STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8/31/21 through 9/2/21. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
E 007 SS=E	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession	E 007	1. Residents requiring wheelchairs, walkers, and adaptive eating utensils have been identified by running a specific report through Point Click Care to identify and list all residents in these categories. The new list has been added to the Emergency Preparedness Manual under the E007 Section. 2. A new report of "At Risk and Vulnerable Patients" has been developed to include patients in the following categories: Residents Requiring Insulin, Residents with Memory Impairment, Residents Requiring Significant Assistance to Transport, Residents Requiring Dialysis, Residents with Significant Medication Needs, Residents Requiring Portable Oxygen, Residents with Significant Medical Treatments, and Residents with Special Diets. The new report listing the identified residents has been developed and placed in the Emergency Preparedness Manual under the E007 Section. 3. The Director of Nurses, or designee, will run an updated report identifying the "At Risk and Vulnerable Patients" on a weekly basis and place it in the Emergency Preparedness Manual under the E007 Section.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Regional Director of Operations	09/27/21

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

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E 007	Continued From page 1 plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to identify through the emergency preparedness plan risk assessments the needs of at risk or vulnerable patient populations. The findings included: During an interview with the Administrator and the Regional Corporate Director of Compliance at 9:22 a.m. on 09/01/21 they were asked if the facility had an emergency preparedness plan that addressed the needs of the patient population of the facility. The administrative staff was asked for documentation of how many residents required wheelchairs, walkers, and adaptive eating utensils. The Administrator stated, the facility did not have documentation of residents requiring or needing wheelchairs, walkers, and adaptive eating utensils. The facility staff failed to maintain an emergency preparedness plan to address the patient population and persons at risk during an emergency and continuity of care.	E 007	4. The Administrator will monitor the Emergency Preparedness Manual at least monthly to ensure the "At Risk and Vulnerable Patients" report continues to be updated appropriately. These findings will be reported and discussed during the Quality Assurance and Performance Improvement meeting quarterly. 5. Corrective action will be completed by 10/01/2021.	
E 033 SS=E	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)	E 033	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	

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E 033	Continued From page 2 (4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means	E 033	1. The current emergency preparedness communication plan will be updated to include the new policy and procedure, "Sharing Patient Medical Information During an Emergency Evacuation" to demonstrate the process more clearly and thoroughly. 2. The new policy and procedure, "Sharing Patient Medical Information During an Emergency Evacuation" will be added to the Emergency Preparedness Manual to ensure the changes are in place for all residents. 3. The facility Director of Nurses, Assistant Director of Nurses, Nursing Unit Managers, and Nursing Supervisors will be educated on the new policy and procedure to ensure they are familiar with the new policy and procedure. 4. A Tabletop exercise will be held within the next quarter to review and improve the facilities emergency evacuation policies and procedures, including the new "Sharing Patient Medical Information During an Emergency Evacuation" policy, to ensure efforts are made for continued improvement in the plan and the plan is well implemented. 5. Corrective Action will be completed by 10/01/2021.	

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E 033	Continued From page 3 of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to maintain an emergency preparedness communication plan that included a method of sharing information and medical documentation for Residents under the facility's care as necessary with other health providers to maintain continuity of care. The findings included: During an interview with the Administrator and the Regional Corporate Director of Compliance at 9:42 a.m. on 09/01/21 they were asked if the facility had an emergency preparedness plan that addressed the methods of sharing information and medical documentation of residents under the facility's care with other health care providers in the event of an evacuation. The administrative staff was asked for documentation of how residents medical information would be shared with other health care providers during an emergency to maintain continuity of care. The Administrator stated, the facility's emergency preparedness communication plan did not address a means to share information with other health care providers in the event of an emergency evacuation. The facility staff failed to maintain an emergency preparedness plan to address methods of sharing information and medical documentation in the event of an evacuation wit other health care	E 033		

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E 033	Continued From page 4 providers.	E 033		
E 034 SS=E	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c)]: (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced	E 034	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. The current emergency preparedness communication plan will be updated to include the new policy and procedure, "Sharing Information on Occupancy / Needs". The policy includes the procedures for reporting the facility needs, reporting of a facility's ability to provide assistance, and facility occupancy reporting. 2. The new policy and procedure, "Sharing Information on Occupancy / Needs" will be added to the Emergency Preparedness Manual to ensure the changes are in place and actionable for the safety of all residents. 3. The facility Director or Nurses, Assistant Director of Nurses, Nursing Unit Managers, Nursing Supervisors, and the facility Maintenance Director will be educated on the new policy and procedure to ensure they are familiar with the new process. 4. A Tabletop exercise will be held within the next quarter to review and improve the facility's emergency evacuation policies and procedures, including this new policy, to ensure efforts are made for continued improvement in the plan	

