STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495279	A. BUILDING _____ B. WING _____	C 09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CULPEPER HEALTH & REHABILITATION CENTER	602 MADISON ROAD CULPEPER, VA 22701

(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 09/13/2022 through 09/15/2022. 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 standard survey was conducted 9/13/22 through 9/15/22. Four complaints were investigated during the survey (VA00056155 - unsubstantiated; VA00056022 - unsubstantiated; VA00055841 - substantiated with deficiencies; VA900054842 - unsubstantiated). 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 180 bed facility was 176 at the time of the survey. The survey sample consisted of 46 current resident reviews and 9 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the	F 578		10/19/22

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

Electronically Signed | 10/03/2022

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F 578	Continued From page 1 requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 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 determine if a resident had an Advance Directive for one of 55 residents in the survey sample, Resident #110 (R110). The findings include: On the most recent MDS (minimum data set) assessment, a Medicare five day assessment,	F 578	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	

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F 578	Continued From page 2 with an assessment reference date of 8/11/2022, the resident scored a 5 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired for making daily decisions. The physician orders dated 8/4/2022, documented, "DNR (do not resuscitate)." Further review of the clinical record failed to evidence documentation of a discussion regarding an advance directive for R110. A request was made on 9/13/2022 at 5:00 p.m. for the documentation related to the advance directive discussion with the resident and/or responsible party. On 9/14/2022 at 8:00 a.m., ASM (administrative staff member) #1, the administrator, stated the facility did not have any documentation related to R110's advance directive. An interview was conducted on 9/15/2022 at 8:16 a.m. with OSM (other staff member) #8, the discharge planning assistant. When asked the process for determining if a resident has an advance directive, OSM #8 stated she just started doing this. It's an admission assessment, within five days of the admission, we go in and do a short assessment that includes the resident's discharge goals, any trauma related care needed, if the resident has glasses and/or hearing aids, and at the very end we ask if they have an advance directive. If they don't have one, we offer if they would like to initiate one as the facility has the paperwork to give them. When asked about R110, OSM #8 stated the resident was admitted during the time the previous director	F 578	F578 Advance Directive 1. For Resident #110 her Advance Directive was updated on 9/22/2022 and reflected in the medical record. 2. An audit of current residents was conducted to ensure that an advanced directive discussion was present in the residents□ medical record. 3. The Administrator or designee will educate the Discharge planning department on the admission process of a new resident to ensure that their Advance Directive status is discussed and documents in the medical record. 4. The Administrator or designee will audit new admission charts weekly for the presence of Advance Directive discussion in the medical record. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance October 19, 2022	

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F 578	Continued From page 3 was here. OSM #8 stated she had been instructed to go back 20 days of new admission residents. (R110) was prior to that time. The facility policy, "Advance Directives" documented in part, " POLICY: Discharge planning staff will assist with requests for information regarding Advance Directives upon patient's admission to the Center and throughout the patient's stay to allow each patient an opportunity to plan in advance for medical treatment. PROCEDURE: 1. Upon admission, patient an/or responsible party request, provide information and education to patients/responsible party regarding living wills, durable power of attorney for health care and anatomical gifts. Include appropriate medical and clinical staff as needed for clarification and assistance. 2. If requested, assist patient/responsible party with resources for obtaining Advance Directive forms....5. Provide written summary note of initiative and outcomes in Discharge Planning Progress Notes and indicate status of Advance Directive throughout assessment process." On 9/14/2022 at 4:45 p.m. ASM #1, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services, were made aware of the above concern. No further information was provided prior to exit.	F 578		
F 583 SS=D	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.	F 583		10/19/22

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F 583	Continued From page 4 §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. §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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to respect the resident's right to privacy for one of 55 residents, Resident #467. The findings include:	F 583	F583 Personal Privacy 1. Residents # 467□s roommate was moved to the other side of the room and the curtain pulled to offer privacy. 2. Current residents have the potential to be affected. 3. The DON or designee will educate current staff on resident□s right to	

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F 583	Continued From page 5 The facility staff failed to respect the resident's right to privacy by keeping the privacy curtain closed for Resident #467. The privacy curtain was observed to be pulled back halfway between the two beds on 9/13/22 at 11:00 AM, again at 1:00 PM and the roommate was seated between the two beds with the privacy curtain behind her wheelchair watching TV at approximately 3:00 PM. Resident #467 was admitted to the facility on 9/2/22 with diagnosis that included but were not limited to: cerebral vascular infarction, COPD (chronic obstructive pulmonary disease), atrial fibrillation and diabetes. The most recent MDS (minimum data set) assessment, a 5 day Medicare assessment, with an ARD (assessment reference date) of 9/9/22, coded the resident as scoring a 99 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was unable to complete the interview. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing; total dependence for eating, bathing and hygiene. Walking and locomotion did not occur. A review of the comprehensive care plan with a revision date of 9/13/22, revealed, "FOCUS: Resident has a terminal prognosis. INTERVENTIONS: Encourage support system of family and friends. Keep the environment quiet and calm. Keep linens clean, dry and wrinkle free. Keep lighting low and familiar objects near. Involve family in discussion." A review of the physician orders dated 9/13/22,	F 583	personal privacy of not only their own physical body, but of their personal space, including accommodations and personal care. 4. The DON or Designee will do a weekly audit of 20 residents to ensure their personal privacy is being respected. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance October 19, 2022	

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F 583	Continued From page 6	F 583		

revealed, "Comfort Care: No weights, IVs (intravenous), TFs (tube feedings), labs, Dialysis or Hospitalizations."

On 9/13/22 at 12:40 PM, the daughter for the Resident #467 stated, "We do not have privacy with my mother. Her roommate's TV (television) remote is missing and the staff do not have a replacement. The roommate asks that the privacy curtain be pulled back half way so she can watch my mother's TV." The Resident was unable to be interviewed.

On 9/13/22 at 1:15 PM, an interview was conducted with LPN (licensed practical nurse) #1. When shown the curtain pulled back halfway between beds A and B in room 3 and asked if the resident's privacy was being maintained, LPN #1 stated, no, it is not with the curtain pulled back and visitors in the room. When asked what is done to insure a resident's privacy, LPN #1 stated, we pull the curtains between the beds, keep the hall door partially closed or closed if we are caring for the resident.

On 9/14/22 at 4:40 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were informed of the findings.

According to the facility's "Resident Handbook" with no date, "It is the policy at this Health & Rehabilitation Center that all residents shall have the following rights and privileges. Privacy and Confidentiality: The Health & Rehabilitation Center protects the resident's right to personal privacy as well as confidentiality of their personal and clinical records."

