensure that no other DNRs were posted on the walls in other resident rooms. 3.The ADON/designee will provide education to all staff to ensure that when rounding in residents' rooms, they remove any and all confidential information visible. Quality monitoring teams will audit their assignment and report in the AM meeting of any issues with confidentiality of resident records discovered.	9/1/2022

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F 583	Continued From page 14	F 583		

quarterly assessment with an ARD (assessment reference date) of 4/24/22, the resident's cognitive skills for daily decision making was coded as severely impaired.

On 7/19/22 at 2:46 p.m., an observation of R7's room was conducted. The resident's durable DNR order was posted on the wall behind the resident's bed. The order documented R7's name, the date the form was signed and the following: "I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest...I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain..."

On 7/20/22 at 3:24 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of a DNR order is to alert nurses to not initiate CPR (cardiopulmonary resuscitation) on a resident if there is an emergency where CPR is needed. LPN #4 stated a DNR order contains confidential information and she usually gets the DNR from

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the chart. LPN #4 stated she didn't know who made the decision to place residents' DNR orders on the wall in residents' rooms but she would find out. On 7/20/22 at 4:01 p.m., another interview was conducted with LPN #4. LPN #4 stated that during the time of COVID, some residents were rapidly declining so the former executive director made the decision to post DNR orders on the wall in residents' rooms so nurses would know when to withhold CPR. LPN #4 stated a confidential document should not be posted on the wall in residents' rooms.

On 7/20/22 at 5:37 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Clinical/Medical Records" documented, "Information contained in the resident's clinical record, regardless of the form or storage method, is considered confidential. The Center has the property right to the clinical record, but the resident has the protected right of information."

No further information was presented prior to exit.

2. The facility staff failed to maintain confidentiality of Resident #88's (R88) durable DNR (do not resuscitate) order. The order was posted on the wall in R88's room.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/3/22, the resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately cognitively impaired for making daily decisions.

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On 7/19/22 at 2:44 p.m., an observation of R88's room was conducted. The resident's durable DNR order was posted on the wall behind the resident's bed. The order documented R88's name, the date the form was signed and the following: "I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest...I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain..."

On 7/20/22 at 3:24 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of a DNR order is to alert nurses to not initiate CPR (cardiopulmonary resuscitation) on a resident if there is an emergency where CPR is needed. LPN #4 stated a DNR order contains confidential information and she usually gets the DNR from the chart. LPN #4 stated she didn't know who made the decision to place residents' DNR orders on the wall in residents' rooms but she would find out. On 7/20/22 at 4:01 p.m., another interview

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was conducted with LPN #4. LPN #4 stated that during the time of COVID, some residents were rapidly declining so the former executive director made the decision to post DNR orders on the wall in residents' rooms so nurses would know when to withhold CPR. LPN #4 stated a confidential document should not be posted on the wall in residents' rooms.

On 7/20/22 at 5:37 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

3. The facility staff failed to maintain confidentiality of medical information for Resident #25 (R25). The facility had posted on the wall behind the resident's bed, a DDNR (durable do not resuscitate) form.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/22/2022, the resident scored a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions.

Observation was made of R25's room on 7/19/2022 at approximately 12:50 p.m. A DDNR form was posted above the bed in a plastic sleeve.

A second observation was made on 7/20/2022 9:15 a.m. the DDNR form was still posted above the resident's bed. The order documented R25's name, the date the form was signed and the following: "I, the undersigned, state that I have a

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bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest...I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain..."

The comprehensive care plan dated 8/16/2018 documented in part, "Focus: (R25) wishes to be DNR (do not resuscitate)."

The physician order dated 8/12/2020, documented, "Do NOT resuscitate."

On 7/20/22 at 3:24 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of a DNR order is to alert nurses to not initiate CPR (cardiopulmonary resuscitation) on a resident if there is an emergency where CPR is needed. LPN #4 stated a DNR order contains confidential information and she usually gets the DNR from the chart. LPN #4 stated she didn't know who made the decision to place residents' DNR orders on the wall in residents' rooms but she would find out. On 7/20/22 at 4:01 p.m., another interview

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was conducted with LPN #4. LPN #4 stated that during the time of COVID, some residents were rapidly declining so the former executive director made the decision to post DNR orders on the wall in residents' rooms so nurses would know when to withhold CPR. LPN #4 stated a confidential document should not be posted on the wall in residents' rooms.

ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3 the director of clinical services were made aware of the above concern on 7/20/2022 at 5:23 p.m.

No further information was provided prior to exit.

4. The facility staff failed to maintain confidentiality of medical information for Resident #96 (R96). The facility had posted on the wall behind the resident's bed, a DDNR (durable do not resuscitate) form.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/8/2022, the resident scored a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions.

Observation was made of R96's room on 7/19/2022 at approximately 12:45 p.m. A DDNR form was posted above the bed in a plastic sleeve.

A second observation was made on 7/20/2022 10:18 a.m. The DDNR form was still posted above the resident's bed. The order documented

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R96's name, the date the form was signed and the following: "I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest...I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain..."

The physician order dated 7/17/2020, documented, "Do NOT resuscitate."

The comprehensive care plan dated, 4/9/2021, does not address the resident's status for resuscitation.

On 7/20/22 at 3:24 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of a DNR order is to alert nurses to not initiate CPR (cardiopulmonary resuscitation) on a resident if there is an emergency where CPR is needed. LPN #4 stated a DNR order contains confidential information and she usually gets the DNR from the chart. LPN #4 stated she didn't know who made the decision to place residents' DNR orders

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F 583	Continued From page 21 on the wall in residents' rooms but she would find out. On 7/20/22 at 4:01 p.m., another interview was conducted with LPN #4. LPN #4 stated that during the time of COVID, some residents were rapidly declining so the former executive director made the decision to post DNR orders on the wall in residents' rooms so nurses would know when to withhold CPR. LPN #4 stated a confidential document should not be posted on the wall in residents' rooms. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3 the director of clinical services were made aware of the above concern on 7/20/2022 at 5:23 p.m. No further information was provided prior to exit.	F 583		
F 585 SS=D	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 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.	F 585		

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F 585	Continued From page 22 §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 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	F 585	1. The facility ordered a new Prevalon boot (boot to keep the heel lifted off the bed, wick moisture and keep the foot and ankle in place) in a timely manner for R32. The grievance the facility had was about “toe shoes” 2. All residents with orders for specialty boots/shoes are at risk to be impacted by the alleged deficient practice. A quality review was conducted by the SSD/designee of grievances since July 1 to ensure follow up completed and closed out. 3.SSD will be re-educated by the ED/designee related to the completion of all grievances including the documentation of follow up. The IDT will review grievances in AM meeting to discuss follow up and ensure each is resolved and closed out with follow up with the grievant. 4. The ED (Executive Director)/DCS to conduct quality monitoring of grievances weekly x 6 weeks to ensure follow up and resolution. The findings of these quality monitoring’s to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	9/1/2022

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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 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 resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff

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failed to act upon a reported grievance for a missing personal item for one of 33 residents in the survey sample, Resident #32 (R32).

The findings include:

The facility staff failed to respond to a known grievance regarding a missing Prevalon boot (boot to keep the heel lifted off the bed, wick moisture and keep the foot and ankle in place) in a timely manner for R32.

R32 was admitted to the facility with diagnoses that included but were not limited to paraplegia and chronic ulcer of left calf.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/20/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section G documented R32 requiring extensive assistance of two or more persons for transfers, personal hygiene and extensive assistance of one person for dressing. Section G documented R32 using a wheelchair and having functional limitations in range of motion in both lower extremities. Section G further documented R32 being dependent on staff for putting on/taking off footwear.

On 7/19/2022 at 12:59 p.m., an interview was conducted with R32. R32 stated that they had special boots with a hard bottom that they were supposed to wear but the pair they had were worn out and would not fasten anymore. R32 stated that the supply clerk had ordered replacement boots for them but they had never

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received them. R32 stated that physical therapy had re-evaluated them and recommended they wear the boots for the supply clerk to order another pair. R32 stated that they had not worn the boots in about six months because the ones they had were worn and did not work. R32 stated that when they checked the status of the order for the new boots they were told that they had already received them. R32 stated that they had reported that they did not have the replacement pair that was ordered to the social worker and the physical therapist but no one had followed up with them.

Review of the facility grievances from 12/20/2020 to the present were reviewed, there were no grievances for R32 related to the missing Prevalon Boots.

The comprehensive care plan for R32 documented in part, "[Name of R32] has an ADL (activities of daily living) self-care performance deficit r/t (related to) Impaired balance, Limited Mobility, Limited ROM (range of motion), Paraplegia. Date Initiated: 01/20/2021..." The care plan further documented, "[Name of R32] is at risk for skin breakdown r/t disease process: paraplegia, anxiety, complicated UTI (urinary tract infection), Afib (atrial fibrillation), PVD (peripheral vascular disease), impaired mobility, fragile skin, incontinence of bowel, suprapubic catheter, hx (history) of altered skin integrity: scarring: sacrum, right shoulder, Date Initiated: 06/26/2021. Revision on: 03/24/2022..." Under "Interventions" it documented in part, "...Prevalon boots to bilateral feet as needed. Date Initiated: 03/14/2022..."

The physician orders for R32 documented in part,

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"Order Date: 4/5/2022. Prevalon boots to bilateral feet as needed, check skin integrity Q (every) shift..."

On 7/20/2022 at 3:33 p.m., an interview was conducted with OSM (other staff member) #11, central supply. OSM #11 stated that Prevalon boots were ordered through the therapy department. OSM #11 stated that after therapy evaluated and determined the need for the boots they would come to her and ask her to order them. OSM #11 stated that they remembered OSM #13, the director of rehab requesting them to order the boots for R32. OSM #11 stated that they had ordered the boots, they arrived and they delivered them to physical therapy who would provide them to the resident. OSM #11 stated that the facility would replace worn boots as long as they were approved by therapy for the resident. OSM #11 stated that it had been "a couple of months" since the new boots for R32 had arrived and been delivered to therapy.

On 7/20/2022 at 4:05 p.m., an interview was conducted with OSM #13, the director of rehab, physical therapy assistant. OSM #13 stated that R32 had reported that their Prevalon boot was broken and they had requested OSM #11 to order a new one. OSM #13 stated that a new left boot had come in and they had provided it to R32. OSM #13 stated that recently R32 had reported to them that they had never received the boot. OSM #13 stated that they did not remember reporting the grievance to the social worker. OSM #13 stated that the facility process was to file a grievance for missing items and report it during the stand up meetings. OSM #13 stated that the grievance would be investigated by the social worker to try to resolve it.

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On 7/20/2022 at 4:22 p.m., an interview was conducted with OSM #12, social services assistant and OSM #3, the director of social services. OSM #3 stated that they had received a grievance regarding a missing boot for R32 and that it was in the grievance book provided on entry for the survey. OSM #3 was made aware that a grievance was not found in the grievance book, and stated that they would check the book again and their office to find it. OSM #3 stated that it was reported about 3 weeks ago and they sometimes give missing items a little more time because they show up out of no where. OSM #3 stated that if the boot was not found they would replace it.

On 7/20/2022 at approximately 4:30 p.m., OSM #11, central supply provided a copy of a purchase order dated 3/25/2022 for a "SoftProAmbulating AFO Boot." OSM #11 stated that 3/25/2022 was when the boot was ordered for R32.

The facility policy "Clinical Guideline-Complaint Grievance" dated 11/30/2014 documented in part, "...The intent of this guideline is to support each resident's right to voice grievances (e.g., those about treatment, care, management of funds, lost clothing, or violation of rights) and to assure that after receiving a complaint/grievance, the center actively seeks a resolution and keeps the resident appropriately apprised of its progress toward resolution. Prompt efforts by the center to resolve grievances the resident may have, including those with respect to the behavior of other residents...The resident should have reasonable expectations of care and services and the center should address those expectations in a timely, reasonable, and consistent manner...An

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F 585	Continued From page 28 employee receiving a complaint/grievance from a resident, family member and/or visitor shall initiate a Complaint/Grievance Form or electronic equivalent...Original grievance forms are then submitted to the Grievance Officer /designee for further action...The grievance follow-up should be completed in a reasonable time frame; this should not exceed 14 days...The individual voicing the grievance shall receive follow up communication with the resolution, a copy of the grievance resolution will be provided to the resident upon request..." On 7/21/2022 at approximately 9:45 a.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the concern. No further information was presented prior to exit.	F 585		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §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;	F 622		

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F 622	Continued From page 29 (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger 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)	F 622	1.The facility recognizes that it was unable to provide complete hospital transfer documentation for Residents #37, 40, 350 and 1. 2.All residents that are transferred to the hospital are at risk to be impacted by the alleged deficient practice. A quality review was conducted by the DCS (Director of Clinical Services)/designee of residents discharged to the hospital since July 1 to gauge hospital transfer documentation. 3.All licensed nurses will be re-educated by the DCS/designee related to hospital transfer documentation required upon discharge. The IDT will review hospital transfers in the AM meeting to ensure hospital transfer documentation was provided to the hospital. 4.The ED (Executive Director)/DCS/designee to conduct quality monitoring of transferred residents' medical record to ensure proper documentation provided to the hospital weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	9/1/2022

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(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation, it was determined the facility staff failed to provide evidence that all required information was provided to the hospital staff when 4 out of 33 residents in the survey sample were transferred to the hospital; Residents #37, #40, #350 and #1.

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The findings include:

1. The facility staff failed to evidence provision of required resident information to a receiving facility at the time of discharge for Resident #37. Resident #37 was transferred to the hospital on 6/27/22.

Resident #37 was admitted to the facility on 5/16/16 with diagnosis that included but were not limited to: end stage renal disease, diabetes mellitus, heart failure and encephalopathy.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/21/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; supervision for locomotion and independence for eating. Section O-special procedures/treatments coded the resident as dialysis "no".

A review of the comprehensive care plan dated 2/26/22, which revealed, "FOCUS: The resident is on Hemodialysis via Left arterial-venous Fistula related to End Stage Renal Disease. Transferred to hospital for clogged AV shunt 6/27/22. INTERVENTIONS: Communicate with dialysis facility as needed. Dialysis 3 times/week: Tuesday, Thursday & Saturday.

Further review of the clinical record failed to evidence any documentation of any documents;

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medication list, resident information and care plan goals, having been sent to the hospital upon transfer.

A review of the facilities "Acute Care Transfer Document Checklist (INTERACT version 4.0 tool)", "Copies of Documents sent with Resident/Patient (check all that apply): dated 2014 transfer form are enclosed 3.face sheet 4.current medication list or current MAR (medication administration record) 5.SBAR (Situation, Background, Assessment, and Recommendation) and/or other change in condition progress includes the following: Documents recommended to accompany resident/patient: 1.Resident/Patient transfer form 2.Personal belongings identified on resident/patient note if completed 6.Advance Directives 7.Advance Care Orders.
Send these documents if available: 1.most recent history and physical 2.recent hospital discharge summary 3.recent MD/NP/PA (physician/nurse practitioner/physician assistant) and Specialist orders 4.Flow sheets 5.relevant lab results 6.relevant x-rays and other diagnostic test results 7.SNF/NF (skilled nursing facility/nursing facility) capabilities checklist. EMERGENCY DEPARTMENT: Please ensure that these documents are forwarded to the hospital unit if this resident/patient is admitted."

This checklist was on the front of an envelope which is to contain the forms and includes a tear off front page which reveals, "Tear off front page to keep with the resident's medical record.

An interview was conducted on 7/20/22 at 9:30 AM with LPN (licensed practical nurse) #3. When asked what information is provided to the hospital

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upon transfer of a resident, LPN #3 stated, "I'll get you a sample of what we send with the resident to the acute care facility. It is a transfer document checklist and we tear off the top copy, it should go to medical records."