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E 034	Continued From page 5 by: Based on record review and staff interview, the facility staff failed to maintain an emergency preparedness communication plan that included a means of providing information about the facility's occupancy, needs and its ability to provide assistance. The findings included: During an interview with the Administrator and the Regional Corporate Director of Compliance at 9:49 a.m. on 09/01/21 they were asked if the facility had an emergency preparedness communication plan that addressed the means of providing information about the facility's occupancy, needs and its ability to provide assistance during an emergency. The Administrator stated, the facility's emergency preparedness communication plan did not address a means of providing information about the facility's occupancy, needs and its ability to provide assistance during an emergency. The facility staff failed to maintain an emergency preparedness plan to address the means of providing information about the facility's occupancy, needs and ability to provide assistance during an emergency.	E 034	and to ensure the plan is able to be well implemented, should it be needed. 5. Corrective Action will be completed by 10/01/2021.	
E 035 SS=E	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan	E 035	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	

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E 035	Continued From page 6 that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to maintain an emergency preparedness communication plan that included a method of sharing information with residents, families and their representatives. The findings included: During an interview with the Administrator and the Regional Corporate Director of Compliance at 11:17 a.m. on 09/01/21 they were asked if the facility had an emergency preparedness plan that addressed the methods of sharing information with residents, families and their representatives at least annually during review. The Administrator stated, the facility's updated emergency preparedness communication plan had not been shared with residents, families, or their representatives.	E 035	1. An informational notice entitled, "How We Prepare for Emergencies" has been developed regarding the facility's emergency preparedness plan and policies. This notice has been shared with, emailed, or mailed to all residents, family members and resident representatives. 2. A new policy entitled, "Resident and Family Notification of Emergency Plan" has been developed and implemented. The new policy requires that new admissions be provided with information regarding the emergency plan and updates sent to all residents, family members and resident representatives as significant changes to the plan are implemented. 3. The Administrator will be responsible to ensure that significant updates to the emergency plan are communicated, as identified, and keep copies of update notices as changes are communicated. 4. The Administrator will be responsible to review the Emergency Plan, at least quarterly for the next year, to identify any changes that may need to be communicated as indicated in the policy. The Administrator will discuss the findings, at least quarterly, at the QAPI meeting and solicit the committees input as to any changes or improvements that may be beneficial to this process. 5. Corrective Action will be completed by 10/01/2021.	

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E 035	Continued From page 7 The facility staff failed to maintain an emergency preparedness plan to address methods of sharing information with residents, families, and representatives.	E 035		
E 036 SS=E	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of	E 036	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. An Emergency Preparedness Training and Testing program has been developed to include the "Emergency Preparedness Training and Testing Policy". 2. The new program and policy have been added to the Emergency Preparedness Manual to ensure the changes are reflected in the plan for the benefit of all residents. The Administrator will in-service all department heads on the new program and policy. 3. The Administrator will be required to coordinate the first of the two annual training and testing exercises within two weeks. The first training and testing exercise will involve the facilities new fire safety plan (keeping in compliance with the 1135 waiver). The Regional Director of Risk Management will verify that the training and testing exercise has been completed.	

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E 036	Continued From page 8 this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of an emergency preparedness training and testing program.	E 036	4. The Administrator will report to the Quality Assurance and Performance Improvement committee quarterly to discuss the Emergency Preparedness Hazard and Vulnerability Assessment, policies and procedures related to any upcoming training and testing exercises and report on the compliance of the program as related in the policy. 5. Corrective action will be completed by 10/08/21.	

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E 036	Continued From page 9 The findings included: During an interview with the Administrator and the Regional Corporate Director of Compliance at 11:47 a.m. on 09/01/21 they were asked for documentation of the facility's emergency preparedness training and testing program. The Administrator stated, the facility had not conducted an emergency preparedness training and testing program. The facility staff failed to develop and maintain an emergency preparedness training and testing program.	E 036		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/31/21 through 9/2/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey: VA00049274, Unsubstantiated, lack of sufficient evidence; VA00048873; Unsubstantiated, lack of sufficient evidence; VA00051883, Substantiated with deficiency. The census in this 130 certified bed facility was 94 at the time of the survey. The survey sample consisted of 44 Resident record reviews, current/closed.	F 000		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes	F 567	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists.	

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F 567	Continued From page 10 the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(10)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview,	F 567	This response is also not construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Resident #18 and resident #49 have been able to receive their requested amount of money from their patient fund account. 2. All residents residing in a facility who have authorized the facility to manage their personal funds have access to the funds in their personal accounts. 3. The Administrator/Designee has educated the Business Office Manager on the Resident Funds Trust Fund Policy. The Activities Director has distributed a flyer to residents addressing the hours of banking, who to contact regarding setting up a patient fund account, and who contact regarding questions concerning their patient fund account. 4. Business Office Manager/Designee will interview residents 4 a week for 6 weeks to see if there are any questions regarding their patient fund account or setting up a patient find account and if there are any concerns about receiving money in a timely manner when requested. Corrective action will be taken to resolve any issues identified in the resident interviews. Business Office Manager/Designee will identify any issues, patterns, or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 09/23/2021	

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facility document review and clinical record review, it was determined that the facility staff failed to ensure access to resident funds for one of 49 sampled residents, Resident #49.