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F 583	Continued From page 7 No further information was provided prior to exit.	F 583		
F 656 SS=D	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). (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	F 656		10/19/22

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F 656	Continued From page 8 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, it was determined that the facility staff failed to implement the comprehensive care plan for 2 of 55 residents in the survey sample; Residents #146 and #82. The findings include: 1. For Resident #146, the facility staff failed to implement the comprehensive care plan for the use of fall mats. Resident #146 was admitted to the facility on 9/11/20. The most recent MDS (Minimum Data Set), an annual assessment dated 8/16/22 coded the resident as being severely cognitively impaired in ability to make daily life decisions. A review of the clinical record revealed the comprehensive care plan dated 9/12/20 for "[Resident #146] has had an actual fall and is at risk for falls r/t (related to) Confusion, Deconditioning, Poor communication/comprehension, Unaware of safety needs" and included the intervention, dated 9/13/20 for "assistive Devices: assist bars to bed, geri chair, fall mats, low bed, concave mattress." A review of the clinical record revealed a	F 656	F 656 Comprehensive Care Plan 1. Residents # 146 second fall matt was placed during the survey. Resident #82 was placed at the correct oxygen setting during the survey. 2. Resident with fall matts were audited to ensure, fall matts placed per the care plan. Residents with oxygen were audited to ensure oxygen was at appropriate settings. 3. The DON or designee will educate current nursing staff on following the care plan interventions to ensure fall matts are placed per the care plan for resident safety. The DON or designee will educate the current licensed nursing staff to ensure the residents is oxygen is placed at the correct setting. 4. The DON or designee will randomly audit the residents with fall matts to ensure correct placement at the beside weekly. The DON or designee will audit 20 percent of the resident on oxygen to ensure oxygen delivery is at the correct setting per MD orders. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted	

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F 656	Continued From page 9 physician's order dated 9/29/20 for "Low bed and fall mats." On 9/13/22 at 11:46 AM, the resident was observed in bed asleep. The bed was in low position. There was a fall mat on the resident's left side, but on the right side, the fall mat was folded up, leaning against the wall. On 9/14/22 at approximately 11:10 AM, an interview was conducted with RN #2 (Registered Nurse). She stated that the fall mats should be down on both sides, but that the resident has not had a fall, has declined in condition and does not move at all by themselves. She stated that the resident required total care with turning. She stated that the fall mats were probably not applicable any longer for this resident. When asked if the physicians orders and care plan was being followed when they documented fall "mats" was plural, meaning more than one, if only one mat was in place, she stated that it was not. The facility policy, "Nursing Assessment and Care Planning" was reviewed. This policy documented, "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient." The facility policy, "Falls Management Program" was reviewed. This policy documented, "A licensed nurse will review, revise, and implement interventions to the care plan..."	F 656	on a random basis. 6. Date of Compliance October 19, 2022	

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F 656	Continued From page 10	F 656		

On 9/14/22 at 4:50 PM, ASM #1 (Administrative Staff Member), ASM #2 and ASM #5 (the Administrator, Director of Nursing, and Regional Clinical Nurse, respectively) were notified of the findings. No further information was provided by the end of the survey.

2. For Resident #82 (R82), the facility staff failed to implement the comprehensive care plan for oxygen administration.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/29/22, 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.

A review of R82's clinical record revealed a physician's order dated 7/1/22 for oxygen at 3 liters per minute. R82's comprehensive care plan revised on 7/1/22 documented, "(R82) has Congestive Heart Failure. O2 (Oxygen) as ordered."

On 9/13/22 at 4:03 p.m. and 9/14/22 at 7:56 a.m., R82 was observed lying in bed receiving oxygen at three and a half liters per minute via nasal cannula, as evidenced by the middle of the ball in the oxygen concentrator flow meter positioned on the three and a half liter line.

On 9/14/22 at 3:31 p.m., an interview was conducted with LPN (Licensed practical nurse) #2. LPN #2 stated the comprehensive care plan tells the nurses the plan of care for the patient: what the nurses are providing as well as anything the nurses need to know. LPN #2 stated the care plan is, "A holistic photo of the patient." In regards to implementing the care plan, LPN #2

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F 656	Continued From page 11 stated the nurses can pull the care plan up anytime and they have access to it 24 hours a day, 7 days a week. In regards to oxygen administration, LPN #2 stated physicians' orders for oxygen display on the medication administration record or the treatment administration records and nurses should check residents' oxygen concentrators to ensure oxygen is administered at the correct rate every time they go into residents' rooms. LPN #2 stated the middle of the ball in the oxygen concentrator flow meter should be on the three liter line if the physician's order is for three liters. On 9/14/22 at 4:55 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The oxygen concentrator manufacturer's instructions documented, "Check the flow meter to make sure that the flow meter ball is centered on the line next to the prescribed number of your flow rate." No further information was presented prior to exit.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		10/19/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to provide care and services to maintain a resident's highest level of well-being for one of 55 residents in the survey sample, Resident #367. The facility staff failed to ensure Resident #367's (R367) high white blood cell count (1) result was addressed by the nurse practitioner on 7/8/22. The findings include: On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/29/22, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. Review of R367's clinical record revealed laboratory results dated 6/29/22 that documented a high white blood cell count of 10.60 thousand per cubic milliliter (with a reference range of 4.1-10.9) and a urine culture that documented urine bacteria. An antibiotic was initiated for R367 on 6/30/22. A note signed by ASM (administrative staff member) #3 (R367's primary nurse practitioner) on 7/7/22 documented, "Asked to see patient by nursing for nausea and meal refusal. Patient states that he does not feel good in his stomach. He states that he is not able to eat. Finds himself nauseated. He does state that he has been drinking. Has been having some diarrhea. Labs done this am for BMP (basic metabolic panel)	F 684	F 684 Quality of Care 1. Resident #367 is no longer a resident of the facility. 2. Current residents have potential to be affected. 3. The DON or designee will educate current nurse practitioners on the process for reviewing and sign off labs in the Point Click Care system. The DON or designee will educate the current Licensed nursing staff on the process of notifying the care practitioner when labs are received in computer system and are ready for review in medical record. 4. The DON or designee will audit 15 lab results weekly to ensure timely notification and review of labs by the care practitioner and implementation of orders if given. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance October 19, 2022	

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(2)."

Further review of R367's clinical record revealed laboratory results dated 7/8/22 for a C. diff test (3), a BMP and a CBC (complete blood count) (4). The white blood cell count was flagged as high and was 19.2 thousand per cubic milliliter (with a reference range of 4.1-10.9) (Note: there was no physician's orders for these lab results in the clinical record).

Nurses' notes dated 7/8/22 and 7/9/22 documented R367 denied any pain or shortness of breath and was resting comfortably.

A nurse's note dated 7/10/22 documented, "Patient's family is concerned about lack of appetite. After checking patients recent labs from Wednesday and Thursday, (ASM #3) was worried patient could possibly be septic. Nurses were advised to send patient to the ER for evaluation..."

On 9/14/22 at 1:01 p.m., an interview was conducted with ASM #3 (with ASM #4 [the other nurse practitioner] in the room). ASM #3 stated that she was already closely monitoring R367's sodium level due to a history of a low level. ASM #3 stated on 7/7/22, she reviewed R367's BMP and the resident was reporting nausea and diarrhea so she gave verbal orders to complete another BMP, a CBC and a C. diff test. ASM #3 stated the nurses must not have entered the orders into the computer system. ASM #3 stated the lab notifies the nurses and/or nurse practitioners if a lab level is critical. ASM #3 stated the lab did not document R367's 7/8/22 white blood cell count of 19.2 as critical but she thought that level was high enough to be notified.

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ASM #3 stated she was off of work on 7/8/22, 7/9/22 and 7/10/22 so she would not have personally reviewed the labs until Monday 7/11/22. ASM #3 stated ASM #4 is responsible for the residents under her care while she is off. ASM #4 stated she could not recall if she reviewed R367's 7/8/22 labs but if a resident's white blood cell count is high and the resident is currently on antibiotics then she typically will not prescribe further treatment.

Further review of R367's clinical record revealed the resident was prescribed an antibiotic on 6/30/22 for an infection/inflamed bladder but the antibiotic was completed on 7/6/22. On 9/14/22 at 3:05 p.m., this was reviewed with ASM #3. ASM #3 stated that if she had been working and reviewed R367's 7/8/22 white blood cell count, she would have offered the resident another treatment option or offered a transfer to the hospital. ASM #3 stated that if the resident elected another treatment option, she would have prescribed a different antibiotic. ASM #3 stated that by the time the nurses called her on 7/10/22 and told her how R367 presented, she said to send the resident to the hospital.