An interview was conducted on 7/20/22 at 2:12 PM, with OSM (other staff member) #6, the medical records coordinator. When asked if she has copies of the transfer document checklist, and shown the transfer document checklist, OSM #6 stated, "No we do not get a copy of that for the medical records. I do not know what they do with it. I bet they send all of it to the hospital with the resident."

On 7/20/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. ASM #1 asked what top form and was shown the transfer document checklist envelop with the tear off front page.

A review of the facilities "Transfer/Discharge Notification and Right to Appeal" policy dated 9/2017, revealed the following: "Contents of the Notice: The written notice must include the following:
The reason for transfer or discharge; The effective date of transfer or discharge; The location to which the resident is transferred or discharged; A statement of the resident's appeal rights including the name, address (mailing and email), and telephone number of the entity which receives such request; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal

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hearing request; The name, address (mailing and email) and telephone number of the State Long-Term Care Ombudsman. Orientation for Transfer or Discharge: The Center must provide and document sufficient preparation and orientation, in a form and manner that the resident understands, to ensure safe and orderly transfer or discharge."

No further information was provided prior to exit.

2. The facility staff failed to evidence provision of required resident information to a receiving facility at the time of discharge for Resident #40. Resident #40 was transferred to the hospital on 3/22/22, 4/1/22, 4/12/22 and 4/26/22.

Resident #40 was admitted to the facility on 2/18/22 with diagnosis that included but were not limited to: hemiplegia, hemiparesis, diabetes mellitus and cerebrovascular disease.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/28/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing and hygiene; supervision for eating and total dependence for bathing.

Further review of the clinical record failed to evidence any documentation of any documents; medication list, resident information and care plan goals, having been sent to the hospital upon transfer.

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A review of the comprehensive care plan dated 2/19/22, which revealed, "FOCUS: The resident has (chronic) pain related to Depression, Diabetes, and back pain. ER evaluation related to pain per resident's request 3/22/22. ER evaluation related to pain per residents request 4/1/2022. 4/12 sent to ER for unrelieved pain per resident. 4/15 medication adjustment related to unrelieved pain. 4/26/22 Sent to ER for chest pain. INTERVENTIONS: Evaluate the effectiveness of pain interventions (q shift) Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition."

A review of the facilities "Acute Care Transfer Document Checklist (INTERACT version 4.0 tool)", "Copies of Documents sent with Resident/Patient (check all that apply): dated 2014 transfer form are enclosed 3.face sheet 4.current medication list or current MAR (medication administration record) 5.SBAR (Situation, Background, Assessment, and Recommendation) and/or other change in condition progress includes the following: Documents recommended to accompany resident/patient: 1.Resident/Patient transfer form 2.Personal belongings identified on resident/patient note if completed 6.Advance Directives 7.Advance Care Orders.
Send these documents if available: 1.most recent history and physical 2.recent hospital discharge summary 3.recent MD/NP/PA (physician/nurse practitioner/physician assistant) and Specialist orders 4.Flow sheets 5.relevant lab results 6.relevant x-rays and other diagnostic test results 7.SNF/NF (skilled nursing facility/nursing

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facility) capabilities checklist. EMERGENCY DEPARTMENT: Please ensure that these documents are forwarded to the hospital unit if this resident/patient is admitted."

This checklist was on the front of an envelope which is to contain the forms and includes a tear off front page which reveals, "Tear off front page to keep with the resident's medical record.

An interview was conducted on 7/20/22 at 9:30 AM with LPN (licensed practical nurse) #3. When asked what information is provided to the hospital upon transfer of a resident, LPN #3 stated, "I'll get you a sample of what we send with the resident to the acute care facility. It is a transfer document checklist and we tear off the top copy, it should go to medical records."

An interview was conducted on 7/20/22 at 2:12 PM, with OSM (other staff member) #6, the medical records coordinator. When asked if she has copies of the transfer document checklist, and shown the transfer document checklist, OSM #6 stated, "No we do not get a copy of that for the medical records. I do not know what they do with it. I bet they send all of it to the hospital with the resident."

On 7/20/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. ASM #1 asked what top form and shown the transfer document checklist envelop with the tear off front page.

A review of the facilities "Transfer/Discharge Notification and Right to Appeal" policy dated

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9/2017, revealed the following: "Contents of the Notice: The written notice must include the following:
The reason for transfer or discharge; The effective date of transfer or discharge; The location to which the resident is transferred or discharged; A statement of the resident's appeal rights including the name, address (mailing and email), and telephone number of the entity which receives such request; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; The name, address (mailing and email) and telephone number of the State Long-Term Care Ombudsman. Orientation for Transfer or Discharge: The Center must provide and document sufficient preparation and orientation, in a form and manner that the resident understands, to ensure safe and orderly transfer or discharge."

No further information was provided prior to exit.

3. The facility staff failed to evidence provision of required resident information to a receiving facility at the time of discharge for Resident #350. Resident #350 was transferred to the hospital on 1/11/22.

Resident #350 was admitted to the facility on 11/29/21 with diagnosis that included but were not limited to: atrial fibrillation, hypertension and coronary artery disease.

The most recent MDS (minimum data set) assessment, a 5 day Medicare assessment, with an ARD (assessment reference date) of 12/6/21, coded the resident as scoring a 10 out of 15 on the BIMS (brief interview for mental status) score,

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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, dressing and hygiene; supervision for eating and total dependence for bathing.

Further review of the clinical record failed to evidence any documentation of any documents; medication list, resident information and care plan goals, having been sent to the hospital upon transfer.

A review of the comprehensive care plan dated 12/18/21, which revealed, "FOCUS: The resident has an ADL (activities daily living) self-care performance deficit related to limited mobility and stroke. INTERVENTIONS: Provide assist with all ADLs. A second focus dated 12/30/21, which revealed "FOCUS: The resident does not cooperate with care related to adjustment to nursing home, personal choice: refuses medication and refuses to allow staff to change soiled dressing and brief, refusing shower, refused medication prior to wound care and refuses to be turned and repositioned by staff. INTERVENTIONS: Allow the resident to make decisions about treatment regime to provide a sense of control. If possible, negotiate a time for ADLs so that the resident participates in the decision making process."

A review of the facilities "Acute Care Transfer Document Checklist (INTERACT version 4.0 tool)", "Copies of Documents sent with Resident/Patient (check all that apply): dated 2014 transfer form are enclosed 3.face sheet 4.current medication list or current MAR (medication administration record) 5.SBAR

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(Situation, Background, Assessment, and Recommendation) and/or other change in condition progress includes the following: Documents recommended to accompany resident/patient: 1.Resident/Patient transfer form 2.Personal belongings identified on resident/patient note if completed 6.Advance Directives 7.Advance Care Orders.
Send these documents if available: 1.most recent history and physical 2.recent hospital discharge summary 3.recent MD/NP/PA (physician/nurse practitioner/physician assistant) and Specialist orders 4.Flow sheets 5.relevant lab results 6.relevant x-rays and other diagnostic test results 7.SNF/NF (skilled nursing facility/nursing facility) capabilities checklist. EMERGENCY DEPARTMENT: Please ensure that these documents are forwarded to the hospital unit if this resident/patient is admitted."

This checklist was on the front of an envelope which is to contain the forms and includes a tear off front page which reveals, "Tear off front page to keep with the resident's medical record.

An interview was conducted on 7/20/22 at 9:30 AM with LPN (licensed practical nurse) #3. When asked what information is provided to the hospital upon transfer of a resident, LPN #3 stated, "I'll get you a sample of what we send with the resident to the acute care facility. It is a transfer document checklist and we tear off the top copy, it should go to medical records."

An interview was conducted on 7/20/22 at 2:12 PM, with OSM (other staff member) #6, the medical records coordinator. When asked if she has copies of the transfer document checklist, and shown the transfer document checklist, OSM

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#6 stated, "No we do not get a copy of that for the medical records. I do not know what they do with it. I bet they send all of it to the hospital with the resident."

On 7/20/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. ASM #1 asked what top form and shown the transfer document checklist envelop with the tear off front page.

A review of the facilities "Transfer/Discharge Notification and Right to Appeal" policy dated 9/2017, revealed the following: "Contents of the Notice: The written notice must include the following:
The reason for transfer or discharge; The effective date of transfer or discharge; The location to which the resident is transferred or discharged; A statement of the resident's appeal rights including the name, address (mailing and email), and telephone number of the entity which receives such request; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; The name, address (mailing and email) and telephone number of the State Long-Term Care Ombudsman. Orientation for Transfer or Discharge: The Center must provide and document sufficient preparation and orientation, in a form and manner that the resident understands, to ensure safe and orderly transfer or discharge."

No further information was provided prior to exit.
4. The facility staff failed to provide the required documents to the receiving facility for a transfer to

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the hospital on 5/4/2022 for Resident #1 (R1).

On the most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 7/7/2022, the resident was coded as having both short and long term memory difficulties.

The Change In Condition form dated 5/4/2022 at 12:35 p.m. documented in part, "On arrival at the facility, report received from the outgoing nurse, rounds done, treatment nurse went to Resident room to do (their) treatment and observed resident twitching and jerging (sic) she alerted writer, writer rush to the room vs done 132/94 (blood pressure),90 (heart rate),98.0 (temperature) o2 (oxygen) sat (saturation) 88- 90. MD (medical doctor) notified." The form further documented, "new order in place to transfer resident to hospital ER (emergency room) via 911 (emergency ambulance service). At 0720 (7:20 a.m.) 911 call, at 0730 (7:30 a.m.) 911 arrived at the facility, at 0745, 911 left the facility with the resident via stretcher. Report given to KD (initials of) the ER nurse, RP (responsible party) made aware resident sister in law and brother."

Further review of the clinical record failed to evidence any documentation of any documents; medication list, resident information and care plan goals, having been sent to the hospital upon transfer.

A request was made on 7/20/2022 at approximately 12:30 p.m. for the documents. As of 7/21/2022 at 10:00 a.m. the facility did not provide any further documentation of the documents sent to the hospital with the resident.

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F 622	Continued From page 42 An interview was conducted with LPN (licensed practical nurse) #5 on 7/21/2022 at 7:40 a.m. When asked what documents the nurses send to the hospital when a resident is transferred, LPN #5 stated they send the face sheet, care plan, SBAR (change in condition form), an infection control sheet that includes immunization status, medication list and bed hold notice. When asked where that is documented, LPN #5 stated in the clinical record and on the envelope with the resident's information in it. When asked if she tore off the first copy of the multiple copies on the envelope to keep at the facility, LPN #5 stated she did not remember tearing anything off. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3 the director of clinical services were made aware of the above concern on 7/21/2022 at 10:00 a.m. No further information was provided prior to exit.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623		

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F 623	Continued From page 43 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 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	F 623	1.The facility recognizes that it was unable to provide written RP notification for resident #37, #40, #29 and #1. 2.All residents that are transferred to the hospital are at risk to be impacted by the alleged deficient practice. A quality review was conducted by the DCS (Director of Clinical Services)/designee of residents discharged to the hospital since July 1 to gauge written RP/Ombudsman notification documentation. 3.All licensed nurses and Social Worker will be re-educated by the DCS/designee related to hospital transfer and RP /Ombudsman notification/documentation required upon discharge. The IDT will review hospital transfer and RP /Ombudsman notification/documentation in the AM meeting to ensure RP's and Ombudsman are notified when residents are transferred to the hospital. 4.The ED (Executive Director)/DCS/designee to conduct quality monitoring of transferred residents' medical record to ensure proper documentation provided to the hospital weekly x 6 weeks. The findings of these	9/1/2022

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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 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

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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 of written RP (responsible party) and/or ombudsman notification was provided for 4 of 33 residents, Residents #37, #40, #29 and #1.

The findings include:

1. The facility staff failed to evidence provision of written RP notification was provided for Resident #37. Resident #37 was transferred to the hospital on 6/27/22.

Resident #37 was admitted to the facility on 5/16/16 with diagnosis that included but were not limited to: end stage renal disease, diabetes mellitus, heart failure and encephalopathy.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/21/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; supervision for locomotion and independence for eating. Section O-special procedures/treatments coded the resident as dialysis "no".

A review of the comprehensive care plan dated 2/26/22, which revealed, "FOCUS: The resident is

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on Hemodialysis via Left arterial-venous Fistula related to End Stage Renal Disease. Transferred to hospital for clogged AV shunt 6/27/22. INTERVENTIONS: Communicate with dialysis facility as needed. Dialysis 3 times/week: Tuesday, Thursday & Saturday.

An interview was conducted on 7/20/22 at 7:45 AM with LPN (licensed practical nurse) #3. When asked what evidence of RP or ombudsman notification is provided upon transfer of a resident to the hospital, LPN #3 stated, we call the family, the doctor and do not know that we send anything to them. We do not do anything with the ombudsman.

An interview was conducted on 7/20/22 at 2:33 PM with OSM (other staff member) #3, the director of social services. When asked what evidence of RP or ombudsman notification is provided upon transfer of a resident to the hospital, OSM #3 stated, the ombudsman notification is by your chair for your residents.

An interview was conducted on 7/21/22 at 7:41 AM, with LPN #5. When asked what evidence of RP or ombudsman notification is provided upon transfer of a resident to the hospital, LPN #3 stated, we call the family, we do not give them anything in writing. We do not do anything with the ombudsman.

On 7/20/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

A review of the facility's policy "Family

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Notification" dated 11/2014, revealed the following, "All significant family contact will be documented. This should include discussion of transfer, discharges, problem with care or roommate, significant changes in family support systems, etc."

No further information was provided prior to exit.

2. The facility staff failed to evidence provision of written RP notification was provided for Resident #40. Resident #40 was transferred to the hospital on 3/22/22, 4/1/22, 4/12/22 and 4/26/22.

Resident #40 was admitted to the facility on 2/18/22 with diagnosis that included but were not limited to: hemiplegia, hemiparesis, diabetes mellitus and cerebrovascular disease.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/28/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing and hygiene; supervision for eating and total dependence for bathing.

A review of the comprehensive care plan dated 2/19/22, which revealed, "FOCUS: The resident has (chronic) pain related to Depression, Diabetes, and back pain. ER evaluation related to pain per resident's request 3/22/22. ER evaluation related to pain per residents request 4/1/2022. 4/12 sent to ER for unrelieved pain per resident. 4/15 medication adjustment related to

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unrelieved pain. 4/26/22 Sent to ER for chest pain. INTERVENTIONS: Evaluate the effectiveness of pain interventions (q shift) Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition."

An interview was conducted on 7/20/22 at 7:45 AM with LPN (licensed practical nurse) #3. When asked what evidence of RP or ombudsman notification is provided upon transfer of a resident to the hospital, LPN #3 stated, we call the family, the doctor and do not know that we send anything to them. We do not do anything with the ombudsman.

An interview was conducted on 7/20/22 at 2:33 PM with OSM (other staff member) #3, the director of social services. When asked what evidence of RP or ombudsman notification is provided upon transfer of a resident to the hospital, OSM #3 stated, the ombudsman notification is by your chair for your residents.

An interview was conducted on 7/21/22 at 7:41 AM, with LPN #5. When asked what evidence of RP or ombudsman notification is provided upon transfer of a resident to the hospital, LPN #3 stated, we call the family, we do not give them anything in writing. We do not do anything with the ombudsman.

On 7/20/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

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A review of the facility's policy "Family Notification" dated 11/2014, revealed the following, "All significant family contact will be documented. This should include discussion of transfer, discharges, problem with care or roommate, significant changes in family support systems, etc."

No further information was provided prior to exit.
3. The facility staff failed to provide the resident and/or responsible party with a written notification for the reason for transfer to the hospital on 5/4/2022 for Resident #1 (R1).

On the most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 7/7/2022, the resident was coded as having both short and long term memory difficulties.