The findings included:

On 8/31/21 at approximately 4:30 p.m., an interview was conducted with Resident #18 (another sampled resident). Resident #18 stated that other residents had come to her crying because they did not have access to their resident fund account. Resident #18 stated that their 30 dollars that they are supposed to receive every month was not available or able to be accessed. Resident #18 stated that even though she did not have a resident fund account, she brought this concern to the attention of the facility administrator. Resident #18 stated that she was told by the facility administrator that the facility had used the residents' monies to pay for overhead things such as a printer and ink etc. Resident #18 stated that she heard that the facility's corporate card had not come in during that time to pay for overhead items. When asked how long ago all this occurred, Resident #18 stated when the new company had took over (February of 2021). When asked what residents had come to her upset about not accessing their account, Resident #18 would not mention specific residents.

On 9/2/21 at 8:18 a.m., an interview was conducted with Other Staff Member (OSM) #4, the Business Office Manager. When asked if there was a time when residents did not have access to their resident funds, OSM #4 stated that residents always had access to their accounts, however she was only allowed to

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distribute a limited amount of money when facility had switched companies. OSM #4 stated that the facility had switched companies February 1, 2021 and for approximately two weeks she only had 500 dollars in her lock box to be distributed among residents who requested money out of their accounts. OSM #4 stated that sometimes she could not give them the full amount requested. OSM #4 stated that there was a delay in the transition of accounts. OSM #4 stated that once the new account was in place, she gave the residents the rest of their money that was requested. OSM #4 stated that she was never out of money because she would put a limit on the amount that could be pulled from each resident. OSM #4 stated that some residents were able to get their full amount requested. When asked about petty cash, OSM #4 stated that she was not given extra cash to cover her until the accounts were in place. OSM #4 stated with the old company she always had approximately $900 dollars available. OSM #4 stated now she always has 1400 available. OSM #4 stated that 2/24/21 was the approximate time that resident were able to obtain their full amount of money. OSM #4 denied administration ever taking money from residents for overhead costs such as printer and ink. OSM #4 stated that that was not legal. OSM #4 could not recall a specific resident who could not access their funds during the two week period if the transition of accounts.

Review of the facility grievances revealed that a current sampled resident, Resident #49 had filed a grievance on 2/24/21 with the facility social worker related to not being able to access her resident fund account.

Resident #49 was admitted to the facility on

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12/13/18 and readmitted on 2/27/19 with diagnoses that included but were not limited to cancer, anemia, heart failure, high blood pressure, and anxiety disorder. Resident #49's most recent Minimum Data Set Assessment (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 7/22/21. Resident #49 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status Exam.

Review of the facility grievance dated 2/24/21 documented the following: "2/24/21...To: Business office...Concerns: Delay in receiving money from patient fund account. Requested for three days. - Social worker has informed (Name of Business Office Manager) of concern...Response: (Name of Business Office Manager) met with (Name of Resident #49) to provide money requested and to explain delay of funds due to transition of accounts from (Name of previous company) to (Name of current company)."

The following note from Resident #49 also documented in part: "2/24/21 Request 1. Friday. I'm Coming. 2. Monday. I'm Coming. 3. Tuesday I'm Coming. 4. Left message Wednesday. Why is it so hard to get money..."

On 9/2/21 at approximately 8:30 a.m., further interview was conducted with OSM #4. OSM #4 read the grievance filed by Resident #49 but could not recall when her requests for money was first made. OSM #4 stated that the time period was during the transition. OSM #4 stated, "I don't recall this." OSM #4 was asked to provide any requests or receipts of when Resident #49 was able to access her money.

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F 567	Continued From page 14 Review of Resident #49's receipt from the Business Office Manager revealed that she was able to pull out $50.00 on 2/24/21 after her grievance was filed with the facility social worker. Review of Resident #49's bank statement for February 2021 through current revealed no evidence that the facility was taking her social security money. On 9/2/21 at 9:00 a.m., an interview was conducted with OSM #1, the facility social worker. OSM #1 stated that she received a grievance from Resident #49 that she could not get access to her money for three days. OSM #1 stated that the first time she was aware of the issue was on 2/24/21. OSM #1 stated that she followed up with the Business Office Manager immediately and was able to resolve the issue. On 9/2/21 several attempts were made to interview Resident #49. She was out of her room almost the entire day and outside with a group of other residents. She could not be reached for an interview. On 9/2/21 at 6:30 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the acting Director of Nursing (DON), ASM #3 the Assistant Director of Nursing (ADON) and ASM #4 the Regional Director of Compliance were made aware of the above concerns. Facility policy titled, "Deposit of Resident Funds" documents in part, the following: "Resident personal funds that are held and managed by the facility will be safeguarded...Should the resident permit the facility to hold, safeguard and manage	F 567		

