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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	C 08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8/22/2022 through 8/25/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 08/22/2022 through 08/25/2022. Corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three (3) complaints were investigated during the survey: 1. VA00053794 - substantiated, no deficiencies. 2. VA00053036 - unsubstantiated. 3. VA00050006 - substantiated with deficiency. The Life Safety Code survey report will follow. The census in this 145 certified bed facility was 104 at the time of the survey. The survey sample consisted of 21 current resident reviews and 5 closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Nathan Libassi

TITLE
Administrator

(X6) DATE
9/16/2022

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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F 580	Continued From page 1 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).	F 580	F580 Notification of Changes 1. Resident #103 no longer in facility. Discharged on 8/7/2022. 2. All residents with IV orders in the last 30 days that the facility would have started charts were reviewed for MD/RP notifications if the IV was not able to be started to carry out the MD order. All residents have the potential to be affected. 3. DON or designee will educate all facility nurses on notification of MD/RP of any orders that are obtained that are not able to be carried out and to document in the nurses note to as why and the new orders obtained and the RP response. Education completed on 9/16/2022 4. DON or designee will audit all dialysis orders and care plan monthly to ensure that correct dialysis site needs are care planned. Report findings to QAPI monthly times 3. 5. DOC 9/30/2022	9/30/2022

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F 580	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interviews, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure a resident's medical provider and/or responsible party (RP) was notified of the inability to carry out a medical provider order for one (1) of 26 sampled residents, Resident #103. For Resident #103, the facility staff failed to notify the resident's medical provider and/or responsible party of the inability to carry out a medical provider's order for intravenous (IV) fluids. The findings include: Resident #103's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 9/2/20, was dated as completed on 9/8/20. Resident #103 was assessed as being able to make self understood and as being able to understand others. Resident #103's Brief Interview for Mental Status (BIMS) summary score was documented as a seven (7) out of 15; this indicated severe cognitive impairment. Resident #103 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #103's diagnoses included, but were not limited to: high blood pressure, pneumonia, dementia, heart disease, and lung disease. Resident #103's medical provider orders included an order dated 9/17/20 for one (1) bag of Normal Saline (an IV fluid) to be provided at 50mL per hour. Resident #103's nursing notes included an entry,	F 580		

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F 580	Continued From page 3 dated 9/17/20 at 11:14 a.m., which documented a medical provider had given an order for one (1) bag of Normal Saline (an IV fluid) to be administered at 50mL per hour. Resident #103's clinical documentation did not include evidence the aforementioned medical provider ordered IV fluids had been administered. On 8/24/22 at 8:13 a.m., the Director of Nursing (DON) was asked about the administration of Resident #103's medical provider ordered IV fluids. The DON reported they did not see evidence of the IV fluids being administered. On 8/24/22 at 10:39 a.m., the Assistant Director of Nursing (ADON) reported they spoke with the nurses (Registered Nurse (RN) #21 and RN #22) who was providing care for Resident #103 when the medical provider gave the order for the IV fluids. The ADON stated, RN #21 reported that RN #22 made two (2) attempts to obtain IV access on Resident #103; both attempts were unsuccessful. The ADON reported RN #22 was unable to remember details about Resident #103. The ADON stated someone should have notified the medical provider that their IV order for Resident #103 was unable to be followed. The following information was found in a facility policy titled "Resident Change in Condition Policy" (with a revision date of 7/2/21): - "The Resident / Physician or Provider / Family / Responsible Party will be notified when there has been: ... A need to alter the resident's medical treatment, including a change in provider orders ..." - "The nurse will record the information related to the change in condition and subsequent events	F 580		