On 9/14/22 at 4:55 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

On 9/15/22 at 8:49 a.m., ASM #2 stated the facility standard of practice (Clinical Nursing Skills & Techniques- 8th Edition, by Perry, Potter and Ostendorf) did not contain documentation regarding generalized assessment, monitoring and treatment.

No further information was presented prior to exit.

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Complaint deficiency.

References:

(1) "A high white blood cell count is an increase in disease-fighting cells in your blood. The exact threshold for a high white blood cell count varies from one laboratory to another. In general, for adults a count of more than 11,000 white blood cells (leukocytes) in a microliter of blood is considered a high white blood cell count." This information was obtained from the website: https://www.mayoclinic.org/symptoms/high-white-blood-cell-count/basics/definition/sym-20050611

(2) "A basic metabolic panel (BMP) is a test that measures eight different substances in your blood. It provides important information about your body's chemical balance and metabolism." This information was obtained from the website: https://medlineplus.gov/lab-tests/basic-metabolic-panel-bmp/

(3) "C. diff testing checks for signs of a C. diff infection, a serious, sometimes life-threatening disease of the digestive tract. C. diff, also known as C. difficile, stands for Clostridium difficile. It is a type of bacteria found in your digestive tract." This information was obtained from the website: https://medlineplus.gov/lab-tests/c-diff-testing/

(4) "Your blood contains red blood cells (RBC), white blood cells (WBC), and platelets. Blood count tests measure the number and types of cells in your blood." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=

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F 684	Continued From page 16 medlineplus-bundle&query=cbc&_gl=1*15z407d*_ga*MTY2ODk3OTY4NS4xNjYzNTk1MDMx*_ga_P1FPTH9PL4*MTY2MzU5NTAzMS4xLjEuMTY2MzU5NTU2Ny4wLjAuMA..&_ga=2.112117764.1424311420.1663595032-1668979685.1663595031	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide treatment to a pressure ulcer in a sanitary manner for one of 55 residents in the survey sample, Resident #107 (R107). For R107, the nurse providing wound care failed to wash/sanitize hands between glove changes (between dirty and clean parts of the procedure). The findings include: On the most recent MDS (minimum data set), a	F 686	F 686 Treatment of Pressure Ulcer 1. Registered Nurse #3 was educated during the survey on hand washing during a dressing change to maintain a sanitary manner. 2. Current Residents have the potential to be affected. 3. The DON or Designee will educate the Licenses nursing staff on the proper way to perform a treatment for pressure ulcer to maintain a sanitary manner. 4. The DON or designee will observe 5 pressure ulcer treatments per week to ensure the nurse is maintaining a sanitary	10/19/22

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quarterly assessment with an ARD (assessment reference date) of 8/5/22, R107 was coded as being in a persistent vegetative state. R107 was coded as having no pressure ulcers during the look back period.

On 9/14/22 at 10:59 a.m., RN (registered nurse) #3 was observed as she provided wound care to R107. RN #3 removed the old dressing from the top of R107's right foot wound. RN#3 cleansed the wound with wound cleanser, and wiped the wound with dry gauze. RN #3 threw the soiled gauze in the trash can, removed her dirty gloves and put on a clean pair of gloves. RN #3 did not wash/sanitize her hands between removing the dirty gloves and putting on the clean gloves. RN #3 repeated this same process when she removed the old dressing from R107's right heel wound, cleansed the wound with wound cleanser, wiped the wound with dry gauze, disposed of her dirty gloves, and put on clean gloves without washing/sanitizing her hands between the dirty and clean gloves.

A review of R107's physician's orders revealed the following orders:

"Right Ankle Front: Cleanse with wound cleanser, pat dry. Apply Xeroform and calcium alginate. Cover with border foam daily and prn. Every day shift for Skin Care." This order was dated 9/9/22

"Right Heel: Cleanse with wound cleanser, pat dry. Apply betadine and cover with border foam dressing daily and prn (as needed) for soiled or dressing coming off." This order was dated 8/29/22.

On 9/14/22 at 2:20 p.m., RN #3 was interviewed.

manner throughout the procedure.
5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis.
6. Date of Compliance October 19, 2022

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F 686	Continued From page 18 When asked if she could think of anything she would have done differently during R107's wound care, after removing soiled gloves, she stated: "I should have washed my hands." She stated she usually washes or sanitizes her hands between removing dirty gloves and putting on clean gloves, but she was nervous and forgot. She stated hand washing at this time helps to prevent the possibility of spreading contaminated material or bacteria to the resident's wound. On 9/14/22 at 4:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services, were informed of these concerns. A review of the facility policy, "General Wound Care/Dressing Changes," revealed, in part: "Licensed nurses will follow recognized standards of practice regarding dressing change(s), including date and initials on dressing." A review of the facility policy, "Hand Hygiene," did not provide information related to hand washing/sanitizing after removing gloves. No further information was provided prior to exit. "Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene...immediately after glove removal." This information is taken from the Centers for Disease Control website, https://www.cdc.gov/handhygiene/providers/index.html.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		10/19/22

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F 689	Continued From page 19 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement interventions to prevent accidents and hazards for one of 55 residents in the survey sample; Resident #146. The findings include: For Resident #146, the facility staff failed to follow physician's orders for the use of fall mats. Resident #146 was admitted to the facility on 9/11/20. The most recent MDS (Minimum Data Set), an annual assessment dated 8/16/22 coded the resident as being severely cognitively impaired in ability to make daily life decisions. A review of the clinical record revealed a physician's order dated 9/29/20 for "Low bed and fall mats." On 9/13/22 at 11:46 AM, the resident was observed in bed asleep. The bed was in low position. There was a fall mat on the resident's left side, but on the right side, the fall mat was	F 689	F 689 Accidents and Incidents 1. Residents #146□s fall matts were correctly placed during the survey. 2. Resident with fall matts were audited to ensure, fall matts placed per the care plan. 3. The DON or designee will educate current nursing staff on following the care plan interventions to ensure fall matts are placed per the care plan for resident safety. 4. The DON or designee will randomly audit the residents with fall matts to ensure correct placement at the beside weekly. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis 6. Date of Compliance October 19, 2022	

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folded up, leaning against the wall.

A review of the clinical record revealed the comprehensive care plan dated 9/12/20 for "[Resident #146] has had an actual fall and is at risk for falls r/t (related to) Confusion, Deconditioning, Poor communication/comprehension, Unaware of safety needs" and included the intervention, dated 9/13/20 for "assistive Devices: assist bars to bed, geri chair, fall mats, low bed, concave mattress."

On 9/14/22 at approximately 11:10 AM, an interview was conducted with RN #2 (Registered Nurse). She stated that the fall mats should be down on both sides, but that the resident has not had a fall, has declined in condition and does not move at all by themselves. She stated that the resident required total care with turning. She stated that the fall mats were probably not applicable any longer for this resident. When asked if the physicians orders and care plan was being followed when they documented fall "mats" was plural, meaning more than one, if only one mat was in place, she stated that it was not.

The facility policy, "Physician's Orders" was reviewed. This policy focused specifically on admission orders and did not specify the requirement to follow physician orders.

The facility policy "Falls Management Program" was reviewed. This policy did not specify following physician's orders related to fall interventions.