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F 567	Continued From page 15 his or her personal funds, the facility will: Provide the resident acess to funds of 50 dollars or less within twenty-four hours, and access to funds in excess of fifty dollars within three banking days...Funds not on deposit in the resident's account are deposited into the resident petty cash fund managed by the facility on behalf of the residents..."	F 567		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a	F 622	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Residents #62 and #18 returned from the emergency room or hospital and therefore no corrective action can be taken with the residents at this time. It is the policy of Waterview Health and Rehab to ensure that transfer and discharge requirements are met. All residents have the potential to be affected by the alleged deficient practice. 2. Residents that transferred to the emergency room or admitted to the hospital in the last 30 days and remain outside of this facility will be reviewed to ensure that the comprehensive care plan summary and goals were sent with the resident. Any variances will be corrected. 3. The Director of Nursing/designee has educated clinical nursing staff, including RN's and LPN's, on transfer and discharge requirements. The education included, but was not limited to, sending comprehensive care plan	

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F 622	Continued From page 16 resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is	F 622	summary and goals with the resident upon discharge or transfer and documentation ion the medical record that the information was provided to the resident upon transfer or discharge to the hospital. 4. The Director of Nursing/designee will review all emergency room and hospital transfers for six weeks to ensure the comprehensive care plan summary and goals was sent with the resident and documented in the medical record. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 10/15/2021	

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necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure that the care plan or care plan goals were sent with two of 49 sampled residents at the time of an acute care transfer for Resident #62 and #18.

The findings included:

1. Resident #62 was admitted to the facility on 7/9/21 with diagnoses that included but were not limited to stroke, atrial fibrillation, heart failure, diabetes mellitus, and renal insufficiency.
Resident #62's most recent Minimum Data Set (MDS) assessment was an admission assessment with an assessment reference date (ARD) of 7/14/21. Resident #62 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the Brief Interview For Mental Status (BIMS) exam.

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F 622	Continued From page 18 Review of Resident #62's clinical record revealed that she had been sent out to the hospital on 8/2/21. The following nursing note was documented on 8/2/21: "When resident returned from dialysis resident (sic) appeared to have AMS (Altered Mental Status), slight droop to R (right) side of face and c/o (complaints) pain. Resident was very confused. Provider was notified and came to assess pt. (patient). Provider then gave orders to send Resident to ER (Emergency Room) for possible CVA (Cerebrovascular Accident) (Stroke). Resident was sent to (Name of Hospital)." There was no evidence in Resident #62's clinical record that the care plan or care plan goals were sent with Resident #62 at the time of transfer. Further review of Resident #62's clinical record revealed that she arrived back to the facility on 8/7/21 with a diagnosis of a stroke. On 9/2/21 at 10:07 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #3, the unit manager. When asked if a resident is sent out the to the hospital for an acute care transfer, what information was sent with each resident, LPN #3 stated that any pertinent information was sent with the resident such as abnormal laboratory tests, a face sheet, the last three days of nursing notes, the bed hold paper form, and the transfer e-Interact form. When asked if the care plan or care plan goals were sent with each resident at the time of transfer, LPN #3 stated, "Generally not. Never done that." On 9/2/21 at 6:30 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2,	F 622		

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F 622	Continued From page 19 the acting Director of Nursing (DON), ASM #3 the Assistant Director of Nursing (ADON) and ASM #4 the Regional Director of Compliance were made aware of the above concerns. Facility policy titled, "Transfer Form" documents in part, the following: "This facility provides a completed and accurate Transfer Form to a resident transferred or discharged from our facility...The transfer form will be completed by Nursing Service and will include:...Comprehensive care plan goals..." 2. Resident #18 was admitted to the facility on 5/4/19 and readmitted on 6/25/21 with diagnoses that included but not limited to anemia, coronary artery disease, diabetes mellitus, Chronic Obstructive Pulmonary Disease (COPD) and hyperlipemia. Resident #18's most recent Minimum Data Set (MDS) Assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 6/25/21. Resident #18 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status Exam (BIMS). Review of Resident #18's clinical record revealed that she was sent to the hospital on 6/18/21. The following was documented in a nursing note dated 6/18/21: @ (at) 0035 (12:35 a.m.), resident called this nurse and she c/o (complained) of weakness, severe H/A (headache), Nauseated, No appetite to eat, acting like not on her usual self with some body jerking, stayed in bed all day yesterday, Pulse Ox (oxygen) fluctuating between 88-90% with O2 (oxygen) infusing via NC (nasal cannula) @ 2L/min (liters/min). V/S (vital signs)	F 622		