The Change In Condition form dated 5/4/2022 at 12:35 p.m. documented in part, "On arrival at the facility, report received from the outgoing nurse, rounds done, treatment nurse went to Resident room to do (their) treatment and observed resident twitching and jerging (sic) she alerted writer, writer rush to the room vs done 132/94 (blood pressure),90 (heart rate),98.0 (temperature) o2 (oxygen) sat (saturation) 88- 90. MD (medical doctor) notified." The form further documented, "new order in place to transfer resident to hospital ER (emergency room) via 911 (emergency ambulance service). At 0720 (7:20 a.m.) 911 call, at 0730 (7:30 a.m.) 911 arrived at the facility, at 0745, 911 left the facility with the resident via stretcher. Report given to KD (initials of) the ER nurse, RP (responsible party) made aware resident sister in law and brother."

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Further review of the clinical record failed to evidence any documentation of a written notification to the resident and/or responsible party for the reason for the transfer to the hospital.

A request was made on 7/20/2022 at approximately 12:30 p.m. for the documentation of a written notification.

On 7/21/22 8:34 a.m., OSM (other staff member) # 3, the social worker. OSM # 3 presented a form, "Virginia Involuntary Transfer/Discharge Notice." with R1's name. The form documented the resident's name, date of transfer and an X was documented next to: "The facility can no longer meet the resident's medical needs." OSM # 3 stated, they don't give the Transfer/Discharge form to the resident and/or RP (responsible party), they use this form to notify the ombudsman.

ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3 the director of clinical services were made aware of the above concern on 7/21/2022 at 10:00 a.m.

No further information was provided prior to exit.

4. The facility staff failed to provide the resident and/or responsible party with a written notification for the reason for the transfer to the hospital on 7/18/2022 for Resident #29 (R29).

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/15/2022, the resident scored a 12 out of 15 on the BIMS (brief

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interview for mental status) score, indicating the resident is moderately cognitively impaired for making daily decisions.

The nurse's note dated 7/18/2022 at 2:31 p.m. documented, " Patient c/o (complained of) chest pain around 11:40am. MD (medical doctor) was notified. Order received to send Patient to ER for further evaluation via 911. 911 was called and came in around 11:48am. Medication list, care plan, transfer form, face sheet, recent labs advance directive and bed hold policy for were given to paramedics. Report was called in to (name of Charge Nurse). Emergency contact (name of emergency contact) is oriented to the transfer."

Further review of the clinical record failed to evidence any documentation of a written notification to the resident and/or responsible party for the reason for the transfer to the hospital.

A request was made on 7/20/2022 at approximately 12:30 p.m. for the documentation of the written notification.

On 7/21/22 8:34 a.m., OSM (other staff member) # 3, the social worker. OSM # 3 presented a form, "Virginia Involuntary Transfer/Discharge Notice." with R29's name. The form documented the resident's name, date of transfer and an X was documented next to: "The facility can no longer meet the resident's medical needs." OSM # 3 stated, they don't give the Transfer/Discharge form to the resident and/or RP (responsible party), they use this form to notify the ombudsman. OSM #3 stated, R29 was their own RP so we wouldn't call anyone. This form would

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F 623	Continued From page 52 not be given to resident. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3 the director of clinical services were made aware of the above concern on 7/21/2022 at 10:00 a.m. No further information was provided prior to exit.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625		

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F 625	Continued From page 53 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 when 3 out of 33 residents in the survey sample were transferred to the hospital; Residents #37, #40 and #1. The findings include: 1. The facility staff failed to evidence provision of bed hold notification for Resident #37. Resident #37 was transferred to the hospital on 6/27/22. Resident #37 was admitted to the facility on 5/16/16 with diagnosis that included but were not limited to: end stage renal disease, diabetes mellitus, heart failure and encephalopathy. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/21/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; supervision for locomotion and independence for eating. Section O-special procedures/treatments coded the resident as dialysis "no". An interview was conducted on 7/20/22 at 7:45 AM with LPN (licensed practical nurse) #3. When asked if a bed hold is provided upon transfer of a	F 625	1.The facility recognizes that it was unable to provide evidence of offered bed hold for Residents #37, 40 upon transfer to the hospital. Both residents returned back to the facility. 2.All residents transferred to the hospital are at risk to be impacted by the alleged deficient practice. A quality review was conducted by the DCS (Director of Clinical Services)/designee of hospital transfers since July 1 to gauge compliance with bed hold policy. 3.All licensed nurses will be re-educated by the DCS/designee related to the bed hold policy and documentation. The IDT will review hospital transfers in the AM meeting to ensure documentation of bed hold policy being provided at time of transfer. 4.ED (Executive Director)/DCS/designee to conduct quality monitoring of discharged residents' medical record to ensure documentation of bed hold policy being offered at time of transfer weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	9/1/2022

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resident to the hospital, LPN #3 stated, we send a bed hold. When asked if there is any evidence of the bed hold, LPN #3 stated, maybe medical records has it.

An interview was conducted on 7/20/22 at 2:12 PM with OSM (other staff member) #6, the medical records coordinator. When asked what evidence of bed hold there was in the medical records, OSM #6 stated there is not bed hold for those residents.

On 7/20/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. ASM #1 and ASM #2 verified there was not bed hold evidence for this resident.

A review of the facility's "Bed Hold" policy dated 11/2017, which revealed, "Resident or Resident Representative will be notified on admission, and at the time of transfer (to the hospital or therapeutic leave) of the bed hold policies, according to Federal and/or State requirements."

No further information was provided prior to exit.

2. The facility staff failed to evidence provision of bed hold notification for Resident #40. Resident #40 was transferred to the hospital on 3/22/22, 4/1/22, 4/12/22 and 4/26/22.

Resident #40 was admitted to the facility on 2/18/22 with diagnosis that included but were not limited to: hemiplegia, hemiparesis, diabetes mellitus and cerebrovascular disease.

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The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/28/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing and hygiene; supervision for eating and total dependence for bathing.

An interview was conducted on 7/20/22 at 7:45 AM with LPN (licensed practical nurse) #3. When asked if a bed hold is provided upon transfer of a resident to the hospital, LPN #3 stated, we send a bed hold. When asked if there is any evidence of the bed hold, LPN #3 stated, maybe medical records has it.

An interview was conducted on 7/20/22 at 2:12 PM with OSM (other staff member) #6, the medical records coordinator. When asked what evidence of bed hold there was in the medical records, OSM #6 stated, there is not bed hold for those residents.

On 7/20/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. ASM #1 and ASM #2 verified there was not bed hold evidence for this resident.

A review of the facility's "Bed Hold" policy dated 11/2017, which revealed, "Resident or Resident Representative will be notified on admission, and

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at the time of transfer (to the hospital or therapeutic leave) of the bed hold policies, according to Federal and/or State requirements."

No further information was provided prior to exit.
3. The facility staff failed to provide a bed hold notice upon transfer to the hospital on 5/4/2022 for Resident #1 (R1).

On the most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 7/7/2022, the resident was coded as having both short and long term memory difficulties.

The Change In Condition form dated 5/4/2022 at 12:35 p.m. documented in part, "On arrival at the facility, report received from the outgoing nurse, rounds done, treatment nurse went to Resident room to do (their) treatment and observed resident twitching and jerging (sic) she alerted writer, writer rush to the room vs done 132/94 (blood pressure),90 (heart rate),98.0 (temperature) o2 (oxygen) sat (saturation) 88- 90. MD (medical doctor) notified." The form further documented, "new order in place to transfer resident to hospital ER (emergency room) via 911 (emergency ambulance service). At 0720 (7:20 a.m.) 911 call, at 0730 (7:30 a.m.) 911 arrived at the facility, at 0745, 911 left the facility with the resident via stretcher. Report given to KD (initials of) the ER nurse, RP (responsible party) made aware resident sister in law and brother."

Further review of the clinical record failed to evidence any documentation of a bed hold notice was provided to the resident and/or responsible party upon discharge on 5/4/2022.

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F 625	Continued From page 57 A request was made on 7/20/2022 at approximately 12:30 p.m. for the documentation the bed hold notice was provided upon transfer. As of 7/21/2022 at 10:00 a.m. the facility did not provide any further documentation that a bed hold notice was provided to the resident and/or responsible party upon transfer to the hospital. ASM #1 stated they had no further information related to the bed hold notification for R1. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3 the director of clinical services were made aware of the above concern on 7/21/2022 at 10:00 a.m. No further information was provided prior to exit.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication.	F 636		

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F 636	Continued From page 58 (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)	F 636	1. Resident #25 was screened for therapy on 7/21/2022 2. All residents have the potential to be affected. A quality monitoring audit will be completed to ensure that all ordered therapy screens have been completed as ordered. 3. The IDT will be education by the ED/designee regarding carrying out screens/orders as indicated. IDT team will review and identify any residents with a change in functional status in the AM meeting. The MDS Coordinator will submit a list of residents weekly to the nursing leadership team and therapy dept. for screening. 4. The ED (Executive Director)/DCS/designee to conduct quality monitoring of residents with screen orders to ensure appropriate follow up weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	9/1/2022

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(iii)Not less than once every 12 months.
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 complete a comprehensive assessment with a change in ADL (activity of daily living) status for one of 33 residents in the survey sample, Resident #25 (R25).

The findings include:

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/22/2022, the resident scored a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is moderately cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member physical assistance for moving in the bed, transfers, moving on the unit, dressing, toileting, personal hygiene and bathing. The resident was coded as requiring supervision with one staff member physical assistance for eating.

The MDS prior to the 5/22/2022, an annual assessment, with an ARD of 2/10/2022, the resident scored a 10 out of 15 on the BIMS score, indicating the resident is moderately cognitively impaired for making daily decisions. In Section G - Functional Status, R25 was coded as being independent with set up assistance only for moving in the bed, transfers, eating and personal hygiene. The resident was coded as requiring limited assistance of one staff member for toileting. The activity of moving on the unit, only occurred once with no assistance from the staff.

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The activity of moving off the unit, only occurred once and required set up assistance from the staff.

An interview was conducted with RN (registered nurse) #2, the MDS coordinator, on 7/20/2022 at 3:25 p.m. RN #2 was asked to review the two MDS assessments documented above. RN #2 requested to look into it and get back to the survey team. RN #2 returned and stated that the granddaughter was trying to find placement closer to her and that did not occur. RN #2 stated that had caused a bit of depression. RN #2 was asked to explain why a significant change assessment was not completed when there was a decline in the resident's functional status. RN #2 was also asked to provide any therapy consults for this decline in condition.

On 7/20/2022 at 4:01 p.m. RN #2 stated there was no therapy screen done. When asked why a significant change assessment was not completed, RN #2 stated she could not answer that. When asked if a significant change assessment and a referral to therapy should have been completed due to the decline in the resident's functional status, RN #2 stated, I believe it was an oversight. It should have been a significant change assessment completed.

The RAI (resident assessment instrument) manual, documented in part, "A "significant change" is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting"; 2. Impacts more than one area of the resident's health status; and 3. Requires

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F 636	Continued From page 61 interdisciplinary review and/or revision of the care plan." ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3 the director of clinical services were made aware of the above concern on 7/20/2022 at 5:23 p.m.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to provide an accurate assessment for one of 33 residents, Resident #37. The facility staff failed to complete an accurate MDS (minimum data set); annual assessment for Resident #37. The findings include: Resident #37 was admitted to the facility on 5/16/16 with diagnosis that included but were not limited to: end stage renal disease, diabetes mellitus, heart failure and encephalopathy. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/21/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score,	F 641		

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F 641	Continued From page 62 indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; supervision for locomotion and independence for eating. Section O-special procedures/treatments coded the resident as dialysis "no". A review of the comprehensive care plan dated 2/26/22, which revealed, "FOCUS: The resident is on Hemodialysis via Left arterial-venous Fistula related to End Stage Renal Disease. Transferred to hospital for clogged AV shunt 6/27/22. INTERVENTIONS: Communicate with dialysis facility as needed. Dialysis 3 times/week: Tuesday, Thursday & Saturday. A review of physician orders, dated 10/21/20, revealed the following, "Dialysis three times a week, Tuesday, Thursday and Saturday @ 10:30AM-3:15PM." An interview was conducted on 7/20/22 at 2:07 PM with RN (registered nurse) #2, the MDS coordinator. When asked to review the MDS Section O for Resident #37, RN #2 stated, "The MDS, that should not be coded as 'no', she is a dialysis resident and has been for years. I coded this myself. I will do a modification now." When asked what standard is followed for completion of a MDS, RN #2 stated, "We follow the RAI (resident assessment instrument)." On 7/20/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.	F 641	1.Resident #37 had a modified MDS to reflect their dialysis status. RN #2 was re-educated on coding section O of the MDS correctly. 2.All residents on dialysis caseload are at risk for being impacted by the alleged deficient practice. A quality review was conducted by the DCS (Director of Clinical Services)/designee of residents' on dialysis section O to ensure accuracy. 3.The MDS coordinator will be re-educated by the DCS/designee related to section O completion per the RAI. The MDS coordinator will have the DCS review section O of any dialysis resident prior to submission to validate accuracy. 4.The Regional MDS coordinator/designee to conduct quality monitoring of dialysis residents and their MDS section O weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee. 5.9/1/2022	9/1/2022

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F 641	Continued From page 63 A review of the facility's policy "MDS" dated 11/2014, reveals the following, "The center conducts initial and periodic standardized, comprehensive and reproducible assessments no less than every three months for each resident including, but not limited to, the collection of data regarding functional status, strengths, weaknesses and preferences using the federal and/or state required RAI. Procedure: Each person completing a section or portion of a section of the MDS signs the Attestation Statement indicating its accuracy." No further information was provided prior to exit.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as 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).	F 656		

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F 656	Continued From page 64 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to implement the comprehensive care plan for 6 of 33 residents in the survey sample, Residents #82, #88, #37, #25, #83 and #94. The findings include: 1. The facility staff failed to implement Resident #82's (R82) comprehensive care plan for weights per physician's order. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/30/22, the resident scored 9 out of 15 on the BIMS (brief interview for mental	F 656	1.Resident #82's medical record was reviewed and updated as indicated per the care plan. Resident #83 Care Plan was reviewed and updated to reflect Hospice cooperation. Hospice plan of care assessment notes were obtained and uploaded on PCC on 8/2/2022 Resident #88's medical record was reviewed and updated as indicated per the care plan. Resident #94's oxygen was immediately set at 2L/min as prescribed by the physician. Care Plan updated. Resident #37's medical record/dialysis communication book was reviewed and updated as indicated. Resident #25 was evaluated for therapy services. 2.All residents with daily weight orders, on dialysis and requiring a therapy screen are at risk to be impacted by the alleged deficient practice. A quality review was conducted by the DCS (Director of Clinical Services)/designee of residents with daily weight orders to ensure weights are being obtained as ordered. A quality review was conducted by the DCS/designee of dialysis communication books to gauge compliance. A quality review was conducted by the DCS/designee of those needing therapy screens to ensure they are completed. 3.All licenses nurses and therapy staff will be re-educated by the DCS/designee related to following orders and plans of care to include obtaining daily weights, compliance with dialysis communication and therapy screens completed as ordered.	9/1/2022

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F 656	Continued From page 65 status), indicating the resident was moderately cognitively impaired for making daily decisions. R82's comprehensive care plan dated 10/2/18 documented, "(R82) is at risk for alteration ineffective breathing patterns and cardiovascular status due to: CHF (congestive heart failure)...weights as ordered..." A review of R82's clinical record revealed a physician's order dated 6/3/22 for daily weights. Further review of R82's clinical record only revealed weights for the following dates: 6/7/22, 7/6/22 and 7/16/22. On 7/20/22 at 3:24 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of obtaining daily weights is to monitor residents who are losing weight, residents who are gaining too much weight and residents who have CHF. LPN #4 stated the order for daily weights should appear on the MAR (medication administration record) or TAR (treatment administration record). LPN #4 stated the CNAs (certified nursing assistants) obtain daily weights then the nurses document the weights on the MAR or TAR. No weights were documented on R82's June 2022 or July 2022 MARs or TARs. On 7/20/22 at 4:01 p.m., another interview was conducted with LPN #4. LPN #4 stated the purpose of the care plan is to know the status and current condition of the residents. LPN #4 stated nurses can ensure they are implementing residents' care plans by reviewing the care plans. On 7/20/22 at 5:37 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made	F 656	The IDT will review daily weight and oxygen records in the AM meeting to determine compliance. They will also review dialysis communication in the AM meeting to ensure each visit has a communication sheet present. The IDT will also review orders for therapy screens and ensure they are completed as indicated. 4.The ED (Executive Director)/DCS/designee to conduct quality monitoring of 10 records to ensure daily weights obtained, therapy screens completed and dialysis communication sheets are present weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	

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aware of the above concern.