On 9/14/22 at 4:50 PM, ASM #1 (Administrative Staff Member), ASM #2 and ASM #5 (the Administrator, Director of Nursing, and Regional

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F 689	Continued From page 21 Clinical Nurse, respectively) were notified of the findings. No further information was provided by the end of the survey.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who 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, the facility staff failed to provide respiratory care and services per the plan of care for one of 55 residents in the survey sample, Resident #82. For Resident #82 (R82), the facility staff failed to administer to oxygen at the physician prescribed rate of 3 liters per minute. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/29/22, 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. A review of R82's clinical record revealed a physician's order dated 7/1/22 for oxygen at 3	F 695	F 695 Oxygen 1. Resident # 82□s oxygen was placed at the correct setting during survey. 2. Current residents with oxygen have the potential to be affected. Residents with oxygen were audited to ensure oxygen was at appropriate settings. 3. The DON or designee will educate the current licensed nursing staff to ensure the residents is oxygen is placed at the correct setting per MD orders. 4. The DON or designee will audit 20 percent of the resident on oxygen to ensure oxygen delivery is at the correct setting per MD orders. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis	10/19/22

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F 695	Continued From page 22 liters per minute. R82's comprehensive care plan revised on 7/1/22 documented, "(R82) has Congestive Heart Failure. O2 (Oxygen) as ordered." On 9/13/22 at 4:03 p.m. and 9/14/22 at 7:56 a.m., R82 was observed lying in bed receiving oxygen at three and a half liters per minute as evidenced by the middle of the ball in the oxygen concentrator flow meter positioned on the three and a half liter line. On 9/14/22 at 3:31 p.m., an interview was conducted with LPN (Licensed practical nurse) #2. LPN #2 stated physicians' orders for oxygen display on the medication administration record or the treatment administration records and nurses should check residents' oxygen concentrators to ensure oxygen is administered at the correct rate every time they go into residents' rooms. LPN #2 stated the middle of the ball in the oxygen concentrator flow meter should be on the three liter line if the physician's order is for three liters. On 9/14/22 at 4:55 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Respiratory/Oxygen Equipment" documented, "3. Set appropriate flow rate and place oxygen delivery device on the patient." The oxygen concentrator manufacturer's instructions documented, "Check the flow meter to make sure that the flow meter ball is centered on the line next to the prescribed number of your flow rate."	F 695	6. Date of Compliance October 19, 2022	

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F 695	Continued From page 23 No further information was presented 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, clinical record review, and facility document review, it was determined that the facility staff failed to provide care and service for a complete dialysis program for one of 55 residents in the survey sample, Residents #87 (R87). The findings include: For (R87) the facility staff failed to provide dialysis communication forms for (R87's) dialysis visits on 08/03/2022, 08/05/2022, 08/10/2022, 08/15/2022, 08/17/2022, 08/19/2022, 08/31/2022 and failed to complete dialysis communication forms on 08/12/2022, 08/22/2022, 08/24/2022, 08/26/2022, 08/29/2022, 09/05/2022, 09/09/2022 and on 09/12/2022. (R87) was admitted to the facility with diagnoses included but were not limited to: end stage renal failure (1). On the most recent MDS (minimum data set), a 5-Day assessment with an ARD (assessment reference date) of 08/01/2022, the resident	F 698	F698 Dialysis Communication 1. Resident # 87 was not affected by the deficient practice. 2. Current Dialysis residents have the potential to be affected. 3. The DON or designee will educate the current Licensed nursing staff on completion of dialysis communication form to include current set of vital signs upon return to the facility. 4. The Unit Manager of Designee will audit completion of the dialysis communication for the include vital signs weekly for current dialysis residents. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis 6. Date of Compliance October 19, 2022	10/19/22

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CULPEPER HEALTH & REHABILITATION CENTER	602 MADISON ROAD CULPEPER, VA 22701

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F 698	Continued From page 24	F 698		

scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded (R87) for "Dialysis" while a resident.

The physician's order for (R87) documented in part, "DIALYSIS @ (at) (Name of Dialysis Center) M-W-F (Monday-Wednesday-Friday). Order Date: 06/27/2022."

The comprehensive care plan for (R87) dated 06/29/2022 documented in part, DIALYSIS: (R87) needs dialysis r/t (related to) renal failure. Created on: 06/29/2022." Under "Interventions" it documented in part, "DIALYSIS @ (Name of Dialysis Center) M-W-F Created on: 08/18/2022."

Review of (R87's) dialysis communication book failed to evidence the facility's "Dialysis Communication Forms" for 08/03/2022, 08/05/2022, 08/10/2022, 08/15/2022, 08/17/2022, 08/19/2022, and on 08/31/2022. Further review of (R87's) dialysis communication book revealed blanks, indicating that nothing was documented, under the heading "Upon return to (Name of Nursing Home), please document the following: Vital Signs on 08/12/2022, 08/22/2022, 08/24/2022, 08/26/2022, 08/29/2022, 09/05/2022, 09/09/2022 and on 09/12/2022.

Review of (R87's) clinical record failed to evidence (R87's) blood pressure, pulse, respiration, temperature, and oxygen saturation were obtained on 08/22/2022, 08/24/2022, 08/26/2022, 08/29/2022 and 09/09/2022; failed to evidence pulse, respiration, temperature, and oxygen saturation were obtained on 08/12/2022

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F 698	Continued From page 25 and on 09/12/2022.	F 698		

On 09/14/2022 at approximately 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) #5 regarding the procedure for the facility's dialysis communication forms for (R87). LPN #5 stated that there should be a communication for each visit (R87) makes to the dialysis center and that the resident's vital signs should be obtained each time (R87) returned from the dialysis center and documented under section "C" of the dialysis communication form. LPN #5 stated that if (R87's) vital signs were not documented on the communication form they would be documented in the resident's clinical record and If the vital signs were not documented on the communication form or in the clinical record, then they were not obtained and the dialysis form would be incomplete. When asked to describe what vital signs were required to be obtained LPN #5 stated that the vital signs included blood pressure, temperature, respiration, pulse and oxygen saturation. LPN #5 further stated that if one of the vital signs was not obtained then the communication form would be incomplete. After reviewing (R87's) dialysis communication book and (87's) clinical record, LPN #5 acknowledged that dialysis communication forms for (R87) were missing for 08/03/2022, 08/05/2022, 08/10/2022, 08/15/2022, 08/17/2022, 08/19/2022, 08/31/2022 and incomplete complete dialysis communication forms on 08/12/2022, 08/22/2022, 08/24/2022, 08/26/2022, 08/29/2022, 09/05/2022, 09/09/2022 and on 09/12/2022.

The facility's policy "Hemodialysis" documented in part, "7. The Dialysis Communication Form will be initiated prior to sending patient for dialysis. A

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F 698	Continued From page 26 Communication Form." On 09/14/2022 at approximately 4:40 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was presented prior to exit. References: (1) The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.	F 698		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced	F 710		10/19/22

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F 710	Continued From page 27 by: Based on staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to ensure the nurse practitioner and/or physician supervised the residents care for one of 55 residents in the survey sample, Resident #367. The covering nurse practitioner failed to address Resident #367's (R367) reported high white blood cell count (1) on 7/8/22 when reported by the laboratory. The findings include: On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/29/22, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. A review of R367's clinical record revealed the resident was assessed by a nurse practitioner on 6/23/22, 6/24/22, 6/28/22, 6/29/22, 6/30/22, 7/1/22, 7/5/22, 7/6/22 and 7/7/22. Further review of R367's clinical record revealed laboratory results dated 6/29/22 that documented a high white blood cell count of 10.60 thousand per cubic milliliter (with a reference range of 4.1-10.9) and a urine culture that documented urine bacteria. An antibiotic was initiated for R367 on 6/30/22. A note signed by ASM (administrative staff member) #3 (R367's primary nurse practitioner) on 7/7/22 documented, "Asked to see patient by nursing for nausea and meal refusal. Patient	F 710	F 710 Care Supervised by a Physician 1. Resident # 367 is no longer a resident in the facility. 2. Current residents have the potential to be affected. 3. The DON or designee will educate current nurse practitioners on the process for reviewing and sign off labs in the Point Click Care system. The DON or designee will educate the current Licensed nursing staff on the process of notifying the care practitioner when labs are received in computer system and are ready for review in medical record. 4. The DON or designee will audit 15 lab results weekly to ensure timely notification and review of labs by the care practitioner and implementation of orders if given. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis 6. Date of Compliance October 19, 2022	

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states that he does not feel good in his stomach. He states that he is not able to eat. Finds himself nauseated. He does state that he has been drinking. Has been having some diarrhea. Labs done this am for BMP (basic metabolic panel) (2)."