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F 622	Continued From page 20 97.3-79-18-106/63. BS (blood sugar) 103. Patient's afraid that she may have a CO2 (carbon) dioxide poisoning per her hx (history) experience. Code Status Full Code. @ 0045 (12:45 a.m.), On call, Provider (Name of provider) was notified and ordered to send this patient to ER (Emergency Room) for eval (evaluation) and tx (treatment). 911 called and arrived at 0115 (1:15 a.m.). Resident left via 911 to (Name of hospital) for eval and treatment @ 0124 (1:24 a.m.)..." There was no evidence in Resident #18's clinical record that the care plan or care plan goals were sent with Resident #18 at the time of transfer. Further review of Resident #18's clinical record revealed that she arrived back to the facility on 6/19/21 with diagnoses of pneumonia with exacerbation of COPD. On 9/2/21 at 10:07 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #3, the unit manager. When asked if a resident is sent out the to the hospital for an acute care transfer, what information was sent with each resident, LPN #3 stated that any pertinent information was sent with the resident such as abnormal laboratory tests, a face sheet, the last three days of nursing notes, the bed hold paper form, and the transfer e-Interact form. When asked if the care plan or care plan goals were sent with each resident at the time of transfer, LPN #3 stated, "Generally not. Never done that." On 9/2/21 at 6:30 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the acting Director of Nursing (DON), ASM #3 the Assistant Director of Nursing (ADON) and ASM	F 622		

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F 622	Continued From page 21 #4 the Regional Director of Compliance were made aware of the above concerns. No further information was presented prior to exit.	F 622		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.	F 645	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. A Preadmission Screening and Resident Review (PASARR) has been completed for Resident #23 on 09/02/2021 and remains at a Level 1. Facility was unable to retrieve original PASARR from former facility ownership. 2. An audit has been completed an audit of current residents Preadmission Screening and Resident Review (PASARR) to ensure that all residents have a PASARR on admission or within the first 30 days of admission. Those residents identified that do not have a PASARR evaluation on file will be resubmitted for a new PASARR screening. 3. Administrator/Designee has educated Social Worker(s) and Admission Director on the requirements of the Preadmission Screening and Resident Review (PASARR) on admission. 4. Administrator/Designee will audit each residents Preadmission Screening and Resident Review (PASARR) at the time of admission for four weeks and then quarterly thereafter. The	

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F 645	Continued From page 22 §483.20(k)(2) Exceptions. For purposes of this section- (i) The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and facility document review the facility staff failed to ensure that a Level I Preadmission Screening and Resident Review	F 645	Administrator/Designee will identify any issues, patterns, or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 09/23/2021	

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F 645	Continued From page 23	F 645		

(PASRR) was conducted prior to admission or within 30 days of admission to the nursing facility for 1 of 44 residents in the survey sample, Resident #23 with diagnoses of mental disorders.

The finding included:

Resident #23 was admitted to the nursing facility on 5/10/13 with diagnoses that included Bipolar Disorder, Anxiety Disorder, and Major Depressive Disorder.

Resident #23's most recent Minimum Data Set (MDS) was an annual assessment with an Assessment Reference Date (ARD) of 6/30/21. The Brief Interview for Mental Status (BIMS) was coded as a 14 out of a possible 15, indicating Resident #23 was cognitively intact and capable of daily decision making. Under Section A1500 Preadmission Screening and Resident Review (PASARR): Is the resident currently considered by the state level II PASRR process to have mental illness and/or intellectual disability or a related condition? Resident #23 was coded: No.

Upon review of the electronic medical record (EMR) a PASARR for Resident #23 could not be located.

On 9/2/21 at 8:50 A.M. an interview was conducted with the Social Worker regarding Resident #23's PASARR and if she was able to locate it. The Social Worker stated, "No, I wasn't able to locate it. I looked in the hard chart as well."

On 9/2/21 at 10:00 A.M. the Social Worker provided the surveyor with a PASARR that was completed on 9/2/21 indicating a Level II

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F 645	Continued From page 24 PASARR was not required. On 9/2/21 at 1:05 P.M. an interview was conducted with Director of Nursing regarding Resident #23"s PASARR and when should a PASARR screening be conducted. The Director of Nursing stated, "We are unable to locate {Name) Resident #23's PASARR. The resident should have had one completed before admission or one completed within 30 days of admission." The facility policy titled "Behavioral Assessment, Intervention and Monitoring" revised March 2019 was reviewed and is documented in part, as follows: Policy Statement: 1. The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. 4. Behavioral health services will be provided by qualified staff who have the competencies and skills necessary to provide appropriate services to the residents. Assessment: 1. As part of the initial assessment, the nursing staff and attending physician will identify individuals with a history of impaired cognition, altered behavior, substance use disorder, or mental disorder. a. All residents will receive a Level I PASARR screen prior to admission. b. If the level I screen indicates that the individual may meet the criteria for a mental disorder,	F 645		