The facility policy titled, "Plans of Care" documented, "Develop and implement an Individualized Person-Centered comprehensive plan of care by the Interdisciplinary Team..."

No further information was presented prior to exit.

2. The facility staff failed to implement Resident #88's (R88) comprehensive care plan for daily weights.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/3/22, the resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately cognitively impaired for making daily decisions.

A review of R88's clinical record revealed a physician's order dated 6/3/22 for daily weights for CHF (congestive heart failure). R88's comprehensive care plan dated 6/6/22 documented, "The resident has Congestive Heart Failure...daily weught (sic)..." Further review of R88's clinical record only revealed weights for the following dates: 6/7/22 and 7/6/22.

On 7/20/22 at 3:24 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of obtaining daily weights is to monitor residents who are losing weight, residents who are gaining too much weight and residents who have CHF. LPN #4 stated the order for daily weights should appear on the MAR (medication administration record) or TAR (treatment administration record). LPN #4 stated the CNAs (certified nursing assistants)

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obtain daily weights then the nurses document the weights on the MAR or TAR.

No weights were documented on R88's June 2022 or July 2022 MARs or TARs.

On 7/20/22 at 4:01 p.m., another interview was conducted with LPN #4. LPN #4 stated the purpose of the care plan is to know the status and current condition of the residents. LPN #4 stated nurses can ensure they are implementing residents' care plans by reviewing the care plans.

On 7/20/22 at 5:37 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

3. The facility staff failed to implement the comprehensive care plan for dialysis care for Resident #37.

Resident #37 was admitted to the facility on 5/16/16 with diagnosis that included but were not limited to: end stage renal disease, diabetes mellitus, heart failure and encephalopathy.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/21/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; supervision for locomotion

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and independence for eating. Section O-special procedures/treatments coded the resident as dialysis "no".

A review of the comprehensive care plan dated 2/26/22, which revealed, "FOCUS: The resident is on Hemodialysis via Left arterial-venous Fistula related to End Stage Renal Disease. Transferred to hospital for clogged AV shunt 6/27/22. INTERVENTIONS: Communicate with dialysis facility as needed. Dialysis 3 times/week: Tuesday, Thursday & Saturday.

A review of physician orders, dated 10/21/20, revealed the following, "Dialysis three times a week, Tuesday, Thursday and Saturday @ 10:30AM-3:15PM."

A review of Resident #37's dialysis communication book revealed missing communication to the dialysis facility for 21 of 52 visits from 4/2/22-7/19/22.

An interview was conducted on 7/20/22 at 9:30 AM with LPN (licensed practical nurse) #3. When asked the purpose of the care plan, LPN #3 stated, "The purpose of the care plan is to insure there are goals and interventions that are unique for that resident."

When asked what information is provided to the dialysis facility when a resident is sent for hemodialysis, LPN #3 stated, the binder is how we communicate with dialysis, their status and their condition. Important issues like labs, bruit, thrill and all basic nursing assessments. When asked if this information is not provided, is the care plan being followed, LPN #3 stated if the interventions are not implemented then the care

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plan is not being followed.

On 7/20/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #2, the regional director of clinical services were made aware of the findings.

A review of the facility's "Plans of Care" policy dated 9/2017, which revealed, "Develop and implement an Individualized Person-Centered comprehensive plan of care by the Interdisciplinary Team that includes but is not limited to - the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident, and, to the extent practicable, the participation of the resident and the resident's representative(s).
The Individualized Person Centered plan of care may include but is not limited to the following: Resident's strengths and needs. Services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required by state and federal regulatory requirements. Alternative treatments as applicable."

No further information was provided prior to exit.
4. The facility staff failed to implement the comprehensive care plan to have therapy evaluate Resident #25 (R25).

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/22/2022,

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the resident scored a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is moderately cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member physical assistance for moving in the bed, transfers, moving on the unit, dressing, toileting, personal hygiene and bathing. The resident was coded as requiring supervision with one staff member physical assistance for eating.

The MDS prior to the 5/22/2022, an annual assessment, with an ARD of 2/10/2022, the resident scored a 10 out of 15 on the BIMS score, indicating the resident is moderately cognitively impaired for making daily decisions. In Section G - Functional Status, R25 was coded as being independent with set up assistance only for moving in the bed, transfers, eating and personal hygiene. The resident was coded as requiring limited assistance of one staff member for toileting. The activity of moving on the unit, only occurred once with no assistance from the staff. The activity of moving off the unit, only occurred once and required set up assistance from the staff.

The comprehensive care plan dated, 2/26/2021, documented in part, "Focus: (R25) supervision-limited assist for most ADLs (activities of daily living)." The "Interventions" documented in part, "PT (physical therapy) & OT (occupational therapy) evaluate and treat as ordered.

On 7/20/2022 at 2:48 p.m. an interview was conducted with LPN (licensed practical nurse) # 2. When asked if the care plan states an

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intervention and the intervention is not followed, is that implementing the care plan, LPN #2 stated, no.

An interview was conducted with RN (registered nurse) #2, the MDS coordinator, on 7/20/2022 at 3:25 p.m. When asked to provide any therapy consults for the decline in the resident's functional status, RN # 2 stated she would get back to the survey team.

On 7/20/2022 at 4:01 p.m. RN #2 stated there was no therapy screen done. RN #2 stated, I believe it was an oversight. It should have been a significant change assessment completed and a therapy screen should have been completed.

An interview was conducted with OSM (other staff member) #12, the director of therapy, on 7/20/2022 at 4:19 p.m. When asked the process for the therapy department to screen residents that are in need of therapy, OSM #12 stated that (RN #2) normally sends her a list of resident to screen when she completes the MDS assessments. When asked if she had screened R25 since his 5/22/2022 MDS assessment, OSM #12 stated she had last screened the resident is January of this year (2022). When asked if therapy has worked with him since the MDS assessment, OSM #12 stated, no.

ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3 the director of clinical services were made aware of the above concern on 7/20/2022 at 5:23 p.m.

No further information was provided prior to exit.

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5. The facility staff failed to implement the comprehensive care plan to work cooperatively with the hospice team for Resident #83 (R83).

On the most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 7/1/2022, the resident scored a 6 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired for making daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was not coded as being on hospice.

The comprehensive care plan dated, 6/21/2022, documented in part, "The resident has a terminal prognosis r/t (related to) admission to (name of hospice) DX: Alzheimer's." The "Interventions" documented in part, "Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met."

The physician order dated, 6/21/2022, documented, "Resident admitted to (name of hospice) DX (diagnosis) - Alzheimer's. Call (name of hospice) (phone number of hospice) with any questions, concerns or change in condition."

Review of the clinical record failed to evidence documentation or notes from the hospice company.

A request was made on 7/20/2022 at approximately 11:00 a.m. for the hospice care notes.

On 7/21/2022 at 7:46 a.m. copies of "Client Coordination Note Report" for 6/22/2022,

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7/4/2022 and 7/14/2022 were provided by ASM (administrative staff member) #1, the executive director. The fax information on the tops of the notes was dated 7/20/2022 at 4:55 p.m. When asked where these notes came from, ASM #1 stated he would have to ask the DON (director of nursing) were he obtained them from.

On 7/20/2022 at 2:48 p.m. an interview was conducted with LPN (licensed practical nurse) # 2. When asked if the care plan states an intervention and the intervention is not followed, is that implementing the care plan, LPN #2 stated, no.

On 7/21/2022 at 7:56 a.m. an interview was conducted with ASM #2, the director of nursing. When asked where the above notes were obtained from, ASM #2 stated the hospice emailed them to him last night. When asked if they should have already been in the record, ASM #2 stated, yes. When asked the process for maintaining the hospice notes in the facility, ASM #2 stated the hospice fax the notes to medical records and then they scan them in. When asked should there be communication between the hospice and the facility, ASM #2 stated the facility staff "catch" them while there are here, or we call them, and they speak with the physician. ASM #2 stated when the hospice staff come in they speak with us. When asked where the documentation of these conversations and the coordination of care is, ASM #2 failed to answer.

On 7/21/2022 at 8:47 a.m. an interview was conducted with OSM (other staff member) # 6, the medical records staff member. When asked how hospice note are put in the clinical record, OSM #6 stated, "To be honest, I have never

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scanned them, they don't give me notes. I see them in the charts. All the doctor's email or fax me their notes and I scan them in." When asked about (the name of the hospice company caring for R83, OSM #6 stated, she had never scanned any hospice notes. OSM #6 stated the DON and she were talking on working on a process to obtain those records.

ASM #1, the executive director, ASM #2, the director of nursing, and ASM #3 the director of clinical services, were made aware of the above concern on 7/21/2022 at 10:00 a.m.

No further information was provided prior to exit.

6. The facility staff failed to implement the comprehensive care plan to administer oxygen as ordered for Resident #94 (R94).

On the most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 7/7/2022, the resident was not coded for cognitive. In the nurse's notes it is documented the resident refused to answer the questions. In Section O - Special Treatments, Procedures and Programs, the resident was not coded as using oxygen.

The comprehensive care plan dated 1/3/2020, documented in part, "Focus: (R94) is on oxygen therapy r/t (related to) altered respiratory status." The "Interventions" documented in part, "Oxygen as ordered."

The physician order dated 9/10/2020, documented, "Oxygen at 2 LPM (liters per

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F 656	Continued From page 75 minute) via nasal cannula continuously." Observation was made of R94 on 7/19/2022 at approximately 12:00 p.m. R94 was in the bed with the oxygen on via a nasal cannula. The oxygen concentrator was set with the bottom of the black ball sitting on the 1.5 line and the top of the ball on the 2.0 line. A second observation was made on 7/20/2022 at 2:48 p.m. The oxygen was in use via nasal cannula. The oxygen concentrator was set with the top of the ball sitting just under the black line for 2.0. LPN (licensed practical nurse) # 2, was asked to read the oxygen concentrator, LPN #2 stated the oxygen was set at 1.5. When asked how to read the oxygen concentrator, LPN #2 stated the line should be at the top of the ball. LPN #2 reset the oxygen so the top of the ball was touching the 2.0 line. When asked if the care plan states to administer oxygen as ordered and it's not being given per the physician order, is that implementing the care plan, LPN #2 stated, no. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3 the director of clinical services were made aware of the above concern on 7/20/2022 at 5:23 p.m. No further information was provided prior to exit.	F 656		
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	F 660		

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F 660	Continued From page 76 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 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	F 660	1. The Plan of care was reviewed and revised for residents R32. Resident has decided not to discharge. 2. Residents who plan to discharge back to the community or another facility are at risk for being impacted by the alleged deficient practice. A quality review was conducted by the ED/SSD of those residents requesting discharge to the community to ensure discharge planning is being coordinated. 3. The SSD will be re-educated by the ED/designee related to discharge planning expectations. The IDT will discuss those residents wishing to discharge in the AM meeting to ensure appropriate discharge planning in accordance with the plan of care is completed. 4.The ED (Executive Director)/DCS/designee to conduct quality monitoring of residents that request discharge medical records to ensure appropriate discharge planning in process weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	9/1/2022

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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 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 resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to actively assist one of 33 residents in the survey sample with discharge planning for a resident requested discharge, Resident #32 (R32).

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The findings include:

The facility staff failed to actively participate when requested by R32 to coordinate a discharge from the facility.

R32 was admitted to the facility with diagnoses that included but were not limited to paraplegia.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/20/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section G documented R32 using a wheelchair and having functional limitations in range of motion in both lower extremities.

On 7/19/2022 at 12:59 p.m., an interview was conducted with R32. R32 stated that they were paralyzed and used a manual wheelchair every day. R32 stated that they had been trying to discharge from the facility but were not getting assistance from the facility staff. R32 stated that they were told that the resident or the residents family had to arrange for a discharge if they wanted to leave. R32 stated that the social worker had provided them phone numbers to the VA (veterans administration) facilities in the area for them to call and try to get transferred to but they had not been able to speak to anyone. R32 stated that they felt that the facility staff would have better access to reach the other facilities than they did and should not just give them numbers to call. R32 stated that they would eventually like to discharge to the community into an apartment with an aide to help them after getting more specialized rehab services than

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what they had received at the facility. R32 stated that they had advised the facility staff that they wanted to discharge from the facility because they felt that they did not need to be in a long term care facility. R32 stated that when they asked the social worker to assist them in discharging them from the facility they were told that it was their job to keep them there, not to send them out when they were "making money" off of them.

The comprehensive care plan for R32 documented in part, "[Name of R32 wishes to be discharged to another facility that has the rehab machines that can assist him walk again. Date Initiated: 02/09/2021. Revision on: 04/13/2022." Under "Interventions" it documented in part, "Establish a pre-discharge plan with the resident/resident's representative/caregivers and evaluate progress and revise plan as needed. Date Initiated: 02/09/2021..." The care plan further documented, "[Name of R32] has an ADL (activities of daily living) self-care performance deficit r/t (related to) Impaired balance, Limited Mobility, Limited ROM (range of motion), Paraplegia. Date Initiated: 01/20/2021..."

The progress notes for R32 documented in part,
- "1/26/2022 14:47 (2:47 p.m.) Social Service Progress Note. [Name of R32] wanting to be transferred to another facility that has specific rehab equipment that he thinks will benefit him on his spinal cord. Social service again shared with him that long term care facilities do not have the equipment that he desires."
- "1/26/2022 15:09 (3:09 p.m.) Social Service Progress Note. Note Text: Resident was giving the telephone number and contact at the Veteran's Administration- [Name of VA Center].

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That information is [Phone number]. Writer did call as well and left a voicemail for [Name of intake specialist].
- "2/17/2022 09:52 (9:52 a.m.) Social Service Progress Note. Note Text: Resident was given information again to the Veterans Administration [Name of VA Center]. The reason is because he lost the original sheet of paper that was given to him prior to his recent hospitalization. Resident was encouraged to make to call and speak to the intake department for long term care admission as well as rehab. Resident continues want to try to walk again with the assistance of special equipment that most LTC (long term care) do not have but possibly the Veterans Administration have."
- "2/23/2022 13:50 (1:50 p.m.) Social Service Progress Note. Note Text: Writer asked resident if he got in touch with the Va. Administration - [Name of VA Center]. He stated that he has left messages with admissions but did not receive a call back. Writer encouraged him to ask the telephone operator to page the contact on the PA (public address) system instead."
- "3/18/2022 12:21 (12:21 p.m.) Social Service Progress Note. Note Text: Resident was asked by the SSD (social service director) if he was able to reach the intake coordinator of the [Name of VA Center]. He stated that he has not been successful in reaching anyone in that department and has left messages for a return call, in which he never received any. Writer called the intake department and had to leave a message as well."
- "4/7/2022 13:55 (1:55 p.m.) Social Service Progress Note. Writer spoke with resident today to see if he has follow through on his request to discharge from the facility into a Veterans Administration Center. He stated that he is working on it but the persons that he is contacting

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are not returning his calls."
- "4/11/2022 13:19 (1:19 p.m.) Note Text: Care plan/IDT (interdisciplinary team) team met to discuss residents plan of care, resident attended. [Name of R32] is alert and oriented x3 (person, place and time) and requires limited to extensive assist with ADL's... He is a full code, would like to transfer to a VA facility for therapy services... Discussed residents desire to transfer to another facility and the requirements and expectations of him regarding this transition, resident agreed and acknowledged understanding. Staff will continue with the current plan of care."
- "4/22/2022 11:10 (11:10 a.m.) Social Service Progress Note. Writer spoke with resident today to see if he has follow through on his request to discharge from the facility into a Veterans Administration Center. Writer has given some information of some facility that the resident can contact."
- "6/8/2022 13:36 (1:36 p.m.) Note Text: Care plan/IDT team met to discuss the residents plan of care, resident attended... Emergency contacts remain the same, he is a full code, d/c (discharge) plan is to transfer to another facility... Resident request for therapy eval (evaluation) d/t (due to) decline in functional status, referral submitted. Staff will continue with the current plan of care."
- "7/14/2022 14:40 (2:40 p.m.) Social Service Progress Note. Note Text: Social Service met resident to review everything in pertaining his transfer to a Veteran Health administration centers for some specific therapy machine to help him walk again. Resident reported that he does not want to go to a nursing home that does not have the therapy machine he is looking for. Writer has given resident some VA administration center which he can verify if they have that specific

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therapy machine he is looking for before the transfer process can start. Writer has given resident some facility and contacts to call and verify if they have the machine he is looking for." - "7/14/2022 15:15 (3:15 p.m.) Social Service Progress Note. Note Text: Writer has given resident the below Veterans Health centers to call and verify if they have the therapy machine he is looking for to help him walk again before the transfer process. VETERANS HEALTH CENTERS FOR [Name of R32] [Name and phone numbers of five Veterans Centers]."