Further review of R367's clinical record revealed laboratory results dated 7/8/22 for a C. diff test (3), a BMP and a CBC (complete blood count) (4). The white blood cell count was flagged as high and was 19.2 thousand per cubic milliliter (with a reference range of 4.1-10.9) (Note: there was no physician's orders for these lab results in the clinical record).

Nurses' notes dated 7/8/22 and 7/9/22 documented R367 denied any pain or shortness of breath and was resting comfortably.

A nurse's note dated 7/10/22 documented, "Patient's family is concerned about lack of appetite. After checking patients recent labs from Wednesday and Thursday, (ASM #3) was worried patient could possibly be septic. Nurses were advised to send patient to the ER for evaluation..."

On 9/14/22 at 1:01 p.m., an interview was conducted with ASM #3 (with ASM #4 [the other nurse practitioner] in the room). ASM #3 stated that she was already closely monitoring R367's sodium level due to a history of a low level. ASM #3 stated on 7/7/22, she reviewed R367's BMP and the resident was reporting nausea and diarrhea so she gave verbal orders to complete another BMP, a CBC and a C. diff test. ASM #3 stated the nurses must not have entered the orders into the computer system. ASM #3 stated

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the lab notifies the nurses and/or nurse practitioners if a lab level is critical but she is responsible for reviewing and addressing lab results. ASM #3 stated she checks the computer system for lab results multiple times a day. ASM #3 stated the lab did not document R367's 7/8/22 white blood cell count of 19.2 as critical but she thought that level was high enough to be notified. ASM #3 stated she was off of work on 7/8/22, 7/9/22 and 7/10/22 so she would not have personally reviewed the labs until Monday 7/11/22. ASM #3 stated ASM #4 is responsible for the residents under her care while she is off. ASM #4 stated she could not recall if she reviewed R367's 7/8/22 labs but if a resident's white blood cell count is high and the is resident is currently on antibiotics then she typically will not prescribe further treatment.

Further review of R367's clinical record revealed the resident was prescribed an antibiotic on 6/30/22 for an infection/inflamed bladder but the antibiotic was completed on 7/6/22. On 9/14/22 at 3:05 p.m., this was reviewed with ASM #3. ASM #3 stated that if she had been working and reviewed R367's 7/8/22 white blood cell count, she would have offered the resident another treatment option or offered a transfer to the hospital. ASM #3 stated that if the resident elected another treatment option, she would have prescribed a different antibiotic. ASM #3 stated that by the time the nurses called her on 7/10/22 and told her how R367 presented, she said to send the resident to the hospital.

On 9/14/22 at 4:55 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

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On 9/14/22 at 7:06 p.m., ASM #1 documented the facility did not have a policy regarding physician/nurse practitioner services.

No further information was presented prior to exit.

COMPLAINT DEFICIENCY

References:

(1) "A high white blood cell count is an increase in disease-fighting cells in your blood. The exact threshold for a high white blood cell count varies from one laboratory to another. In general, for adults a count of more than 11,000 white blood cells (leukocytes) in a microliter of blood is considered a high white blood cell count." This information was obtained from the website: https://www.mayoclinic.org/symptoms/high-white-blood-cell-count/basics/definition/sym-20050611

(2) "A basic metabolic panel (BMP) is a test that measures eight different substances in your blood. It provides important information about your body's chemical balance and metabolism." This information was obtained from the website: https://medlineplus.gov/lab-tests/basic-metabolic-panel-bmp/

(3) "C. diff testing checks for signs of a C. diff infection, a serious, sometimes life-threatening disease of the digestive tract. C. diff, also known as C. difficile, stands for Clostridium difficile. It is a type of bacteria found in your digestive tract." This information was obtained from the website: https://medlineplus.gov/lab-tests/c-diff-testing/

(4) "Your blood contains red blood cells (RBC), white blood cells (WBC), and platelets. Blood

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F 710	Continued From page 31 count tests measure the number and types of cells in your blood." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=cbc&_gl=1*15z407d*_ga*MTY2ODk3OTY4NS4xNjYzNTk1MDMx*_ga_P1FPTH9PL4*MTY2MzU5NTAzMS4xLjEuMTY2MzU5NTU2Ny4wLjAuMA..&_ga=2.112117764.1424311420.1663595032-1668979685.1663595031	F 710		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		10/19/22

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F 732	Continued From page 32 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to post daily nurse staffing information before the shift. On 09/13/2022 and 09/14/2022 the facility staff failed to post the nurse staffing prior to the beginning of the shift. The findings include: On 09/13/2022 observations in the facility's lobby at 10:30 a.m., on Unit 1 at approximately 11:50 a.m., on Unit 2 at approximately 1:00 p.m. and on Unit 3 at approximately 3:30 p.m., failed to evidence the daily nurse staffing information. On 09/14/2022 observations in the facility's lobby at 7:30 a.m., on Unit 1 at approximately 8:50 a.m., on Unit 2 at approximately 9:15 p.m. and on Unit 3 at approximately 11:30 a.m., failed to evidence the daily nurse staffing information. On 09/14/2022 at 1:35 p.m., an interview was conducted with CNA (certified nursing assistant) #9, the scheduler. When asked about the procedure for completing and posting the the	F 732	F 732 Staff Posting 1. The daily schedule was posted during survey on 9/14/22 after notification by the state surveyor. 2. Current residents have the potential to be affected 3. The Regional Director of Clinical Services/designee will educate the DON, ADON and the scheduler on the process for posting the daily staffing. 4. The DON or designee will audit the daily staff posting 5 times per week to ensure Daily Staffing is posted and up to date. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance October 19, 2022	

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F 732	Continued From page 33 daily nurse staffing information CNA #9 stated that they print two copies, place one copy in a binder in their office and place the other copy in a frame on the facility's receptionist desk in the front lobby of the facility each morning. When informed of the observations stated above, CNA #9 stated that they forgot to post the nurse staffing on Tuesday (09/13/2022) and stated that the nurse staffing for 09/14/2022 was on the receptionist's desk. After an observation of the receptionist's desk with the surveyor CNA #9 agreed that the nurse staffing for 09/14/2022 was not displayed and stated that they did not know where the nurse staffing sheet was located. The facility's policy "Daily Nurse Staffing Report Summary" documented in part, The Director of Nursing is responsible for assuring that the MFA Daily Nurse Staffing Summary is completed timely, accurately, and maintained current per shift by designated nursing staff. This report is posted in a prominent place that is readily accessible for patients and families to view." On 09/14/2022 at approximately 4:40 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 5, regional director of clinical services, were made aware of the above findings. No further information was presented prior to exit.	F 732		
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	F 812		10/19/22

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F 812	Continued From page 34 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined facility staff failed to store food in a sanitary manner in one of one facility kitchens. 1. The facility staff failed to seal one 13.9 ounce package of dry gravy mix in one of one dry food storage rooms. 2. The facility staff failed to close a box containing one frozen pie and seal a package of frozen cookie dough in one of one walk-in freezers. The findings include: On 09/13/22 at approximately 10:45 a.m., an observation of the facility's kitchen was conducted with OSM (other staff member) #1, dietary manager. 1. At approximately 10:50 a.m., an observation of	F 812	F 812 Food 1. The Gravy mix, the frozen pie and frozen cookie dough was discarded during the survey. 2. Current residents have the potential to be affected. 3. The Regional Dietary Manager /designee will educate the dietary staff on proper storage of dry and frozen food items in the kitchen. 4. The Administrator/designee will audit the storage of dry food items and frozen food items in the kitchen 3 times a week to ensure proper storage. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance October 19, 2022	

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F 812	Continued From page 35	F 812		

the facility's dry storage room revealed a 13.9 ounce package of dry gravy mix sitting on a shelf. Observation of the package revealed that it was opened to the environment. When asked how much of the dry gravy mix was remaining in the package, OSM # 1 stated that there was approximately half of the product remaining in the package.