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F 580	Continued From page 4 and notifications in the resident's health record." On 8/24/22 at 4:34 p.m., a team meeting was held with the facility's Interim Administrator, DON, and Regional Director of Clinical Services (RDCS). The failure of the facility staff to notify Resident #103's medical provider and responsible party of the inability to provide the aforementioned ordered IV fluids was discussed. On 8/25/22 at 11:45 a.m., a team meeting was held with the facility's Interim Administrator, DON, and RDCS. The DON and the RDCS reported Resident #103's medical provider and responsible party should have been notified when facility staff members were unable to administer the ordered IV fluids. This is a complaint deficiency.	F 580		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657	F657 Care Plan Timing and Revision 1. Resident #37 care plan was updated to reflect appropriate dialysis orders on 8/23/2022. 2. All current dialysis residents care plans were reviewed for accuracy and the appropriate orders are reflected. 3. DON or designee reviewed with MDS to ensure that care plans reflects accurate picture of the resident's dialysis site needs. Reviewed with nurse managers to make sure that on admit to facility that dialysis orders reflect what dialysis site the resident actually has and if need for thrill and brut are needed. Education was completed on 9/16/2022 4. DON or desitnee will audit all dialysis orders and care plan monthly to ensure that correct dialsysis site needs are care planned. Report findings to QAPI monthly times 3. 5. DOC 9/30/2022	9/30/2022

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F 657	Continued From page 5 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, and clinical record review, the facility staff failed to review and revise the comprehensive care plan for 1 of 21 current Resident reviews, Resident #37. Resident #37's care plan included the intervention monitor the thrill and bruit. Resident #37 had a permacath in the right subclavian area. A Permacath insertion is the placement of a special IV line into the blood vessel in your neck or upper chest just under the collarbone. The findings included: Resident #37's diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. Section C (cognitive patterns) of Resident #37's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 06/22/22 included a brief interview for mental status (BIMS) summary score of 12 out of a possible 15 points. Section O (special treatments, procedures, and programs) was coded to indicate	F 657		

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F 657	Continued From page 6 Resident #37 received dialysis. The residents comprehensive care plan included the focus area receives dialysis treatments 3 times weekly end stage renal disease (ESRD). Interventions included, but were not limited to, monitor thrill and bruit. 08/23/22 1:20 p.m., Licensed Practical Nurse (LPN) #2 stated Resident # 37's access for dialysis was located in their right upper chest. 08/23/22 3:30 p.m., Resident #37 confirmed their dialysis port was in her right upper chest. 08/23/22 2:02 p.m., LPN #3 stated they would review the care plan. 08/23/22 2:14 p.m., LPN #4, (MDS/care plan nurse) stated this was their first dialysis patient. 08/23/22 4:20 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), and Regional Director of Clinical Services the issue regarding Resident #37's care plan was reviewed. 08/24/22, the DON provided the surveyor with a copy of an updated care plan and stated Resident #37 had a permacath. This care plan had been updated and the intervention to monitor the thrill and bruit was removed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		

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F 684	Continued From page 7 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint deficiency, the facility staff failed to follow a medical provider's orders for one (1) of 26 sampled residents, Resident #103. For Resident #103, the facility staff failed to follow medical provider orders for intravenous (IV) fluids. The findings included: Resident #103's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 9/2/20, was dated as completed on 9/8/20. Resident #103 was assessed as being able to make self understood and as being able to understand others. Resident #103's Brief Interview for Mental Status (BIMS) summary score was documented as a seven (7) out of 15; this indicated severe cognitive impairment. Resident #103 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #103's diagnoses included, but were not limited to: high blood pressure, pneumonia, dementia, heart disease, and lung disease.	F 684	F684 Quality of Care 1. Resident #103 is no longer in facility. Discharged on 8/7/2022. 2. All facility started IV's for the past 30 days reviewed to ensure that MD orders were followed per order. 3. DON or designee educate all facility nurses if not able to start IV and/or follow MD order then they need to notify the MD of the reason and obtain further orders for treatment. Document this notification in nurse's notes. they also need to notify the RP of the inability to follow the orders and why and the new orders obtained. Education completed on 9/16/2022. 4. DON or designee will complete weekly audits of all facility IV starts to ensure that the IV was started as ordered and if not that the MD/RP were notified and this was recorded in the nurse's notes. This audit will be reported to QAPI monthly for 3 months. 5. DOC 9/30/2022	9/30/2022