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F 645	Continued From page 25 intellectual disability or related condition he or she will be referred to the state PASARR representative for the Level II (evaluation and determination) screening process. On 9/2/21 at 6:10 P.M. a pre-exit debriefing was conducted with the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Regional Director of Compliance where the above information was shared. No further information was provided prior to exit.	F 645		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Resident #1 was assessed by nursing staff and medical record reviewed. The residents care plan has been updated to reflect a current individualized plan of care. 2. The Director of Nursing/designee has performed an audit of all current residents' care plans. Care plans have been updated to ensure individualized needs are addressed appropriately and that results are being tracked and addressed appropriately. A process has been developed and implemented to identify resident care needs in the daily interdisciplinary team meeting, and to update the care plans to reflect the needs identified. 3. The Director of Nursing/designee has in-serviced nursing leadership and interdisciplinary team members regarding care plan updates. The in-service includes, but no limited to, the	

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F 657	Continued From page 26 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure an accurate oxygen therapy care plan for one of 49 sampled residents; Resident #1. The findings included: Resident #1 was admitted to the facility on 8/13/21 with diagnoses that included but were not limited to chronic respiratory failure with hypoxia (1), alcoholic cirrhosis of the liver with out ascites, anemia, chronic diastolic heart failure, and generalized edema. Resident #1's most recent Minimum Data Set (MDS) assessment was an admission assessment with an Assessment Reference Date (ARD) of 8/24/21. Resident #1 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status (BIMS) exam. Resident #1 was coded in Section O (Special Treatments, Procedures and Programs) as receiving oxygen therapy. Review of Resident #1's clinical record revealed the following oxygen orders: 1) "Oxygen at 3 lpm (liters per minute) via nasal cannula. Check oxygen setting every shift for accuracy." Review of Resident #1's oxygen care plan dated 8/18/21 documented the following: "(Name of Resident #1) has oxygen therapy r/t (related to)	F 657	importance of care plan reviews and updates with any changes for each resident and care plans being reflective of individualized care needs. 4. The Director of Nursing/designee will conduct an audit of 25% of resident care plans weekly for four weeks to ensure that interventions are appropriate and reflect the individual needs of each resident. The Director of Nursing/designee will also audit the care plans of any new admissions daily for six weeks to ensure that interventions are appropriate and reflect the individual needs of each resident. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to update the resident care plans. The Director of Nursing/designee will identify any trends and/or patters and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 10/15/2021	

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F 657	Continued From page 27 Respiratory failure, Chronic Obstructive Pulmonary Disease (COPD), and asthma...Oxygen settings: 02 via (nasal cannula) @ (at) (4) L (liters) (cont.) (continuous)." Review of a note from the Nurse Practitioner dated 8/31/21 documented in part, the following: "...Continue 2 L (liters) nasal cannula." On 8/31/21 at 3:18 p.m., an observation was made of Resident #1. Resident #1 was on 2 liters of oxygen via nasal cannula. On 9/1/21 at 8:17 a.m., an observation was made of Resident #1. Resident #1 remained on 2 liters of oxygen via nasal cannula. On 9/2/21 at 10:07 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #3, the unit manager. When asked how many liters of oxygen Resident #1 was supposed to be on, LPN #3 stated, "2 liters." When asked why Resident #1's orders documented 3 liters and her care plan documented 4 liters, LPN #3 stated that she wasn't sure, that 4 liters definitely was not appropriate for Resident #1 as she had COPD. LPN #3 then stated that 3 liters was even too high for Resident #1 due to her COPD diagnosis. When asked if Resident #1's care plan was accurate, LPN #3 stated that it was not accurate. When asked the purpose of the care plan, LPN #3 stated that the purpose of the care plan was to serve as a guideline of care for each resident based on diagnoses. On 9/2/21 at 11:24 a.m., further interview was conducted with LPN #3. LPN #3 confirmed that Resident #1 was to receive 2 liters of oxygen. LPN #3 presented this writer an admission report	F 657		