2. At approximately 11:00 a.m., an observation of the facility's walk-in freezer revealed a box containing a frozen pie on the top shelf. Observation of the box containing the pie revealed it was open to the environment. Further observation of the top shelf revealed a bag of cookie dough. Further observation of the bag revealed was open and exposed to the environment.

On 09/14/2022 at approximately 3:20 p.m., an interview was conducted with OSM #1 and OSM #7, regional culinary director. When asked to describe the procedure for storing food after it was opened OSM #7 stated that the food should be wrapped, sealed and dated when it was opened.

The facility's policy "Food Storage-Dry Goods" documented in part, "5. The Dining Service Director or designee ensures that all packaged and canned food items shall be kept clean, dry and properly sealed."

The facility's policy "Food Storage-Cold" documented in part, "5. The Dining Service Director / Cook(s) ensures that all food items are stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination."

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F 812	Continued From page 36 On 09/14/2022 at approximately 4:40 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was presented prior to exit.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		10/19/22

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F 880	Continued From page 37 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 880	F 880 Infection Control	

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F 880	Continued From page 38 document review, clinical record review and in the course of a complaint investigation, the facility staff failed to implement infection control practices for 2 of 55 residents in the survey sample, Residents #104 and #107. The findings include: 1. For Resident #104 (R104), OSM (other staff member) #5 (a housekeeper) failed to implement physician ordered contact isolation transmission based precautions (1) while cleaning the resident's room on 9/13/22. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/3/22, 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. A review of R104's clinical record revealed a physician's order dated 9/5/22 for contact precautions every day and night shift for ESBL (2). R104's comprehensive care plan revised on 9/5/22 documented, "IMMUNOLOGICAL: (R104) is currently on antibiotics r/t (related to) Urinary Tract Infection. Contact Precautions isolation." On 9/13/22 at 11:48 a.m., R104 was observed lying in bed and OSM #5 was observed cleaning R104's room. While cleaning, OSM #5's clothing was observed brushing up against R104's bed linen and privacy curtain. OSM #5 was wearing a mask, eye protection and gloves but was not wearing a gown. On 9/13/22 at 12:02 p.m., OSM #5 was observed wearing a mask, eye protection, gloves and a gown while cleaning R104's bathroom.	F 880	1. The Housekeeper was educated concerning infection control and isolation precautions and a return demonstration of donning doffing PPE was performed by staff member. Resident # 107 is currently receiving wound care following infection control practices. Registered Nurse #3 was educated during the survey on hand washing during a dressing change. 2. Current residents have the potential to be affected. 3. The DON or Designee will educate current staff member on infection control practices to include precaution and PPE management. The DON or designee will educate current licensed staff on the proper way to perform a treatment for pressure ulcer to maintain a sanitary manner throughout the treatment. 4. The DON or designee will observe staff in an isolation room 5 times per week to ensure proper use of PPE for stated precautions. The DON or designee will observe 5 pressure ulcer treatments per week to ensure the nurse in maintaining a sanitary manner. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance October 19, 2022	

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On 9/14/22 at 12:51 p.m., an interview was conducted with OSM #4 (the environmental services director), OSM #5 and OSM #6 (a housekeeper who assisted with language translation). OSM #4 stated the housekeepers should wear a mask, gloves, and gown and safety goggles while cleaning contact isolation rooms so the housekeepers don't infect themselves. With translation assistance from OSM #6, OSM #5 stated the housekeepers should wear gloves, a gown, glasses, a mask and a hair covering while cleaning contact isolation rooms. OSM #4 and OSM #5 stated OSM #5 did not wear a gown while initially in R104's room because there were no gowns available in the cart outside of R104's room. OSM #4 stated a nurse went to obtain gowns because, "They ran out."

On 9/14/22 at 1:00 p.m., another interview was conducted with OSM #4. OSM #4 stated if no gowns are available for an isolation room, then the housekeepers should wait to enter the room after someone has provided gowns. OSM #4 stated OSM #5 should not have entered R104's room without a gown and he was about to in-service the housekeeping staff.

On 9/14/22 at 1:43 p.m., an interview was conducted with RN (registered nurse) #1 (the infection control nurse). RN #1 stated that anyone entering a contact isolation room should wear a gown because staff is going into rooms, touching things, then going into multiple other rooms. RN #1 stated, "You never know what they are carrying on their clothing or if their arm touches something then their arm touches something in another resident room."

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On 9/14/22 at 4:55 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Transmission Based Precautions (TBPs)" documented, "The Center initiates transmission based precautions (to include droplet and contact precautions) as recommended by the Center for Disease Control (CDC). 3. Contact Precautions. c. Gown. In addition to standard precautions, wear a gown when entering the room. Remove the gown before leaving the patient's environment..."

No further information was presented prior to exit.

Complaint deficiency.

References:

(1) The CDC (Centers for Disease Control) documented the following: "Contact Precautions: Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens." This information was obtained from the website: https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html

(2) "To survive the effects of antibiotics, germs are constantly finding new defense strategies, called 'resistance mechanisms.' For example, some Enterobacterales can produce enzymes

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called extended-spectrum beta-lactamases (ESBLs). ESBL enzymes break down and destroy some commonly used antibiotics, including penicillins and cephalosporins, and make these drugs ineffective for treating infections." This information was obtained from the website: https://www.cdc.gov/hai/organisms/ESBL.html

2. For R107, the nurse providing wound care failed to follow infection control procedures related to washing/sanitizing hands between glove changes (between dirty and clean parts of the procedure).

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/5/22, R107 was coded as being in a persistent vegetative state. R107 was coded as having no pressure ulcers during the look back period.

On 9/14/22 at 10:59 a.m., RN (registered nurse) #3 was observed as she provided wound care to R107. RN #3 removed the old dressing from the top of R107's right foot wound. RN#3 cleansed the wound with wound cleanser, and wiped the wound with dry gauze. RN #3 threw the soiled gauze in the trash can, removed her dirty gloves and put on a clean pair of gloves. RN #3 did not wash/sanitize her hands between removing the dirty gloves and putting on the clean gloves. RN #3 repeated this same process when she removed the old dressing from R107's right heel wound, cleansed the wound with wound cleanser, wiped the wound with dry gauze, disposed of her dirty gloves, and put on clean gloves without washing/sanitizing her hands between the dirty and clean gloves.

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A review of R107's physician's orders revealed the following orders:

"Right Ankle Front: Cleanse with wound cleanser, pat dry. Apply Xeroform and calcium alginate. Cover with border foam daily and prn. Every day shift for Skin Care." This order was dated 9/9/22

"Right Heel: Cleanse with wound cleanser, pat dry. Apply betadine and cover with border foam dressing daily and prn (as needed) for soiled or dressing coming off." This order was dated 8/29/22.