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F 684	Continued From page 8 Resident #103's medical provider orders included an order dated 9/17/20 for one (1) bag of Normal Saline (an IV fluid) to be provided at 50mL per hour. Resident #103's nursing notes included an entry, dated 9/17/20 at 11:14 a.m., which documented a medical provider had given an order for one (1) bag of Normal Saline (an IV fluid) to be administered at 50mL per hour. Resident #103's clinical documentation did not include evidence the aforementioned medical provider ordered IV fluids had been administered. On 8/24/22 at 8:13 a.m., the Director of Nursing (DON) was asked about the administration of Resident #103's medical provider ordered IV fluids. The DON reported they did not see evidence of the IV fluids being administered. On 8/24/22 at 10:39 a.m., the Assistant Director of Nursing (ADON) reported they spoke with the nurses (Registered Nurse (RN) #21 and RN #22) who was providing care for Resident #103 when the medical provider gave the order for the IV fluids. The ADON stated, RN #21 reported that RN #22 made two (2) attempts to obtain IV access on Resident #103; both attempts were unsuccessful. The ADON reported RN #22 was unable to remember details about Resident #103. The ADON stated someone should have notified the medical provider that their IV order for Resident #103 were unable to be followed. On 8/24/22 at 4:34 p.m., a team meeting was held with the facility's Interim Administrator, DON, and Regional Director of Clinical Services. The	F 684		

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F 684	Continued From page 9 failure of the facility staff to provide Resident #103's aforementioned medical provider ordered IV fluids was discussed. This is a complaint deficiency.	F 684		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interviews, clinical record reviews, and facility document review, the facility staff failed to ensure medical provider ordered laboratory tests were completed for one (1) of 21 sampled current residents, Resident #15. For Resident #15, the facility staff failed to obtain 'STAT' Keppra and carbamazepine levels. Resident #15 was prescribed Keppra and carbamazepine for the diagnosis of seizures. (STAT is a medical abbreviation meaning immediately or at once.) The findings include: Resident #15's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 5/29/22, was dated as completed on 6/2/22. Resident #15 was assessed as being	F 770	F770 1. new Keppra and Carbamazepine level was completed on 8/24/2022 for resident #15. No actual harm. 2. Labs for the past 30 days were checked to ensure no other missed labs on all current residents. All residents have the potential to be affected. 3. DON or designee will educate all nurses on the lab process to ensure all labs are completed as ordered. Education completed on 9/16/2022. 4. DON or designee will complete audit of labs weekly that all labs for that week were completed as ordered and reported to QAPI montly for 3 months. 5. DOC: 9/30/2022	9/30/2022

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F 770	Continued From page 10	F 770		

able to make self understood and as being able to understand others. Resident #15's Brief Interview for Mental Status (BIMS) summary score was documented as a six (6) out of 15; this indicated severe cognitive impairment. Resident #15 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #15's diagnoses included, but were not limited to: dementia, traumatic brain injury, seizures, and depression.

Resident #15's clinical record included a provider order, dated 7/29/22 at 3:08 p.m., for laboratory blood tests for Keppra and carbamazepine levels to be obtained STAT. Review of Resident #15's clinical record failed to include laboratory test results for the Keppra level and/or the carbamazepine level.

Resident #15 was care planned for being at risk for falls with one of the contributing factors being documented as "conversion disorder with seizures". One (1) of the interventions for the fall risk care plan was "labs [sic] as ordered. contact md [sic] with any abnormal values."

On 8/24/22 at 1:25 p.m., the Director of Nursing (DON) provided the survey team with a copy of a fax from the laboratory company. This fax was dated July 29, 2022 with the time of 7:33 p.m. This fax stated "INCORRECT TUBE TYPE" for one (1) of Resident #15's aforementioned laboratory test (the Keppra level).