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F 657	Continued From page 28 sheet dated 8/13/21 documenting that Resident #1 was to receive 2 liters of oxygen via nasal cannula. LPN #3 also stated that the 4 liters on Resident #1's care plan was an error, that she had found out that a dietary aide had completed the oxygen care plan for Resident #1. When asked why a dietary aide was completing an oxygen care plan, LPN #3 stated that she was not sure. When asked if a dietary aide should be completing oxygen therapy care plans on any resident, LPN #3 stated no. A policy could not be provided regarding the above concern. (1) Hypoxia- Exists when there is a reduced amount of oxygen in the tissues of the body. This information was obtained from The National Institutes of Health. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=hypoxia.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and clinical record reviews, the facility's staff failed to ensure care and services were provided to meet professional standards of quality for 2 residents (Resident #30 and Resident #1) in the survey sample. The facility staff failed to obtain a physician's order prior to	F 658	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. A physician's order has been acquired for resident #30 to use a seat belt on his wheelchair. The resident's care plan has been updated to reflect a current individualized plan of care. 2. The Director of Nursing/designee has performed an audit of all current residents to identify residents using a seat belt on their wheelchair. Any residents identified as using a seat belt have had their physician's orders reviewed to ensure that an order is in	

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F 658	Continued From page 29 use of a seat belt for Resident #30, and to obtain daily weights as ordered by the physician for Resident #1. The findings included: 1. Resident #30 was originally admitted to the facility 7/1/21 and has not been discharged from the facility since this admission. The current diagnoses included; cerebral palsy with spastic hemiplegia and bilateral impairment of the upper and lower extremities. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/12/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #30's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring total care of two or more people with bed mobility, transfers, and toileting, total care of one person with dressing and bathing, extensive assistance of two or more people with personal hygiene extensive assistance of one person with eating, and supervision of two or more people with on unit locomotion. On 8/31/21 at approximately 3:05 p.m., Resident #30 was observed seated in a wheel chair and wearing a seat belt as he read. Section "P0100H" was coded for other restraint. On 9/1/21 at approximately 11:45 a.m., an interview was conducted with Resident #30. The resident stated he wears the seat belt when he is in the wheel chair because he experiences spasms related to the cerebral palsy. The resident further stated he would be afraid of	F 658	place for the seat belt. The care plans have been updated to reflect a current individualized plan of care. 3. The Director of Nursing/designee has educated licensed nursing staff of obtaining a physician's order for seat belt use. The in-service includes, but is not limited to, entering physician orders for restraining devices and ensuring that the devices are applied and used appropriately. 4. The Director of Nursing/designee will conduct an audit of all residents weekly for four weeks to ensure that any resident using a potentially restraining device has a physician's order for the device. The Director of Nursing/designee will also audit any new admissions daily for six weeks to ensure that physician's orders are in place for any newly admitted resident using a restraining device. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to update the physician's orders. The Director of Nursing/designee will identify any trends and/or patters and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 10/15/2021 This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. The medical records of resident #1	

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F 658	Continued From page 30 falling from the wheel chair when the spasms occur if he didn't have the seat belt. Review of Resident #30's care plan dated 7/12/21, revealed a problem which read; The resident uses physical restraints (seatbelt to wheelchair) per his request. The goal read; The resident will remain free of complications related to restraint use, including contractures, skin breakdown, altered mental status, isolation or withdrawal through review date, 10/12/21. The interventions included; Staff to release seatbelt every two hours for a minimum of 15 minutes. Review of the August and September 2021 physician order summary revealed no order for use of a seat belt. On 9/1/21 at approximately 12:05 p.m., an interview was conducted with Certified Nursing Assistant (CNA) #7. CNA #7 stated whenever Resident #30 is in the wheel chair the seat belt is buckled and if we forget he reminds us. On 9/2/21 at approximately at approximately 3:25 p.m., The Assistant Director of Nursing (ADON) was asked if she could identify where in the clinical record the order for the seat belt was located. Upon the ADON's return at approximately 4:30 p.m., she stated there was no order for the seat belt but it has been obtained and the new order was presented. On 9/2/21 at approximately 6:30 p.m., the above findings were shared with the Administrator, Interim Director of Nursing, The Assistant Director of Nursing and Regional Director of Compliance. An opportunity was offered to the facility's staff to present additional information but no additional	F 658	were reviewed and weights have been obtained per physician order. The resident's care plan has been updated to reflect a current individualized plan of care. 2. The Director of Nursing/designee has performed an audit of all current residents weight orders. Any weights not obtained per physician's orders have now been obtained and the provider and resident representative were made aware. The resident's care plans have been updated to reflect a current individualized plan of care. 3. The Director of Nursing/designee has educated licensed nursing staff on obtaining resident weights per physician's order. The in-service includes, but is not limited to, the importance of obtaining weights per physician orders and recording the weights properly in the EHR. 4. The Director of Nursing/designee will conduct an audit of all residents with weight orders weekly for four weeks to ensure that weights are obtained per physician orders. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to obtain the weights and re-educate staff. The Director of Nursing/designee will identify any trends and/or patters and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 10/15/2021	