On 7/20/2022 at 3:43 p.m., an interview was conducted with OSM (other staff member) #3, the director of social services. OSM #3 stated that R32 came from an assisted living facility to the building and had unrealistic expectations about their recovery. OSM #3 stated that R32 had requested to be discharged to a facility with specialized equipment that would help them to walk. OSM #3 stated that they did not have that type of equipment at the facility and they had recommended the VA systems for R32. OSM #3 stated that the facility policy was that a resident who wanted to leave would find placement themselves but they had been providing phone numbers to them. OSM #3 stated that R32 did not want to transfer to another long term care facility because they did not have the equipment they wanted and the plan currently was for them to remain long term care.

On 7/20/2022 at 4:05 p.m., an interview was conducted with OSM #13, the director of rehab, PTA (physical therapy assistant). OSM #13 stated that R32 received physical and occupational therapy when they were first admitted to the facility. OSM #13 stated that

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R32's main goal was to walk again which was not realistic and that had been communicated to them by the facility staff and the physician. OSM #13 stated that they had suggested to R32 that they go to a spinal cord specialist and they had discharged them when they were able to transfer using a sliding board with assistance from staff. OSM #13 stated that initially they had attempted to use the standing frame equipment with R32 but they were unable to bear any weight. OSM #13 stated that they attempted the parallel bars with R32 but did not feel that it was safe with the level of paraplegia they had.

On 7/20/2022 at 4:22 p.m., an interview was conducted with OSM #12, social services assistant and OSM #3, the director of social services. OSM #3 stated that they had reached out to the veterans administration in January of 2022 but had not heard back from them regarding R32. OSM #3 stated that at times R32 would fabricate things. OSM #3 stated that when a client wanted to leave the facility they were the ones who were to help in finding the placement. OSM #3 stated that this month they had provided R32 with additional veterans administration facility phone numbers to call. OSM #3 stated that the facility was collecting money from R32 and why would they want to give it away.

On 7/21/2022 at 7:50 a.m., an interview was conducted with ASM (administrative staff member) #1, the executive director. ASM #1 stated that as long as the facility was aware of a resident's request for discharge the expectation was for the facility staff to plan for discharge. ASM #1 stated that they would not expect the resident to arrange their discharge themselves.

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F 660	Continued From page 84 The facility policy, "Discharge Planning" dated 11/30/2014, documented in part, "Policy: To evaluate the resident's health status and formulate the best plan of discharge for each resident. Discharge planning begins the day of admission. The process involves the resident and family, Care Management/Social Services and other members of the clinical team..." On 7/21/2022 at approximately 9:45 a.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the concern. No further information was presented prior to exit.	F 660		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following	F 676		

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F 676	Continued From page 85 activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined the facility staff failed to assess for a decline in functional status for one of 33 residents in the survey sample, Resident #25 (R25). The findings include: On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/22/2022, the resident scored a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member physical assistance for moving in the bed, transfers, moving on the unit, dressing, toileting, personal hygiene and bathing. The	F 676	1. Resident #25 was screened for therapy on 7/21/2022 2. All residents have the potential to be affected. A quality monitoring audit will be completed to ensure that all ordered therapy screens have been completed as ordered. 3. The IDT will be education by the ED/designee regarding carrying out screens/orders as indicated. IDT team will review and identify any residents with a change in functional status in the AM meeting. The MDS Coordinator will submit a list of residents weekly to the nursing leadership team and therapy dept. for screening. 4. The ED (Executive Director)/DCS/designee to conduct quality monitoring of residents with screen orders to ensure appropriate follow up weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	9/1/2022

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resident was coded as requiring supervision with one staff member physical assistance for eating.

The MDS prior to the 5/22/2022, an annual assessment, with an ARD of 2/10/2022, the resident scored a 10 out of 15 on the BIMS score, indicating the resident was moderately cognitively impaired for making daily decisions. In Section G - Functional Status, R25 was coded as being independent with set up assistance only for moving in the bed, transfers, eating and personal hygiene. The resident was coded as requiring limited assistance of one staff member for toileting. The activity of moving on the unit, only occurred once with no assistance from the staff. The activity of moving off the unit, only occurred once and required set up assistance from the staff.

The comprehensive care plan dated, 2/26/2021, documented in part, "Focus: (R25) supervision-limited assist for most ADLs (activities of daily living)." The "Interventions" documented in part, "PT (physical therapy) & OT (occupational therapy) evaluate and treat as ordered.

An interview was conducted with RN (registered nurse) #2, the MDS coordinator, on 7/20/2022 at 3:25 p.m. RN #2 was asked to review the two MDS assessments documented above. RN #2 requested to look into it and get back to the survey team. RN #2 returned and stated that the granddaughter was trying to find placement closer to her and that did not occur. RN #2 stated that had caused a bit of depression. RN #2 was asked to explain why a significant change assessment was not completed when there was a decline in the resident's functional status. RN

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#2 was also asked to provide any therapy consults for this decline in condition.

On 7/20/2022 at 4:01 p.m. RN #2 stated there was no therapy screen done. When asked why a significant change assessment was not completed, RN #2 stated she could not answer that. When asked if a significant change assessment and a referral to therapy should have been completed due to the decline in the resident's functional status, RN #2 stated, I believe it was an oversight. It should have been a significant change assessment completed and a therapy screen should have been completed.

An interview was conducted with OSM (other staff member) #12, the director of therapy, on 7/20/2022 at 4:19 p.m. When asked the process for the therapy department to screen residents that are in need of therapy, OSM #12 stated that (RN #2) normally sends her a list of resident to screen when she completes the MDS assessments. When asked if she had screened R25 since his 5/22/2022 MDS assessment, OSM #12 stated she had last screened the resident is January of this year (2022). When asked if therapy has worked with him since the MDS assessment, OSM #12 stated, no.

ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3 the director of clinical services were made aware of the above concern on 7/20/2022 at 5:23 p.m.

On 7/21/2022 at 11:41 a.m. ASM #1 stated the facility did not have a policy on addressing a resident's decline in functional status.

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F 676	Continued From page 88 No further information was obtained prior to exit.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide ADL (activities of daily living) care to dependent residents per resident choice for 2 of 33 residents in the survey sample, Resident #32 (R32) and Resident #22 (R22). The findings include: 1. The facility staff failed to provide showers per resident choice/preference to R32. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/20/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section G documented R32 requiring extensive assistance of two or more persons for transfers, personal hygiene and extensive assistance of one person for dressing. Section G documented R32 being totally dependent on one person for bathing. On 7/19/2022 at 12:59 p.m., an interview was conducted with R32. R32 stated that they had to	F 677		

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F 677	Continued From page 89 ask the staff for showers and that they were not offered. R32 stated that they had not had a shower since they had been readmitted to the facility in March of 2022. R32 stated that the CNA's (certified nursing assistants) gave them bed baths and did not offer a shower. R32 stated that they had purchased a special lift pad that had a mesh bottom for the shower but it had never been used. R32 stated that the CNA's told them that they did not have a shower chair when they asked for a shower. R32 stated that they would like to take a shower because a bed bath was not the same. The comprehensive care plan for R32 documented in part, "[Name of R32] has an ADL (activities of daily living) self-care performance deficit r/t (related to) Impaired balance, Limited Mobility, Limited ROM (range of motion), Paraplegia. Date Initiated: 01/20/2021..." The care plan further documented, "The resident does not cooperate with care (shower) r/t (related to) Personal choice Refuses to use shower sling Date Initiated: 03/15/2022." Under "Interventions" it documented in part, "Allow the resident to make decisions about treatment regime, to provide sense of control. Date Initiated: 03/15/2022..." The shower documentation for R32 dated 5/1/2022-5/31/2022 documented in part, "Showers on Tuesday and Friday 3-11 shift (3:00 p.m.-11:00 p.m.)." It documented a shower was not completed on 5/3/2022 and 5/10/2022. The shower documentation for R32 dated 6/1/2022-6/30/2022 documented in part, "Showers on Tuesday and Friday 3-11 shift." It documented a shower was not completed on 6/3/2022, 6/7/2022 and 6/28/2022.	F 677	1.Shower assistance was immediately provided to residents #22 and #32. 2.All residents are at risk for being impacted by the alleged deficient practice. A quality monitoring audit of all showers given to residents for the month of the July 2022 was completed to identify residents shower/bathing status. 3.The ADON/designee will provide in-service to nurses and certified nursing assistants in ensuring that residents are offered showers per their preference on their scheduled shower days. When residents refuse their showers, this will be documented in residents' medical record. The IDT will review in the AM meeting shower/bathing documentation to ensure shower/baths are being offered and documented on as indicated. 4.The DCS/designee to conduct quality monitoring of residents' shower/bathing documentation weekly x 6 weeks to ensure they are being offered and documented on as indicated. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	9/1/2022

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The progress notes for R32 failed to evidence documentation of refusal of the showers on the dates listed above.

On 7/20/2022 at 2:31 p.m., an interview was conducted with RN (registered nurse) #4. RN #4 stated that showers were administered to residents twice a week and per the residents choice. RN #4 stated that a schedule was kept at the nurses station for the CNA's to know which residents were to get showers each day on each shift. RN #4 stated that R32's showers were scheduled on Tuesdays and Fridays on the 3-11 shift. RN #4 stated that they were not aware of R32 ever refusing showers or not getting showers as scheduled.

On 7/20/2022 at 2:47 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that showers were completed twice a week per the shower schedule kept at the nurses station. LPN #1 stated that there were two shower rooms on the unit. An observation was conducted with LPN #1 of two shower rooms on the unit. Both shower rooms were observed to be empty with a shower stretcher, two shower chairs and a shower bench in one shower room and two shower chairs in the other. LPN #1 stated that they were not aware of any shortages of shower chairs reported.

On 7/20/2022 at 4:05 p.m., an interview was conducted with OSM (other staff member) #13, the director of rehab, PTA (physical therapy assistant). OSM #13 stated that they had worked with R32 in the past. OSM #13 stated that they had discharged R32 when they were able to transfer using a sliding board with assistance.

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OSM #13 stated that occupational therapy had worked with R32 to use a shower bench but they were not stable enough to do this so they had assisted them to use a shower chair with a cut out in the bottom. OSM #13 stated that R32 required one person to assist them because they had spasms in the legs and needed to use either a shower chair or a shower bed. OSM #13 stated that R32 had agreed to use the shower chair so they had ordered a sling with a cut out to use with the shower chair.

On 7/20/2022 at 4:39 p.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated that they had a shower schedule in a book at the nurses station which showed them which residents received showers each day and each shift. CNA #7 stated that R32 received showers on the day shift. CNA #7 stated that A beds had showers on the morning shift and B beds had showers on the evening shift. CNA #7 stated that R32 used a sliding board to transfer with assistance of one staff member. CNA #7 stated that they had never seen R32 take a shower on the evening shift when they worked.

On 7/21/2022 at 8:47 a.m., an interview was conducted with CNA #2. CNA #2 stated that residents received showers twice a week. CNA #2 stated that they worked with R32 on day shift and they received showers then. CNA #2 stated that R32 had never refused a shower that they were aware of. CNA #2 stated that when they assisted R32 to shower they assisted them to transfer to a shower chair. CNA #2 stated that they did not use a mechanical lift for R32 because they were able to transfer themselves with assistance of one person. CNA #2 stated that R32 was stable when in shower chair and

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was able to assist in the showering process. CNA #2 reviewed R32's shower documentation for 5/1/2022-5/31/2022 and 6/1/2022-6/30/2022 and stated that the dates listed above documented a shower was not given. CNA #2 stated that there should be a note saying why a shower was not given.

The facility policy "Bathing/showering" dated 11/30/2014 documented in part, "Policy: Assistance with showering and bathing will be provided at least twice a week and PRN (as needed) to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and PRN cleansing. The resident's frequency and preferences for bathing will be reviewed at least quarterly during care conference..."

On 7/21/2022 at approximately 9:45 a.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the concern.

No further information was presented prior to exit.

2. The facility staff failed to provide showers per resident choice/preference to R22.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/5/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section G documented R22 requiring supervision of one person for transfers, personal hygiene and

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dressing. Section G documented R22 requiring physical help in part of bathing from one person.

On 7/19/2022 at 1:57 p.m., an interview was conducted with R22. A shower chair was observed in R22's room. R22 stated that they had purchased the shower chair for their personal use because the chairs at the facility were too small for them. R22 stated that they had called their insurance case manager last week to report that they were not receiving their showers twice a week as scheduled. R22 stated that they received a shower once every three weeks on average and would like them more often. R22 stated that their showers were supposed to be every Wednesday and Saturday but were not offered or given. R22 stated that some of the staff were great and would take extra steps to make sure that they got their shower but some did not care.