On 9/14/22 at 2:20 p.m., RN #3 was interviewed. When asked if she could think of anything she would have done differently during R107's wound care, after removing soiled gloves, she stated: "I should have washed my hands." She stated she usually washes or sanitizes her hands between removing dirty gloves and putting on clean gloves, but she was nervous and forgot. She stated hand washing at this time helps to prevent the possibility of spreading contaminated material or bacteria to the resident's wound. She stated it is a matter of infection control.

On 9/14/22 at 4:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services, were informed of these concerns.

A review of the facility policy, "General Wound Care/Dressing Changes," revealed, in part: "Licensed nurses will follow recognized standards of practice regarding dressing change(s), including date and initials on dressing."

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F 880	Continued From page 43 A review of the facility policy, "Hand Hygiene," did not provide information related to hand washing/sanitizing after removing gloves. No further information was provided prior to exit. "Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene...immediately after glove removal." This information is taken from the Centers for Disease Control website, https://www.cdc.gov/handhygiene/providers/index.html.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883		10/19/22

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F 883	Continued From page 44 and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. 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 determine and document the pneumococcal vaccination status for two of five residents in the infection control review,	F 883	F883 Flu and PNA 1. Resident # 128 and #218 pneumococcal immunization were updated during the survey in the medical record.	

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F 883	Continued From page 45 Residents #128 and #218. The findings include: 1. For Resident #128 (R128), the facility staff failed to determine and document the pneumococcal vaccination status. On the most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date (ARD) of 8/16/2022, the resident scored a 6 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is severely cognitively impaired for making daily decisions. In Section 0 - Special Treatments, Procedures and Programs, was coded as having not assessed or no information was available to code the MDS for the resident's pneumococcal vaccination status. Review of the clinical record failed to evidence documentation of R128's pneumococcal vaccination status. A request was made on 9/14/2022 at 4:45 p.m. for the documentation of R128's pneumococcal vaccination status. On 9/15/2022 at 7:52 a.m. ASM (administrative staff member) #2, the director of nursing, presented documentation of R128's pneumococcal vaccination status. Pneumococcal Vaccination was completed prior to admission to the facility. When asked where the information was obtained from, ASM #2 stated from the immunization registry. ASM #2 stated the nurse did not fill in the information in the computer/clinical record at the time of the resident's admission.	F 883	2. A review of current resident□s pneumococcal vaccination status was preformed to ensure documentation in the medical record was present. 3. The DON or designee will educate the Infection Preventionist and Nursing Management on ensuring the pneumococcal vaccination status is present in the medical record. 4. The DON or designee will audit new admission charts 5 times per week for the presence of pneumococcal vaccine status in the medical record. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance October 19, 2022	

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An interview was conducted with (registered nurse) #1, the infection preventionist/assistant director of nursing, on 9/15/2022 at 8:26 a.m. When asked the process for determining the pneumococcal vaccination status of a resident, RN #1 stated she has access to the Virginia Immunization Information System. She stated she can look people up. RN #1 stated it gives you what is public knowledge. RN #1 further stated that residents do not have to be vaccinated a second time if they are over 65 years old and have had a previous vaccination. RN #1 stated if a resident is under 65 years old, she offers them the vaccination. When asked why there was no information in the clinical record regarding R128's pneumococcal vaccination status, RN #1 stated, unfortunately she didn't put it in their clinical record. RN #1 stated she is responsible for putting the information in the clinical record after she has looked it up on the registry.

The facility policy, "Influenza & Pneumococcal Vaccinations" documented in part, "2. Pneumococcal Vaccination...d. Vaccination Information Sheet (VIS) for pneumococcal vaccine will be provided to the patient and/or responsible party prior to administration of vaccine. Copy of VIS will be maintained with the Patient Pneumococcal Tracking Log and a copy will be placed in the patient's record as proof of education; include the date on the first page of the VIS education...f. A Patient Pneumococcal Vaccine Tracking Log will be maintained by the Infection Preventionist. All patients' names are to be included on the Tracking Log. New patients' names will be placed on the log at the time of admission and offered the Pneumococcal vaccination if not received as indicated."

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F 883	Continued From page 47	F 883		

ASM #1, the administrator, was made aware of the above findings on 8/15/2022 at 8:26 a.m.

No further information was obtained prior to exit.

2. For Resident #218, the facility staff failed to determine and document the pneumococcal vaccination status.

On the most recent MDS assessment, an admission/Medicare five day assessment, with an assessment reference date of 9/8/2022, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section 0 - Special Treatments, Procedures and Programs, was coded as having not been assessed or no information was available to code the MDS for the resident's pneumococcal vaccination status.

Review of the clinical record failed to evidence documentation of Resident #218's pneumococcal status.

A request was made on 9/14/2022 at 4:45 p.m. for the documentation of Resident #128's pneumococcal vaccination status.

On 9/15/2022 at 7:52 a.m. ASM (administrative staff member) #2, the director of nursing, presented documentation of Resident #218's pneumococcal vaccination status. Pneumococcal Vaccination was completed prior to admission to the facility. When asked where the information was obtained from, ASM #2 stated from the immunization registry. ASM #2 stated the nurse did not fill in the information in the

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F 883	Continued From page 48 computer/clinical record at the time of the resident's admission. An interview was conducted with (registered nurse) #1, the infection preventionist/assistant director of nursing, on 9/15/2022 at 8:26 a.m. When asked the process for determining the pneumococcal vaccination status of a resident, RN #1 stated she has access to the Virginia Immunization Information System. She stated she can look people up. RN #1 stated it gives you what is public knowledge. RN #1 further stated that residents do not have to be vaccinated a second time if they are over 65 years old and have had a previous vaccination. RN #1 stated if a resident is under 65 years old, she offers them the vaccination. When asked why there was no information in the clinical record regarding Resident #218's pneumococcal vaccination status, RN #1 stated, unfortunately she didn't put it in their clinical record. RN #1 stated she is responsible for putting the information in the clinical record after she has looked it up on the registry. ASM #1, the administrator, was made aware of the above findings on 8/15/2022 at 8:26 a.m. No further information was obtained prior to exit.	F 883		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area.	F 919		10/19/22

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F 919	Continued From page 49 §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: 2. The facility staff failed to maintain a functioning call bell system for Resident #217 (R217). There was no MDS (minimum data set) assessment completed at the time of survey. The Admission/Readmission Nursing Collection Tool dated 9/6/2022, documented in part, R217 was cognitively intact. During the resident interview on 9/13/2022 at approximately 11:30 a.m. R217 stated it takes a long time for the staff to answer the call bell. Observation was made of the call bell on 9/13/2022 at approximately 1:30 p.m. The call bell was turned on by one surveyor. The other surveyor observed that the call light outside the room did not turn on. An interview was conducted with LPN (licensed practical nurse) #8 on 9/13/2022 at 1:49 p.m. When asked if a resident's call bell is not working, how does the staff know when the need assistance, LPN #8 stated they make constant rounds. When asked if the call bell system rings at the nurse's station, LPN #8 showed the monitor at the nurse's station. The monitor was not functioning and displayed an error message: "Connecting to server 10.1.10.78 on Port 8081. Object reference not set to an instance of an object." When asked if the monitor was working, LPN #8 stated, it didn't look like it was. An interview was conducted on 9/13/2022 at 2:02	F 919	F 919 Call Bell 1. Residents # 150, #217 and #467 were provided a tap bell during the survey. 2. An audit of call bells was performed facility wide to identify any call bells there were not functioning. A quote is being obtained for a new call bell system. 3. The Administrator or designee will educate the Maintenance Director on the importance of an operational call bell system and identification of those not functioning. The DON or designee will educate current staff members on procedure to take if the call bell is not operating in a resident□s room to include notification of the Maintenance team and or the Administrator of nonfunctioning call bells. 4. The Administrator w/designee will observe call bell functioning 3 times weekly. To ensure that when a bell is pushed the call bell is alerting the care team that the resident needs assistance. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance October 19, 2022	

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p.m. with OSM (other staff member) #2, the director of maintenance. When asked how a staff member informs him of things that are in need of repair, OSM #2 stated there is an app on the computer and it goes directly to his phone. When asked if he was aware of R217's call bell not functioning, OSM #2 stated that this was the first time he had heard of it. When asked if the call bell monitor at the nurse's station works, OSM #2 stated he believed so.