On 8/24/22 at 2:41 p.m., the Assistant Director of Nursing (ADON) reported they had called the laboratory prior to collecting the blood sample for the aforementioned laboratory tests; the laboratory staff told them to collect the blood in a

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F 770	Continued From page 11 red tube. The ADON reported the aforementioned fax from the laboratory company was found on their desk after the surveyor asked about the laboratory test results for Resident #15's Keppra and carbamazepine levels that were ordered on 7/29/22. The ADON reported they did not know when the facility received the fax. Review of the Facility's "Lab Tracking Log" for July 29, 2022 revealed that Resident #15's STAT laboratory orders for a Keppra level and a carbamazepine level were not entered in the log. On 8/24/22 at 3:00 p.m., the ADON confirmed the Keppra level and carbamazepine level laboratory tests had not been entered in the "Lab Tracking Log"; the ADON stated that STAT laboratory tests are not always entered in the "Lab Tracking Log". On 8/24/22 at 3:40 p.m., the ADON provided to the surveyor with documentation indicating a medical provider was notified, on 8/24/22 at 11:30 a.m., of the failure of the facility staff to ensure Resident #15's 7/29/22 STAT orders for a Keppra level and a carbamazepine had been completed. The medical provider gave new orders to obtain the laboratory tests. On 8/24/22 at 4:34 p.m., a team meeting was held with the facility's Interim Administrator, DON, and Regional Director of Clinical Services (RDCS). The failure of the facility staff to obtain Resident #15's aforementioned medical provider ordered STAT laboratory blood test results was discussed.	F 770		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

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F 842	Continued From page 12 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842	F 842 Resident Records 1. Resident #103 is no longer at facility. Discharged on 8/7/2022. Resident #37 the order for checking B&T was discontinued on 8/23/2022. 2. All residents have the potential to be affected. All residents with facility start IV orders for the past 30 days were checked to make sure that IV attempts were documented appropriately in the chart. All residents on dialysis orders were checked to ensure that they reflect accurate dialysis site care needs and orders were updated as needed. 3. DON or designee will educate all facility nurses on when they are signing off the MAR/TAR that the resident has/needs what they are signing. (i.e: that they have a dialysis fistula that would require a B&T checked) and that they document in nurses notes what they actually do or not do. (ie. Attempt IV starts and unable to fulfill orders). Education completed on 9/16/2022. 4. DON or designee will randomly choose 1 dialysis resident per week to check what type of dialysis site, orders reflect accurate orders for that site, TAR is signed off correctly, and care plan is correct. Choose 1 random facility started IV order per week and review the nurse's notes to ensure that all documentation is charted. Report findings to QAPI monthly for 3 months. 5. DOC 9/30/2022	9/30/2022

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F 842	Continued From page 13 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to maintain complete and/or accurate clinical records for two (2) of 26 sampled residents, Resident #37 and Resident #103. For Resident #103, the facility staff failed to document attempts to administer medical provider ordered intravenous (IV) fluids. For Resident #37, the facility nursing staff were documenting they were checking the bruit and	F 842		

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F 842	Continued From page 14	F 842		

thrill and monitoring the arteriovenous (AV) shunt every shift. Resident #37 had a permacath in their right subclavian area.

The findings include:

1. The facility staff failed to document details related to attempts to administer medical provider ordered intravenous (IV) fluids for Resident #103.

Resident #103's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 9/2/20, was dated as completed on 9/8/20. Resident #103 was assessed as being able to make self understood and as being able to understand others. Resident #103's Brief Interview for Mental Status (BIMS) summary score was documented as a seven (7) out of 15; this indicated severe cognitive impairment. Resident #103 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #103's diagnoses included, but were not limited to: high blood pressure, pneumonia, dementia, heart disease, and lung disease.

Resident #103's medical provider orders included an order dated 9/17/20 for one (1) bag of Normal Saline (an IV fluid) to be administered at 50mL per hour.

Resident #103's nursing notes included an entry, dated 9/17/20 at 11:14 a.m., which documented a medical provider had given an order for one (1) bag of Normal Saline (an IV fluid) to be administered at 50mL per hour.