The comprehensive care plan for R22 documented in part, "The resident does not cooperate with care (shower) r/t (related to) Personal choice
Date Initiated: 04/20/2022." Under "Interventions" it documented in part, "Allow the resident to make decisions about treatment regime [sic], to provide sense of control. Date Initiated: 04/20/2022" and "Provide resident with opportunities for choice during care provision. Date Initiated: 04/20/2022." The care plan further documented, "[Name of R22] is supervision with ADL (activities of daily living) selfcare performance Date Initiated: 05/02/2022." Under "Interventions" it documented in part, "BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated. Per resident requested schedule and routine Date Initiated:

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F 677	Continued From page 94 05/02/2022..." The shower documentation for R22 dated 5/1/2022-5/31/2022 documented in part, "Showers on Wednesday and Saturday 3-11 shift (3:00 p.m.-11:00 p.m.)." It documented a shower not completed on 5/7/2022 and 5/11/2022. The shower documentation for R22 dated 6/1/2022-6/30/2022 documented in part, "Showers on Wednesday and Saturday 3-11 shift." It documented a shower not completed on 6/8/2022 and 6/11/2022. On 6/18/2022, 6/22/2022 and 6/25/2022 the documentation area for showering was observed to be blank. The shower documentation for R22 dated 7/1/2022-7/31/2022 documented in part, "Showers on Wednesday and Saturday 3-11 shift." It documented a shower not completed on 7/6/2022, 7/9/2022 and 7/13/2022. The progress notes for R22 failed to evidence documentation of shower refusals on the dates listed above. On 7/20/2022 at 2:47 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that showers were completed twice a week per the shower schedule kept at the nurses station. LPN #1 stated that there were two shower rooms on the unit. LPN #1 stated that R22 had their own shower chair they used. LPN #1 stated that CNA's reported if a resident refused their shower and they talked to the resident to see if they still refused. LPN #1 stated if the resident still refused the shower it was documented in the progress notes.	F 677		

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F 677	Continued From page 95 On 7/21/2022 at 8:47 a.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 stated that residents received showers twice a week. CNA #2 stated that they did not work with R22. CNA #2 stated that showers were given according to the shower schedule and documented in the computer. CNA #2 stated that if a resident refused their shower they informed the nurse and documented it in the medical record. CNA #2 reviewed the shower documentation for 5/1/2022-5/31/2022, 6/1/2022-6/30/2022 and 7/1/2022-7/31/2022 for R22 and stated that the dates listed above documented a shower was not given. CNA #2 stated that they should only document when a shower was given and they could not say that a shower was given if the documentation was blank. CNA #2 stated that there should be a note saying why a shower was not given. On 7/21/2022 at approximately 9:45 a.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the concern. No further information was presented prior to exit.	F 677		
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	F 684		

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F 684	Continued From page 96 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide care and services in accordance with professional standards of practice and comprehensive care plan for 4 of 33 residents in the survey sample, Residents #82, #88, #83 and #19. The findings include: 1. The facility staff failed to obtain Resident's #82 (R82) daily weights per the physician's orders. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/30/22, the resident scored 9 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately cognitively impaired for making daily decisions. R82's comprehensive care plan dated 10/2/18 documented, "(R82) is at risk for alteration ineffective breathing patterns and cardiovascular status due to: CHF (congestive heart failure)...weights as ordered..." A review of R82's clinical record revealed a physician's order dated 6/3/22 for daily weights. Further review of R82's clinical record only revealed weights for the following dates: 6/7/22, 7/6/22 and 7/16/22. On 7/20/22 at 3:24 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of obtaining daily weights is to monitor residents who are losing weight, residents who are gaining too much weight and residents who have CHF. LPN #4	F 684	1.Residents # 88 and #82 were immediately weighed per physician orders and weights recorded under the weight tab in point click care. Hospice note was uploaded for Resident #83 (R83) and #19 on 8/2/2022 2.All residents are at risk for being impacted by the alleged deficient practice. The DON/designee will complete a quality monitoring audit of all residents being weighed daily, Care Plans and needed hospice notes to ensure that physician orders are being followed. 3.The ADON/designee will provide education to all certified nursing assistants and licensed nurses in ensuring that residents who have orders for daily weights are completed as ordered. DON will counsel hospice staff to to ensure that Hospice notes are provided timely The IDT will review daily weight documentation and care plans in the AM meeting to ensure compliance with documentation. 4.The DCS/designee to conduct quality monitoring of 25% of residents with daily weight orders weekly x 6 weeks to ensure accuracy of setting. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee. .	9/1/2022

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stated the order for daily weights should appear on the MAR (medication administration record) or TAR (treatment administration record). LPN #4 stated the CNAs (certified nursing assistants) obtain daily weights then the nurses document the weights on the MAR or TAR.

No weights were documented on R82's June 2022 or July 2022 MARs or TARs.

On 7/20/22 at 5:37 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Physician Orders" documented, "The order will be repeated back to the physician, PA (physician assistant) or ARNP (advanced registered nurse practitioner) for his/her verbal confirmation. The order is transcribed to all appropriate areas of the electronic health record (eMar/eTAR)..."

On 7/20/22 at 5:40 p.m., ASM #1 was asked to provide the facility standard of practice for obtaining weights, CHF and following physician's orders. On 7/21/22 at 7:45 A.M., ASM #1 presented an excerpt from Clinical Nursing Skills & Techniques 9th Edition by Anne Griffin Perry, Patricia A. Potter and Wendy R. Ostendorf regarding oral nutrition. The excerpt documented steps for how to obtain a weight for a nutritional screening. The excerpt failed to document specific information regarding the above concern.

No further information was presented prior to exit.

2. The facility staff failed to obtain Resident's #88 (R88) daily weights per the physician's orders.

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On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/3/22, the resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately cognitively impaired for making daily decisions.

A review of R88's clinical record revealed a physician's order dated 6/3/22 for daily weights for CHF (congestive heart failure). R88's comprehensive care plan dated 6/6/22 documented, "The resident has Congestive Heart Failure...daily weught (sic)..." Further review of R88's clinical record only revealed weights for the following dates: 6/7/22 and 7/6/22.

On 7/20/22 at 3:24 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of obtaining daily weights is to monitor residents who are losing weight, residents who are gaining too much weight and residents who have CHF. LPN #4 stated the order for daily weights should appear on the MAR (medication administration record) or TAR (treatment administration record). LPN #4 stated the CNAs (certified nursing assistants) obtain daily weights then the nurses document the weights on the MAR or TAR.

No weights were documented on R88's June 2022 or July 2022 MARs or TARs.

On 7/20/22 at 5:37 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

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3. The facility staff failed to evidence coordination of hospice services with the facility for Resident #83 (R83).

On the most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 7/1/2022, the resident scored a 6 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired for making daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was not coded as being on hospice.

The physician order dated, 6/21/2022, documented, "Resident admitted to (name of hospice) DX (diagnosis) - Alzheimer's. Call (name of hospice) (phone number of hospice) with any questions, concerns or change n condition."

Review of the clinical record failed to evidence documentation or notes from the hospice company.

The comprehensive care plan dated, 6/21/2022, documented in part, "The resident has a terminal prognosis r/t (related to) admission to (name of hospice) DX: Alzheimers." The "Interventions" documented in part, "Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met."

A request was made on 7/20/2022 at approximately 11:00 a.m. for the hospice care notes.

On 7/21/2022 at 7:46 a.m. copies of "Client

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Coordination Note Report" for 6/22/2022, 7/4/2022 and 7/14/2022 were provided by ASM (administrative staff member) #1, the executive director. The fax information on the tops of the notes was dated 7/20/2022 at 4:55 p.m. When asked where these notes came from, ASM #1 stated he would have to ask the DON (director of nursing) were he obtained them from.

On 7/21/2022 at 7:56 a.m. an interview was conducted with ASM #2, the director of nursing. When asked where the above notes were obtained from, ASM #2 stated the hospice emailed them to him last night. When asked if they should have already been in the record, ASM #2 stated, yes. When asked the process for maintaining the hospice notes in the facility, ASM #2 stated the hospice fax the notes to medical records and then they scan them in. When asked should there be communication between the hospice and the facility, ASM #2 stated the facility staff "catch" them while there are here, or we call them, and they speak with the physician. ASM #2 stated when the hospice staff come in they speak with us. When asked where is the documentation of these conversations and the coordination of care, ASM #2 failed to answer.

On 7/21/2022 at 8:47 a.m. an interview was conducted with OSM (other staff member) # 6, the medical records staff member. When asked how hospice note are put in the clinical record, OSM #6 stated, "To be honest, I have never scanned them, they don't give me notes. I see them in the charts. All the doctor's email or fax me their notes and I scan them in." When asked about (the name of the hospice company caring for R83, OSM #6 stated, she had never scanned any hospice notes. OSM #6 stated the DON and

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she were talking on working on a process to obtain those records.

The facility policy, "Hospice Care" documented in part, "To ensure continuity of care between the center and the hospice provider, the Director of Nursing will designate a clinical member of the interdisciplinary team to work with the hospice included the following: Coordination of the care plan process between the hospice and the center. Communication with hospice representative, hospice medical director, and the patient/patient's attending physician to ensure coordination of care. Ensure the following information is obtained from the hospice: most recent hospice plan of care...The center will ensure the care plan includes the most current hospice plan of care and the center's plan to attain or maintain the patient/resident's highest practicable physical, mental and psychosocial well-being."

ASM #1, the executive director, ASM #2, the director of nursing, and ASM #3 the director of clinical services, were made aware of the above concern on 7/21/2022 at 10:00 a.m.

No further information was provided prior to exit.

4. The facility staff failed to evidence coordination of hospice services with the facility for Resident #19 (R19).

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/6/2022, the resident scored a zero out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired for making daily decisions. In Section O - Special

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Treatments, Procedures and Programs, the resident was coded as receiving hospice care services.

The physician order dated 8/18/2021, documented, "Admit to (name of hospice) routine home care with terminal diagnosis of senile degeneration of the brain. Call (name of hospice and phone number) for any questions, concerns or change in condition."

Review of the clinical record failed to evidence documentation or notes from the hospice company.

The comprehensive care plan dated, 2/15/2022, documented in part, "Focus: (R19) has a terminal prognosis r/t (related to) declining health - (Name of hospice company)."

A request was made on 7/20/2022 at approximately 11:00 a.m. for the hospice care notes.

On 7/21/2022 at 7:46 a.m. copies of "Client Coordination Note Report" for 6/23/2022, 6/30/2022, 7/7/2022 and 7/14/2022 were provided by ASM (administrative staff member) #1, the executive director. The fax information on the tops of the notes was dated 7/20/2022 at 4:55 p.m. When asked where these notes came from, ASM #1 stated he would have to ask the DON (director of nursing) were he obtained them from.

On 7/21/2022 at 7:56 a.m. an interview was conducted with ASM #2, the director of nursing. When asked where the above notes were obtained from, ASM #2 stated the hospice emailed them to him last night. When asked if

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F 684	Continued From page 103 they should have already been in the record, ASM #2 stated, yes. When asked the process for maintaining the hospice notes in the facility, ASM #2 stated the hospice fax the notes to medical records and then they scan them in. When asked should there be communication between the hospice and the facility, ASM #2 stated the facility staff "catch" them while there are here, or we call them, and they speak with the physician. ASM #2 stated when the hospice staff come in they speak with us. When asked where the documentation of these conversations and the coordination of care is, ASM #2 failed to answer. On 7/21/2022 at 8:47 a.m. an interview was conducted with OSM (other staff member) # 6, the medical records staff member. When asked how hospice note are put in the clinical record, OSM #6 stated, "To be honest, I have never scanned them, they don't give me notes. I see them in the charts. All the doctor's email or fax me their notes and I scan them in." When asked about (the name of the hospice company caring for R83, OSM #6 stated, she had never scanned any hospice notes. OSM #6 stated the DON and she were talking on working on a process to obtain those records. When asked where notes from hospice were for R19 were as the resident was on hospice since 8/2022, OSM #6 stated, "They are not in her hard chart." ASM #1, the executive director, ASM #2, the director of nursing, and ASM #3 the director of clinical services, were made aware of the above concern on 7/21/2022 at 10:00 a.m. No further information was provided prior to exit.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690		

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F 690	Continued From page 104 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review,	F 690		

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F 690	Continued From page 105 facility document review and in the course of a complaint investigation, it was determined the facility staff failed to provide care and services for urinary incontinence and catheter care for one of 33 residents, Resident #350. The findings include: Resident #350 was admitted to the facility on 11/29/21 with diagnosis that included but were not limited to: atrial fibrillation, hypertension and coronary artery disease. Resident #350 no longer resided at the facility. The most recent MDS (minimum data set) assessment, a 5 day Medicare assessment, with an ARD (assessment reference date) of 12/6/21, 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 MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing and hygiene; supervision for eating and total dependence for bathing. Section H: coded resident as always incontinent for urine and bowel. Foley catheter use was not coded in Section H. A review of the comprehensive care plan dated 12/18/21 revealed, "FOCUS: The resident has an ADL (activities daily living) self-care performance deficit related to limited mobility and stroke. INTERVENTIONS: Provide assist with all ADLs. A second focus dated 12/30/21, which revealed "FOCUS: The resident does not cooperate with care related to adjustment to nursing home, personal choice: refuses medication and refuses to allow staff to change soiled dressing and brief,	F 690	1.Resident #350 no longer resides in the facility. 2.All residents with catheters are at risk for being impacted by the alleged deficient practice. The DON/designee will complete a quality monitoring audit of residents with urinary catheters to ensure catheter care is being completed. 3.The ADON/designee will provide education to all nurses in providing catheter care to residents. The IDT will review Catheter care documentation in the AM meeting to ensure compliance with care expectations. 4.The DCS/designee to conduct quality monitoring of catheter care of 25% of residents with catheters weekly x 6 weeks to ensure accuracy of setting. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	9/1/2022

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refusing shower, refused medication prior to wound care and refuses to be turned and repositioned by staff. INTERVENTIONS: Allow the resident to make decisions about treatment regime to provide a sense of control. If possible, negotiate a time for ADLs so that the resident participates in the decision making process."

A review of the physician orders dated 12/16/21 revealed, "Catheter care every shift and as needed."

A review of the nursing progress note dated 12/31/21 at 2:21 PM, revealed, "RP (responsible party) would try and encourage her mother to allow staff to provide care and administer medication. Informed RP that staff would continue to try and attempt to provide care and to meet resident's needs as allowed by the resident."

A review of Resident #350's TAR (treatment administration record) included: "catheter care every shift and as needed." December 2021 revealed no missing documentation of care, however January 2022 reveals 7 of 35 shifts was missing documentation of care.

A review of Resident #350's ADL record for December 2021 day/evening/night shift revealed 10 of 31 day shifts missing toilet use documentation and January 2022 day/evening/night shift revealed 6 of 11 day shifts missing toilet use documentation. Incontinence care is documented under toilet use documentation per CNA (certified nursing assistant) #1.

An interview was conducted on 7/20/22 at 6:30

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F 690	Continued From page 107 AM, with CNA (certified nursing assistant) #1. When asked to describe incontinence care, CNA #1 stated it is done every two hours and as needed and they start rounds as soon as they get here. When asked where incontinence care was documented, CNA #1 stated it is documented under toileting. When asked what missing documentation for incontinence care meant, CNA #1 stated if there is missing documentation then the care was not provided. An interview was conducted on 7/21/22 at 8:40 AM, with RN (registered nurse) #3. When asked who provides the catheter care for the residents, RN #3 stated, the nurses do the catheter care and document it on the TAR (treatment administration record). When asked what it means if there is no documentation of catheter care every shift, RN #3 stated, "It means that it was not done. If it is not documented it is not done." On 7/20/22 at 7:39 AM, ASM (administrative staff member) #2 stated, "The standard of practice is Perry and Potter 9th edition." According to Perry and Potter, "Providing regular perineal hygiene, preventing catheter related trauma are important interventions to reduce risk of catheter associated urinary tract infections." On 7/21/22 at approximately 9:45 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		

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F 695	Continued From page 108 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to administer oxygen per the physician order for one of 33 residents in the survey sample, Resident #94 (R94). The findings include: On the most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 7/7/2022, the resident was not coded for cognition. In the nurse's notes it was documented the resident refused to answer the questions. In Section O - Special Treatments, Procedures and Programs, the resident was not coded as using oxygen. Observation was made of R94 on 7/19/2022 at approximately 12:00 p.m. R94 was in the bed with the oxygen on via a nasal cannula. The oxygen concentrator was set with the bottom of the black ball sitting on the 1.5 line and the top of the ball on the 2.0 line. A second observation was made on 7/20/2022 at 2:48 p.m. The oxygen was in use via nasal	F 695	1.Resident #94's oxygen was immediately set at 2L/min as prescribed by the physician. 2.All residents that receive oxygen are at risk for being impacted by the alleged deficient practice. A quality monitoring audit of all residents on oxygen was completed on 07/21/2022 to ensure that the correct number of liters was being administered per physician order and that the dial was set correctly. 3.The ADON/designee will provide education to all nurses to ensure that they know how to correctly set the oxygen dial on all concentrators. The Quality monitoring teams will audit their assignment and report in the AM meeting of any issues with oxygen settings outside of order range. 4.The DCS/designee to conduct quality monitoring of oxygen settings of 10 residents weekly x 6 weeks to ensure accuracy of setting. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	9/1/2022

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cannula. The oxygen concentrator was set with the top of the ball sitting just under the black line for 2.0. LPN (licensed practical nurse) # 2, was asked to read the oxygen concentrator, LPN #2 stated the oxygen was set at 1.5. When asked how to read the oxygen concentrator, LPN #2 stated the line should be at the top of the ball. LPN #2 reset the oxygen so the top of the ball was touching the 2.0 line.