On 9/14/2022 at 4:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services, were made aware of the above concern.

No further information was provided prior to exit.

3. The facility staff failed to maintain a functioning call bell system for Resident #150 (R150).

On the most recent MDS (minimum data set) assessment, an admission/Medicare five day assessment, with an assessment reference date of 8/25/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions.

Observation was made of R150's room on 9/13/2022 at approximately 12:30 p.m. The call bell was lite and flashing outside the door to the room. During an interview with R150 at this time, they stated the call bell has been broken for two weeks. When asked how they let the staff know they need assistance, R150 stated the roommate goes to the door and looks for staff to come in. When asked what happens at night if they need

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assistance and the roommate is asleep, R150 stated they sometimes gets themselves out of bed and goes to the bathroom independently. When asked if the facility had provided her with another way to contact the staff, R150 stated no. Observation did not reveal another type of bell for R150 to call for assistance.

Observation was made outside R150's room on 9/13/2022 at 1:35 p.m. and the call light was still flashing outside the door.

An interview was conducted with CNA (certified nursing assistant) #10 on 9/13/2022 at 1:51 p.m. When shown the call light outside R150's room, CNA #10 stated it's jammed up. Maintenance man is aware. When asked how long it has been out, CNA #10 stated, she believed about four days. When asked how R150 calls for assistance, CNA #10 stated the roommate stands at the door and asked for help for themselves and for R150. When asked if the residents had an alternate way to ask for help, CNA #10 stated sometimes the facility gives the residents hand bells but she didn't see one in R150's room.

An interview was conducted with LPN (licensed practical nurse) #9 on 9/13/2022 at 1:54 p.m. When asked about the flashing call light outside of R150's room, LPN #9 stated it haven't been working for a few days. LPN #9 stated she believed a maintenance order is in place. When asked how the residents in the room ask for assistance, LPN #9 stated she goes down there frequently. When asked how R150 calls for help, LPN #9 stated sometimes they give the resident a bell to ring but currently R150 doesn't have one, which was stated after searching the room.

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An interview was conducted with OSM (other staff member) #2, the director or maintenance, on 9/13/2022 at 2:02 p.m. When asked what the problem is with the call bell system in R150's room, OSM #2 stated, he was aware of it last Wednesday (9/7/2022). OSM #2 stated he was not trained on the system. OSM #2 stated he's been trying for two weeks to get someone to walk them through it. When asked if the administrator was aware of the situation, OSM#2 stated, yes, that she was the one to give them the name of another maintenance director.

On 9/14/2022 at 4:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services, were made aware of the above concern.

No further information was provided prior to exit.

Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure an operational call system for three of 55 residents, Resident #467, #217, and #150.

The findings include:

1. The facility staff failed to ensure an operational call system Resident #467

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Resident #467 was admitted to the facility on 9/2/22 with diagnosis that included but were not limited to: cerebral vascular infarction, COPD

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(chronic obstructive pulmonary disease), atrial fibrillation and diabetes.

The most recent MDS (minimum data set) assessment, a 5 day Medicare assessment, with an ARD (assessment reference date) of 9/9/22, coded the resident as scoring a 99 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was unable to complete the interview. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing; total dependence for eating, bathing and hygiene.

A review of the comprehensive care plan with a revision date of 9/13/22, revealed, "FOCUS: Resident has a terminal prognosis. INTERVENTIONS: Encourage support system of family and friends. Keep the environment quiet and calm. Keep linens clean, dry and wrinkle free. Keep lighting low and familiar objects near. Involve family in discussion."

On 9/13/22 at 12:40 PM, the daughter for the Resident #467 stated, the call bell is not working. On 9/13/22 at 12:47 PM asked the daughter to push the call bell, the call bell console in the room did not light up, and the light outside of room did not light up. The call bell console at the nurse's station did not note the call bell had been pushed in the room.

On 9/13/22 at 1:25 PM, the call bell was tried again. When the call bell was pushed, the call bell console in the room did not light up, and the light outside of the room did not light up. The call bell console at the nurse's station did not note the call bell had been pushed.

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Survey team was informed of the above events on 9/13/22 at 1:30 PM, with the decision to perform call light checks on all 59 facility beds (both occupied and unoccupied) on Unit 1. Unit 2 and Unit 3 were not experiencing any issues with call bells. The survey team conducted an audit beginning at 1:35 PM and found two additional Resident beds with non-functioning call lights.

On 9/13/22 at 2:15 PM, when accompanied by OSM (other staff member) #2, the maintenance director, the call light when pushed in the residents room showed on console in room and lit up outside of room. The residents room appeared on the call system computer at nursing station.

The resident's room had no alternative call system provided, ring or tap bell.

An interview was conducted on 9/13/22 at 1:00 PM with CNA (certified nursing assistant) #6. When asked how they knew a resident's call system was functioning, CNA #6 stated, we only know if the resident or the family says something to us and we can check it out. I know we have been having issues with the call system not working properly and maintenance has been informed. It is an old system that I believe they are working on getting replaced.

An interview was conducted on 9/13/22 at 1:55 PM with OSM #2, the maintenance director. When asked how long he had been maintenance director, OSM #2 stated, four months ago and was the only current maintenance person. OSM #2 stated "The call bell system is finicky and I have never been trained on the call bell system.

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The only person who know how the system worked was the previous director." OSM #2 stated "I have contacted two different regional directors regarding the call bell systems and have not heard back from either one. The administrator knows I have not heard back and gave me another person to contact. I called them today and have not heard back yet." When asked about the console at the nurse's station and reports on the call system functioning, OSM #2 stated, there has been not education about the console but will get education in two weeks. OSM #2 stated, "When there is an issues, I try to narrow it down. Is it the call bell cord, is the light bulb blown or does it need reprogrammed. I do not know how to reprogram or run reports but I will get that training in two weeks. Everybody knows when the call bell is not working. Usually the unit manager lets me know." When told the call bell in the room was not working, OSM #2 stated, (room number) was not on my list, I did not know about that bed. When ask what the alternative is for the resident if the call system does not function, OSM #2 stated, the nurses give them bells, either the kind you ring or the kind you tap.

On 9/14/22 at 4:40 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were informed of the findings.

According to the facility's "Nurse Call System" policy dated 5/2022, "Each nursing unit call system will be thoroughly inspected and tested monthly to verify operating efficiency.
PROCEDURE:
1. Inspect all patient call devices located on the

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F 919	Continued From page 56 unit (patient rooms, shower rooms, bathrooms) monthly. 2. Inspect pull-call cords in all patient/public restrooms/shower rooms and verify that they are in place, in one piece, clean, and hanging freely. Verify pull-call cords are within two (2) to four (4) inches from the floor. Replace as needed. 3. Inspect push button cords in all patient/public restrooms/shower rooms and verify each cord has a clip and that cord is not in contact with the floor. 4. Initiate a call and verify that both the audio and visual sign is received at the nurse station annunciator panel. Verify corridor nurse call indicator light illuminates and verify that wiring and insulation are intact. 5. Document malfunctions, service provisions, and validate completion of repairs as outlined in the preventative maintenance electronic record." No further information was provided prior to exit.	F 919		