Resident #103's clinical documentation did not include evidence the aforementioned medical

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F 842	Continued From page 15 provider ordered IV fluids had been administered. On 8/24/22 at 8:13 a.m., the Director of Nursing (DON) was asked about the administration of Resident #103's medical provider ordered IV fluids. The DON reported they did not see evidence of the IV fluids being administered. On 8/24/22 at 10:39 a.m., the Assistant Director of Nursing (ADON) reported they spoke with the nurses (Registered Nurse (RN) #21 and RN #22) who were providing care for Resident #103 when the medical provider gave the orders for the IV fluids. The ADON stated, RN #21 reported that RN #22 made two (2) attempts to obtain IV access on Resident #103; both attempts were unsuccessful. The ADON reported RN #22 was unable to remember details about Resident #103. Neither of these attempts to obtain an IV access had been documented in the resident's clinical record. The following information was found in a facility policy titled "Resident Change in Condition Policy" (with a revision date of 7/2/21): - "The Resident / Physician or Provider / Family / Responsible Party will be notified when there has been: ... A need to alter the resident's medical treatment, including a change in provider orders ..." - "The nurse will record the information related to the change in condition and subsequent events and notifications in the resident's health record." The following information was found in a policy titled "General Dose Preparation and Medical Administration" (with a revised date of 1/1/22): " ... After medication administration, Facility staff should take all measures required by Facility	F 842		

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F 842	Continued From page 16 policy and Applicable Law, including, but not limited to the following: ... Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN (as needed) medications, application site) on appropriate forms ..." On 8/24/22 at 4:34 p.m., a team meeting was held with the facility's Interim Administrator, DON, and Regional Director of Clinical Services. The failure of the facility staff to document the attempts to obtain IV access, for Resident #103, was discussed. 2. A Permacath insertion is the placement of a special IV line into the blood vessel in your neck or upper chest just under the collarbone. An AV fistula is typically located in your arm, however, if necessary it can be placed in the leg. Resident #37's diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. Section C (cognitive patterns) of Resident #37's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 06/22/22 included a brief interview for mental status (BIMS) summary score of 12 out of a possible 15 points. Section O (special treatments, procedures, and programs) was coded to indicate Resident #37 received dialysis. The residents comprehensive care plan included the focus area receives dialysis treatments 3	F 842		

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F 842	Continued From page 17 times weekly end stage renal disease (ESRD). Resident #37's order summary report as of 08/23/22 included the following active orders: Check bruit and thrill every shift related to dependence on renal dialysis. Order date 07/06/22. Dialysis AV Shunt - Monitor every shift for signs and symptoms of bleeding. Order date 07/06/22. Resident #37's August medication administration records (MARs) included an order to check the bruit and thrill. The nursing staff had documented for the entire month of August that they were checking the bruit and thrill. At least 13 different nurses had signed the MAR as completing this task. Resident #37's August treatment administration sheets (TARs) included the order monitor dialysis AV shunt. The nursing staff had documented for the entire month of August that they were monitoring the AV shunt. At least 11 different nurses had signed this treatment sheet. 08/23/22 1:20 p.m., Licensed Practical Nurse (LPN) #2 stated Resident # 37's access for dialysis was located in their right upper chest. 08/23/22 1:50 p.m., LPN #2 stated the facility had batch orders for dialysis and the admitting person probably needed to uncheck what was not being used when putting the orders in the computer. 08/23/22 3:30 p.m., Resident #37 confirmed their dialysis port was in her right upper chest. 08/23/22 4:20 p.m., during an end of the day meeting the Administrator, Director of Nursing	F 842		

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F 842	Continued From page 18 (DON), and Regional Director of Clinical Services was made aware of the issue regarding Resident #37's clinical record. 08/24/22, the DON confirmed Resident #37 had a permacath and provided the surveyor with a copy of an updated order that read, "perma cath, right subclavian-Monitor every shift for signs and symptoms of bleeding ...." 08/25/22 12:43 p.m., the Regional Director of Clinical Services stated they did not have a policy on documentation regarding this issue. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 842		