The physician order dated 9/10/2020, documented, "Oxygen at 2 LPM (liters per minute) via nasal cannula continuously."

The comprehensive care plan dated 1/3/2020, documented in part, "Focus: (R94) is on oxygen therapy r/t (related to) altered respiratory status." The "Interventions" documented in part, "Oxygen as ordered."

The manufacturer's instructions for the oxygen concentrator, documented in part, "NOTE: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min line prescribed."

The facility policy documented in part, "Review physician's order...Attach administration device to flowmeter or humidifier/nebulizer outlet...Start O2 (Oxygen) flowrate at the prescribed liter flow or appropriate flow for administration device."

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse

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F 695	Continued From page 110 should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3 the director of clinical services were made aware of the above concern on 7/20/2022 at 5:23 p.m. No further information was provided prior to exit.	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review and facility document review, it was determined the facility staff failed to provide dialysis care and services for one of 33 residents in the survey sample, Resident #37. The findings include: The facility failed to provide communication to the dialysis facility for 7 of 13 visits in April 2022, 8 of 13 visits in May 2022, 3 of 10 visits in June 2022 and 3 of 5 visits in July 2022. Resident #37 was admitted to the facility on	F 698		

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F 698	Continued From page 111 5/16/16 with diagnosis that included but were not limited to: end stage renal disease, diabetes mellitus, heart failure and encephalopathy. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/21/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; supervision for locomotion and independence for eating. Section O-special procedures/treatments coded the resident as dialysis "no". A review of the comprehensive care plan dated 2/26/22 revealed, "FOCUS: The resident is on Hemodialysis via Left arterial-venous Fistula related to End Stage Renal Disease. Transferred to hospital for clogged AV shunt 6/27/22. INTERVENTIONS: Communicate with dialysis facility as needed. Dialysis 3 times/week: Tuesday, Thursday & Saturday. A review of physician orders, dated 10/21/20, revealed the following, "Dialysis three times a week, Tuesday, Thursday and Saturday @ 10:30AM-3:15PM." A review of Resident #37's dialysis communication book revealed missing communication to the dialysis facility for 21 of 52 visits from 4/2/22-7/19/22. An interview was conducted on 7/20/22 at 9:15 AM with Resident #37. When asked if she takes	F 698	The facility recognizes that it was unable to provide complete dialysis communication as requested. The resident continues on dialysis and her communication book is accompanying her to visits. 1.All residents on dialysis are at risk to be impacted by the alleged deficient practice. The DON/designee will complete a quality monitoring audit of the dialysis communication books of all dialysis resident within the week to ensure that communication is received from dialysis. 2.The ADON/designee will provide in-service to all nurses to ensure that they are getting communication from the dialysis center on each resident dialysis day. The IDT will review dialysis communication in the AM meeting following visits to ensure communication forms are present. 3.The DCS/designee to conduct quality monitoring of residents on dialysis weekly x 6 weeks to ensure bed hold was provided and included in the medical record. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	9/1/2022

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her dialysis communication book with her to the dialysis center, Resident #37 stated, "Yes, I take the book with me."

An interview was conducted on 7/20/22 at 9:30 AM with LPN (licensed practical nurse) #3. When asked what information is provided to the dialysis facility when a resident is sent for hemodialysis, LPN #3 stated, "It is how we communicate with dialysis, their status and their condition. Important issues like labs, bruit, thrill and all basic nursing assessments."

A review of the dialysis contract on 7/20/22 at 8:00 AM, revealed the following, "Review of dialysis contract: Facility shall ensure that all appropriate medical, social, administrative and other information accompany all designated residents at the time of transfer to the center. This information, shall include but is not limited to, where appropriate the following:
1. Designated resident's name, address, DOB and SS#
2. Name/address/phone number of next of kin
3. Appropriate medical records including history of resident's illness, including labs and x-ray findings
4. Treatment presently being provided to the designated resident, including medications and any changes in a patient's condition, change of medication, diet or fluid intake
5. Any other information that will facilitate the adequate coordination of care and reasonably determined by center

On 7/20/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services

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F 698	Continued From page 113 were made aware of the findings. On 7/21/22 at 9:45 AM, ASM #2, the director of nursing, confirmed that no additional dialysis communication forms were found. A review of the facility's "Coordination of Hemodialysis Services" dated 11/2014, revealed the following, "Residents requiring an outside ESRD facility will have services coordinated by the facility. There will be communication between the facility and the ESRD facility regarding the resident. The facility will establish a Dialysis Agreement/Arrangement if there are any residents requiring Dialysis Services. The agreement shall include how the residents care is to be managed. Procedure: 1. The Dialysis Communication form will be initiated by the facility for any resident going to an ESRD center for hemodialysis. 2. Nursing will collect and complete the information regarding the resident to send to the ESRD Center." No further information was provided prior to exit.	F 698		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff	F 745		

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F 745	Continued From page 114 failed to provide medically related social services to one of 33 residents in the survey sample, Resident #32 (R32). The findings include: The facility staff failed to actively assist R32 in coordinating a resident requested discharge from the facility. R32 was admitted to the facility with diagnoses that included but were not limited to paraplegia. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/20/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section G documented R32 using a wheelchair and having functional limitations in range of motion in both lower extremities. On 7/19/2022 at 12:59 p.m., an interview was conducted with R32. R32 stated that they were paralyzed and used a manual wheelchair every day. R32 stated that they had been trying to discharge from the facility but were not getting assistance from the facility staff. R32 stated that they were told that the resident or the residents family had to arrange for a discharge if they wanted to leave. R32 stated that the social worker had provided them phone numbers to the VA (veterans administration) facilities in the area for them to call and try to get transferred to but they had not been able to speak to anyone. R32 stated that they felt that the facility staff would have better access to reach the other facilities than they did and should not just give them	F 745	1. The Plan of care was reviewed and revised for residents R32. Resident has decided not to discharge. 2. All residents are at risk to be impacted by the alleged deficient practice. A quality review was conducted by the ED/SSD of those residents requesting discharge to the community to ensure discharge planning is being coordinated. 3. The SSD will be re-educated by the ED/designee related to providing medically related social services. The IDT will discuss those residents wishing to discharge in the AM meeting to ensure appropriate discharge planning in accordance with the plan of care is completed. 4.The ED (Executive Director)/DCS/designee to conduct quality monitoring of residents that request discharge medical records to ensure appropriate discharge planning in process weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	9/1/2022

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numbers to call. R32 stated that they would eventually like to discharge to the community into an apartment with an aide to help them after getting more specialized rehab services than what they had received at the facility. R32 stated that they had advised the facility staff that they wanted to discharge from the facility because they felt that they did not need to be in a long term care facility. R32 stated that when they asked the social worker to assist them in discharging them from the facility they were told that it was their job to keep them there, not to send them out when they were "making money" off of them.

The comprehensive care plan for R32 documented in part, "[Name of R32 wishes to be discharged to another facility that has the rehab machines that can assist him walk again. Date Initiated: 02/09/2021. Revision on: 04/13/2022." Under "Interventions" it documented in part, "Establish a pre-discharge plan with the resident/resident's representative/caregivers and evaluate progress and revise plan as needed. Date Initiated: 02/09/2021..."

The progress notes for R32 documented in part,
- "1/26/2022 14:47 (2:47 p.m.) Social Service Progress Note. [Name of R32] wanting to be transferred to another facility that has specific rehab equipment that he thinks will benefit him on his spinal cord. Social service again shared with him that long term care facilities do not have the equipment that he desires."
- "1/26/2022 15:09 (3:09 p.m.) Social Service Progress Note. Note Text: Resident was giving the telephone number and contact at the Veteran's Administration- [Name of VA Center]. That information is [Phone number]. Writer did

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call as well and left a voicemail for [Name of intake specialist].
- "2/17/2022 09:52 (9:52 a.m.) Social Service Progress Note. Note Text: Resident was given information again to the Veterans Administration [Name of VA Center]. The reason is because he lost the original sheet of paper that was given to him prior to his recent hospitalization. Resident was encouraged to make to call and speak to the intake department for long term care admission as well as rehab. Resident continues want to try to walk again with the assistance of special equipment that most LTC (long term care) do not have but possibly the Veterans Administration have."
- "2/23/2022 13:50 (1:50 p.m.) Social Service Progress Note. Note Text: Writer asked resident if he got in touch with the Va. Administration - [Name of VA Center]. He stated that he has left messages with admissions but did not receive a call back. Writer encouraged him to ask the telephone operator to page the contact on the PA (public address) system instead."
- "3/18/2022 12:21 (12:21 p.m.) Social Service Progress Note. Note Text: Resident was asked by the SSD (social service director) if he was able to reach the intake coordinator of the [Name of VA Center]. He stated that he has not been successful in reaching anyone in that department and has left messages for a return call, in which he never received any. Writer called the intake department and had to leave a message as well."
- "4/7/2022 13:55 (1:55 p.m.) Social Service Progress Note. Writer spoke with resident today to see if he has follow through on his request to discharge from the facility into a Veterans Administration Center. He stated that he is working on it but the persons that he is contacting are not returning his calls."

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- "4/11/2022 13:19 (1:19 p.m.) Note Text: Care plan/IDT (interdisciplinary team) team met to discuss residents plan of care, resident attended. [Name of R32] is alert and oriented x3 (person, place and time) and requires limited to extensive assist with ADL's... He is a full code, would like to transfer to a VA facility for therapy services... Discussed residents desire to transfer to another facility and the requirements and expectations of him regarding this transition, resident agreed and acknowledged understanding. Staff will continue with the current plan of care."
- "4/22/2022 11:10 (11:10 a.m.) Social Service Progress Note. Writer spoke with resident today to see if he has follow through on his request to discharge from the facility into a Veterans Administration Center. Writer has given some information of some facility that the resident can contact."
- "6/8/2022 13:36 (1:36 p.m.) Note Text: Care plan/IDT team met to discuss the residents plan of care, resident attended... Emergency contacts remain the same, he is a full code, d/c (discharge) plan is to transfer to another facility... Resident request for therapy eval (evaluation) d/t (due to) decline in functional status, referral submitted. Staff will continue with the current plan of care."
- "7/14/2022 14:40 (2:40 p.m.) Social Service Progress Note. Note Text: Social Service met resident to review everything in pertaining his transfer to a Veteran Health administration centers for some specific therapy machine to help him walk again. Resident reported that he does not want to go to a nursing home that does not have the therapy machine he is looking for. Writer has given resident some VA administration center which he can verify if they have that specific therapy machine he is looking for before the

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transfer process can start. Writer has given resident some facility and contacts to call and verify if they have the machine he is looking for." - "7/14/2022 15:15 (3:15 p.m.) Social Service Progress Note. Note Text: Writer has given resident the below Veterans Health centers to call and verify if they have the therapy machine he is looking for to help him walk again before the transfer process. VETERANS HEALTH CENTERS FOR [Name of R32] [Name and phone numbers of five Veterans Centers]."

On 7/20/2022 at 3:43 p.m., an interview was conducted with OSM (other staff member) #3, the director of social services. OSM #3 stated that R32 came from an assisted living facility to the building and had unrealistic expectations about their recovery. OSM #3 stated that R32 had requested to be discharged to a facility with specialized equipment that would help them to walk. OSM #3 stated that they did not have that type of equipment at the facility and they had recommended the VA systems for R32. OSM #3 stated that the facility policy was that a resident who wanted to leave would find placement themselves but they had been providing phone numbers to them to call. OSM #3 stated that R32 did not want to transfer to another long term care facility because they did not have the equipment they wanted and the plan currently was for them to remain long term care.

On 7/20/2022 at 4:05 p.m., an interview was conducted with OSM #13, the director of rehab, PTA (physical therapy assistant). OSM #13 stated that R32 received physical and occupational therapy when they were first admitted to the facility. OSM #13 stated that R32's main goal was to walk again which was not

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realistic and that had been communicated to them by the facility staff and the physician. OSM #13 stated that they had suggested to R32 that they go to a spinal cord specialist and they had discharged them when they were able to transfer using a sliding board with assistance from staff. OSM #13 stated that initially they had attempted to use the standing frame equipment with R32 but they were unable to bear any weight. OSM #13 stated that they attempted the parallel bars with R32 but did not feel that it was safe with the level of paraplegia they had.

On 7/20/2022 at 4:22 p.m., an interview was conducted with OSM #12, social services assistant and OSM #3, the director of social services. OSM #3 stated that they had reached out to the veterans administration in January of 2022 but had not heard back from them regarding R32. OSM #3 stated that at times R32 would fabricate things. OSM #3 stated that when a client wanted to leave the facility they were the ones who were to help in finding the placement. OSM #3 stated that this month they had provided R32 with additional veterans administration facility phone numbers to call. OSM #3 stated that the facility was collecting money from R32 and why would they want to give it away.

On 7/21/2022 at 7:50 a.m., an interview was conducted with ASM (administrative staff member) #1, the executive director. ASM #1 stated that as long as the facility was aware of a resident's request for discharge the expectation was for the facility staff to plan for discharge. ASM #1 stated that they would not expect the resident to arrange their discharge themselves.

The facility job description "Manager of Social

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ENVOY OF WOODBRIDGE, LLC	14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191

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F 745	Continued From page 120 Services" documented in part, "...Duties and Responsibilities...6. Provide/arrange for social work services as indicated by resident/family needs...12. Act as a liaison between the facility and the community..." The facility policy, "Discharge Planning" dated 11/30/2014, documented in part, "Policy: To evaluate the resident's health status and formulate the best plan of discharge for each resident. Discharge planning begins the day of admission. The process involves the resident and family, Care Management/Social Services and other members of the clinical team..." The facility policy, "Social Services" dated 11/30/2014, documented in part, "Policy: Medically-related social services will be provided to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident...Social Service personnel will identify the medically related social and emotional needs of residents and their families and provide for those needs by: ...g. Identifying and seeking ways to support a resident's individual needs and preferences...k. Finding options that meet the physical and emotional needs of each resident..." On 7/21/2022 at approximately 9:45 a.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the concern. No further information was presented prior to exit.	F 745		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b)	F 802		

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F 802	Continued From page 121 §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to maintain sufficient dietary staff to meet the needs of the residents at the lunch meal on 7/19/22 in one of one facility kitchens. There was insufficient staff from the dietary department working at lunch on 7/19/22, resulting in residents' not receiving lunch at a time compatible with community standards, and resulting in residents being served on disposable dishes. The findings include: On 7/19/22 at 11:24 a.m., initial observation of the kitchen revealed OSM (other staff member) #1, the dietary manager, washing dishes from breakfast in the facility dish room.	F 802	1.The facility recognizes that dietary support has been less than sufficient. The Dietary Manager is to notify the ED immediately with any staffing concerns so that emergency staffing can be implemented. 2.All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Executive Director/Human Resource Coordinator of dietary staff for the upcoming week beginning 8/18/2022 to ensure sufficient dietary support personnel scheduled. 3.Dietary manager will be re-educated by the Executive Director/Human Resource Coordinator related to providing sufficient dietary staffing. The Dietary manager will report in the AM meeting staffing patterns for the upcoming week to discuss any staffing concerns with plans for addressing. The Executive Director will report to the Regional Administrator any anticipated staffing concerns following AM meeting or upon discovery. 4.The Executive Director/Human Resource Coordinator to conduct quality monitoring of dietary staffing, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	9/1/2022

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F 802	Continued From page 122	F 802		

On 7/19/22 at 12:49 p.m., OSM #2, the dietary manager from a sister facility, had arrived in the kitchen, and was encouraging OSM #1. When asked if lunch was being served on time, and at a time compatible to when residents would normally be served lunch in the community, she stated: "No there's a delay." She stated she was not sure what time lunch would start. She stated the delay was due to lack of staffing. She stated OSM #1 was "having to do it all today." She stated the breakfast meal had been late because OSM #1 had to prep, cook, serve, and clean it up. She stated OSM #1 then had to prep, cook, and serve the lunch meal. Two dietary assistants were present in the kitchen waiting to take the trays to the floors. They did not assist in preparation or serving of the food.

On 7/19/22 at 1:25 p.m., OSM #1 began to serve resident lunches from the tray line in the facility's only kitchen. OSM #1 served all the meals on a disposable Styrofoam container. The food was placed on one side of the container, and the other side of the container was folded over to create a cover. Two stacks of facility dishware were observed in a dish cart adjacent to the tray line.

On 7/19/22 at 1:46 p.m., OSM #2, who had also observed the lunch tray line service, was interviewed. She stated OSM #1 was serving on Styrofoam "because they are short staffed." She stated if the facility staff did not serve on disposable dishware, there is no way they would ever be able to turn the dishware around on time to get the dinner meal "out at a decent time." She stated there was not enough staff at the facility to wash the dishware.

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F 802	Continued From page 123 On 7/20/22 at 5:17 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. A review of the facility policy, "Department Staffing," revealed, in part: "The Dining Services department will employ sufficient staff with appropriate competencies and skill sets to carry out the functions of food and nutrition services in a manner that is safe and effective...Adequate staffing will be provided to prepare and serve palatable, attractive, nutritionally adequate meals, at proper temperatures, at appropriate times, and to support proper sanitary techniques being utilized." No further information was provided prior to exit.	F 802		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. 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 serve food at palatable taste and temperature for 3 of 33 residents in the survey	F 804		

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F 804	Continued From page 124 sample, Residents #49 (R49), #28 (R28), #41 (R41). The facility staff failed to serve food at a palatable taste and temperature at lunch on 7/19/22. The findings include: 1. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/10/22, R49 was coded as being cognitively intact for making daily decisions, having scored 14 out of 15 on the BIMS (brief interview for mental status). On 7/19/22 at 1:01 p.m., an interview was conducted with R49. The resident stated the facility food was lousy, cold, and not good. 2. On the most recent MDS, an annual assessment with an ARD of 5/12/22, R28 was coded as being cognitively intact for making daily decisions, having scored 13 of 15 on the BIMS. On 7/19/22 at 11:45 a.m., R28 stated the food was not good, both in taste and temperature. 3. On the most recent MDS, a quarterly assessment with an ARD of 5/30/2022, R41 was coded as cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS. On 7/20/2022 at 8:45 a.m. an interview was conducted with R41. R41 stated that the food served was normally cold when they received it, and it did not taste very good. On 7/19/22 at 1:25 p.m., OSM (other staff member) #1, the dietary manager, took the holding temperature of the baked pasta. The temperature was 173 (degrees Fahrenheit). OSM #1 failed to obtain the holding temperatures for	F 804	1. Food Service Manager educated dietary staff to ensure they are using plate warmer to maintain food temperature and to palatability including seasoning. 2.All the residents that receive a meal tray are at risk to be impacted by the alleged deficient practice. 3.Food Services Manager will educate dietary staff on the use of plate warmer in order to maintain the food temperature, as well as food palatability including seasoning and taste. An audit will be done by the Food Services Manager to ensure timely delivery of meal trays with acceptable temperatures-that temperatures are maintained. Quality monitoring will be done by the Food Services Manager to ensure proper palatability/taste. 4.Food Services Manager/food services assistant will audit 5 trays each week for 4 weeks then monthly for 2 months to ensure proper food temperature/palatability is maintained. Findings will be reported to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.	9/1/2022

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F 804	Continued From page 125 any other food on the tray service line. On 7/19/22 at 2:19 p.m., a test tray was requested. The tray was made and left the unit on the cart at 2:22 p.m. The food on the tray was tested for taste and temperature at 2:30 p.m., after the final tray had been served to residents. The temperatures of the food were as follows (all Fahrenheit): pureed vegetables 116, pureed bread 117, mashed potatoes 121, pureed baked pasta 118, baked ziti 150, and broccoli 115. The pureed bread had a paste-like texture, and did not taste like bread. With the exception of the regular baked pasta, all the food lacked the warmth to be palatable. OSM #2, the dietary manager from a sister facility, who had taken the food temperatures and tasted the food on the tray, stated: "I think it's warm. But it's not a hot lunch. And that does not taste like bread." She explained that this quality of food is not the facility's norm. She explained that the facility has had significant staff turnover, is short staffed, and that OSM #1 does not have a great deal of experience. On 7/20/22 at 5:17 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. A review of the facility policy, "Food Temperatures," revealed, in part: "Food temperatures are monitored at critical control points to ensure safety and acceptability." No further information was provided prior to exit.	F 804		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime	F 809		

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F 809	Continued From page 126 CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based observation, staff interview, and facility document review, it was determined that the facility staff failed to serve a meal at a time compatible with community standards in one of one facility kitchens. The facility staff did not begin to serve the lunch meal on 7/19/22 until 1:25 p.m. The final resident tray was not distributed until 2:30 p.m. The findings include: On 7/19/22 at 11:24 a.m., initial observation of the kitchen revealed OSM (other staff member) #1, the dietary manager, washing dishes from breakfast in the facility dish room. At this time, no	F 809	1. It is the intended practice of this facility to ensure the frequency of meals and snacks is followed in accordance with the regulation. Meals delayed that day due to shortage of staff in the Kitchen. The Dietary department is now fully staffed. The Dietary Manager is recruiting and training staff to assist with mealtimes. 2. All residents needing and/or wanting HS snacks are at risk to be impacted by the alleged deficient practice. 3. Staff will also be informed that when unexpected incidents or resident needs result in a need for additional staff in the dining room, they are to inform the DON/Sup, or E.D, who will assist them by obtaining other staff members who are trained or licensed to assist in the dining room. 4. E.D and/or designee will complete five (5) random audits of resident meals services to ensure residents are eating during scheduled meal times. These audits will be done weekly x 6 weeks. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action	9/1/2022

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F 809	Continued From page 127	F 809		

cooked lunch items were visible in the ovens, steam table, or the steamer.

On 7/19/22 at 12:49 p.m., a follow up observation was made of the kitchen. OSM #2, the dietary manager from a sister facility, had arrived in the kitchen, and was encouraging OSM #1 as he worked to prepare baked pasta, steamed broccoli, salad, bread, and pureed food for lunch. When asked if lunch was being served on time, and at a time compatible to when residents would normally be served lunch in the community, OSM #2 stated: "No there's a delay." She stated she was not sure what time lunch would start. She stated the delay was due to lack of staffing. She stated OSM #1 was "having to do it all today." She stated the breakfast meal had been late because OSM #1 had to prep, cook, serve, and clean it up. She stated OSM #1 then had to prep, cook, and serve the lunch meal. Two dietary assistants were present in the kitchen waiting to take the trays to the floors. They did not assist in preparation or serving of the food.

On 7/19/22 at 12:55 p.m., OSM #1 took the temperature of the baked pasta. The temperature (120 degrees Fahrenheit) did not meet safety standards. The pasta was returned to the oven. At 1:07 p.m. and at 1:23 p.m., this process was repeated with the same result. At 1:25 p.m., the temperature of the baked pasta was 173, and lunch service began. At 2:22 p.m., the last resident tray was served and placed on the transport cart, and was delivered to the unit. The last resident lunch tray was served at 2:30 p.m.

On 7/20/22 at 5:17 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional

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F 809	Continued From page 128 director of clinical services, were informed of these concerns. A review of the policy, "Frequency of Meals," revealed, in part: "At least three daily meals will be provided, at regular times comparable to normal mealtimes in the community." No further information was provided prior to exit.	F 809		
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 that the facility staff failed to store, prepare, and serve food in a sanitary manner in one of one facility kitchens. The cook's refrigerator had two opened,	F 812		

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F 812	Continued From page 129 unlabeled items. The stove top and convection oven were dirty. OSM (other staff member) #1, the dietary manager, failed to take the holding temperatures of hot, perishable foods on the tray lines prior to serving them on 7/19/22. Trays for individual resident meals were wet nesting, and a dietary staff member used the same drying towel to dry all of them. The findings include: On 7/19/22 at 11:24 a.m., initial observation of the kitchen revealed OSM (other staff member) #1, the dietary manager, washing dishes from breakfast in the facility dish room. Initial observation of the kitchen revealed a dirty stove top. The stove contained heavy amounts of debris on the stove top and in the wells of the burners. Some of the debris was burned on; some of the debris was greasy; some of the debris was composed of particles of old food; some of the debris was the consistency of ash. The convection oven doors contained caked-on, burned-on grease, and the walls and bottom of the convection oven contained debris including particles of food and baked-on grease. OSM #1 stated both the stove top and the convection oven were available for use. The cook's refrigerator contained a square pan of grape jelly and a square pan of pineapple tidbits that were open and unlabeled. On 7/19/22 at 12:49 p.m., OSM #2, the dietary manager from a sister facility, had arrived in the kitchen. On 7/19/22 at 12:55 p.m., OSM #1 took the temperature of the baked pasta. The temperature (120 degrees Fahrenheit) did not meet safety standards. OSM #1 stated he did not believe the food thermometer was working	F 812	1. Root Cause Analysis was completed by the Dietary Manager and Nursing Home Administrator to determine the system failure responsible for these alleged deficiencies. Upon completion, it was determined that staffing changes, lack of auditing and staff education all contributed to the undesired outcomes 2. All residents are at risk to be impacted by the alleged deficient practice. Regional Dietary Manager re-educating dietary staff on * Holding Temperatures * Dishes air drying * Food storage, labeling and monitoring and discarding food per manufactural recommendation and facility policy 3. A quality review was conducted by the Dietary Manager and Unit Manager on all the nourishment room/ refrigerators to ensure that there were no expired items per the facility food policy. Newly hired dietary employees will receive the above training as appropriate for their individual job duties. The Dietary Manager will provide the H.R with proof that the employee has had the appropriate training and can demonstrate competency prior to the employee working independently. 4. Food Safety Audit Review of nourishment room refrigerators for food storage and expiration dates to ensure no expired items are present will be performed twice weekly by either the Dietary Manager or designee for a period of 6 weeks, then Monthly. During this time, the Nursing Home Administrator or designee will do an additional random audit weekly for four weeks and then at least monthly.	9/1/2022

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F 812	Continued From page 130 properly. The pasta was returned to the oven. OSM #2 stated she would have a working thermometer in the facility kitchen "soon." At 1:07 p.m. and at 1:23 p.m., this process was repeated with the same result. OSM #1 was asked how he had taken temperatures of the breakfast foods that morning without a working thermometer. OSM #1 admitted he had not taken temperatures of the breakfast food. The new thermometer arrived in the kitchen at 1:24 p.m. At 1:25 p.m., the temperature of the baked pasta was 173, and lunch service began. OSM #1 did not take holding temperatures of any other hot, perishable food on the tray line, including steamed broccoli, white rice, pureed vegetables, pureed bread, and pureed baked pasta. OSM #1 served resident trays including each of the hot foods listed above. As the lunch service continued, OSM #10, an unidentified member of the dietary staff, was observed wiping water from each individual resident's tray before placing the tray on the tray line. The trays were wet nested, and OSM #10 used the same white towel to dry all the wet trays. On 7/19/22 at 1:46 p.m., OSM #2, who had also observed the lunch tray line service, was interviewed. She stated OSM #1 should have taken the temperatures of all hot, perishable items on the steam table. She stated he was so overwhelmed he must have just forgotten. She stated the stove and oven were both dirty, and should have been cleaned at least daily. She stated the trays should not have been wet nested, and she instructed OSM #10 to use a new disposable towel to dry each tray before placing it on the tray line. She stated OSM #1 is "very new" to the position of dietary manager, and had only been employed since December. She stated he received the promotion to dietary manager "by	F 812	DON or Designee will conduct Quality Monitoring Review of nourishment room refrigerators for food storage and expiration dates to ensure no expired items are present weekly x 6 weeks, to ensure compliance. All findings will be reported to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.	

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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 131	F 812		

attrition," and clearly needed additional training and support.

On 7/20/22 at 5:17 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns.

A review of the facility policy, "Food Temperatures," revealed, in part: "Food temperatures are monitored at all critical control points to ensure safety and acceptability...The cook is responsible for checking food temperatures when items are removed from the oven, prior to the beginning of service, and 6 hours after removal from the steam table...The Director of Dining Services is responsible for monitoring temperatures to ensure foods are cooked to the proper internal temperature, held and served at the correct temperature...Hot foods must be 135 degrees Fahrenheit or above when leaving the serving area...Temperatures on the serving line will be taken by the cook approximately 10 minutes before the start of tray service."

A review of the facility policy, "Warewashing," revealed, in part: "All dishware, serviceware, and utensils will be cleaned and sanitized after each use...All dishware will be air dried and properly stored."

A review of the facility policy, "Food Production/Preparation," revealed, in part: "Ground or pureed food must be reheated to 165 degrees after preparation."

A review of the policy, "Safety - Dietary," revealed,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495361	A. BUILDING _____ B. WING _____	C 07/21/2022

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F 812	Continued From page 132 in part: "All oven, stoves, and steam tables are allowed to cool before they are cleaned." A review of the facility policy, "Food Storage: Cold Foods," revealed, in part: "All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination." No further information was provided prior to exit.	F 812		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to evidence required annual continuing	F 947		

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F 947	Continued From page 133 education (in-service) hours for five of five CNA (certified nursing assistant) records reviewed, CNAs #2, #3, #4, #5, and #6. For CNAs #2, #3, #4, and #5, the facility provided no evidence of dementia training in the past year. For CNA #6, the facility provided no evidence of dementia or abuse training in the past year. The findings include: On 7/19/22 at 4:59 p.m., OSM (other staff member) #5, the human resources director, was given a list of five CNAs for whom evidence of annual continuing education (in-services) was needed. On 7/20/22 at 3:38 p.m., OSM #5 provided continuing education transcripts for CNAs #2, #3, #4, and #5. She did not provide any transcripts for CNA #6. For CNAs #2, #3, #4, and #5, there was no evidence of any annual training in dementia. For CNA #6, there was no evidence of any annual abuse or dementia training. OSM #5 stated she had been told about a waiver which relieved the facility staff of any annual training requirements. She stated she began her job in January 2022, and at that time, she began asking for documentation of continuing education that had been done. She stated the facility had access to a computer-based initial and annual staff training, but many of the facility staff members did not know how to access it. She stated she is in the process of getting all facility employees oriented to the computer-based training program, and of getting employees up to date in all training areas. On 7/20/22 at 5:17 p.m., ASM (administrative	F 947	1. Dementia and Abuse in-services were immediately initiated with CNA's #2,#3,#4, #5 and #6 to ensure the continuing competency of Nurses Aides. All Affected Certified Nurses Aides tracking records were/will be updated to reflect their in-services after completion. 2. All Residents have the ability to be affected by this deficient practice. 3. All Certified Nurses Aides will be in-serviced 2x a month then monthly thereafter to complete all Dementia and Abuse in-services. All tracking records of in-services will be updated at the time of the in-services and checked weekly by the DON /Nurse Manager for 3 months and monthly thereafter to ensure completion/compliance. 4. The DON and Administrator will review the findings of these audits and present them to the Quarterly QA committee to determine frequency of future audits.	9/1/2022

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F 947	Continued From page 134	F 947		

staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns.

A review of the facility policy, "In-Service Training - General," revealed, in part: "Employees will be provided in-service training on required topics on an annual basis...The Executive Director, Director of Clinical Services/Designee will be responsible for assigning, coordinating, and monitoring education and in-service training...Required education...may include a combination of requirements based on Federal, State and/or local regulations...In-service Training will be documented and recorded."

No further information was provided prior to exit.