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F 658	Continued From page 31 information was provided. 2. The facility staff failed to obtain physician ordered weights for Resident #9. Resident #9 was originally admitted to the facility 02/11/20 and never discharged from the facility. The current diagnoses included; Alzheimer's disease with Late Onset and Congestive Heart Failure. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 06/09/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 4 out of a possible 15. This indicated Resident #9 cognitive abilities for daily decision making were severely impaired. In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of two persons with bed mobility. Requiring limited assistance of two persons with transfers. Requiring limited assistance of one person with dressing, eating, toilet use, personal hygiene and bathing. The Care plan dated 3/30/21 reads: Resident has a potential for weight change related to her diagnosis of CHF (Congestive Heart Failure) with diuretic mediation use. Goal: Resident will not experience a significant unplanned weight change over the next review period. Interventions: Report if resident has presence of or change in edema. A review of the POS (Physicians Order Summary) date started 07/06/21 read that Resident #9	F 658		

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F 658	Continued From page 32 should receive daily weights upon rising. A review of Resident #9's weights show that multiple daily weights were missed in the clinical record for the months of July and August 2021 on the following dates: July 2021-07/10, 07/15, 07/16, 07/17, 07/24 and 07/31. August 2021-08/04, 08/05, 08/06, 08/07, 08/13, 08/14, 08/15, 08/21, 08/22, 08/26, 08/28, 08/29 and 08/30. On 9/02/21 at approximately 6:55 PM., an interview was conducted with CNA (Certified Nursing Assistant) #4. She stated, Resident #9 requires a Hoyer lift which means 2 staff members need to assist. To be honest, we don't always have two staff members available to help." On 09/02/21 at approximately 6:15 PM., the above findings were shared with the Administrator, the Director of Nursing and the Acting Director of Nursing. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure five of 49 sampled residents; Resident #62, #40, #72, #86, and 1 closed record	F 677	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Residents #62, #40, #72 and #86 were assessed and interviewed by nursing staff and interviewed by social services. The resident and provider were notified of bathing patterns and schedule. The resident plans of care were reviewed and updated to reflect their resident-specific needs.	

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F 677	Continued From page 33 resident, Resident #191, who were unable to carry out Activities of Daily Living (ADLs) received showers. The findings included: 1. Resident #62 was admitted to the facility on 7/9/21 with diagnoses that included but were not limited to stroke, atrial fibrillation, heart failure, diabetes mellitus, and renal insufficiency. Resident #62's most recent Minimum Data Set (MDS) assessment was an admission assessment with an assessment reference date (ARD) of 7/14/21. Resident #62 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the Brief Interview For Mental Status (BIMS) exam. Resident #62 was coded as requiring total dependence on two plus persons with transfers and bathing. On 8/31/21 at 2:03 p.m., an interview was conducted with Resident #62. When asked if she had received showers while at the nursing facility, Resident #62 stated that she had been at the facility for approximately 5 weeks and had yet to receive a shower. Resident #62 stated that she only received bed baths and was not sure why she hasn't been offered a shower. Resident #62 stated that it may have been due to two reasons; she was extensive assistance with bathing or that staff did not want her to get her right central line dressing (used for dialysis) wet. When asked if the facility shower rooms had shower chairs, Resident #62 stated that she was not sure. Resident #62 stated that she would love a shower to feel the water the on her back and to wash her hair. Resident #62 stated that she did not get her hair washed with bed baths. Resident #62 stated	F 677	2. Nursing staff performed assessments and interviews with residents and recorded results in medical record. Nursing has notified residents, responsible parties and provider of bathing patterns and schedule for residents. A resident council meeting was held in October 2021 to address resident bathing concerns. 3. The Director of Nursing/designee has in-serviced clinical nursing staff, including RNs, LPNs, CNA's and NAs regarding resident shower schedules and preferences. The in-service includes, but is not limited to, the importance of showers and regular bathing and providing regular showers to residents per the shower schedule. 4. The Director of Nursing/designee will meet with staff five times a week for 6 weeks to review showers, bathing, and honoring resident bathing preferences. The Director of Nursing/designee will audit ADL documentation and progress notes five times weekly for six weeks to ensure that showers and bathing are being completed per policy. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate action will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 10/15/2021	

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F 677	Continued From page 34 that she was not aware that she could request showers. Review of the facility's shower schedule revealed that Resident #62 was to receive showers on Wednesdays and Saturdays day shift; with Wednesday also being Resident #62's dialysis day with a chair time of 6 a.m. Review of Resident #62's care plan dated 7/22/21 documented the following for Activities of Daily Living (ADL) care: "(Name of Resident #62) has an ADL self-care performance deficit r/t (related to) CVA (Cerebrovascular Accident) (Stroke)/Hemiplegia (one sided weakness/paralysis), Impaired respiratory status, Impaired balance, Limited Mobility, Pain...(Name of Resident #62) requires extensive assistance and is sometimes dependent on staff for bathing/showering...Provide sponge bath when a full bath or shower cannot be tolerated." There was no evidence that Resident #62 was non-complaint or frequently refused showers on her care plan. Review of Resident #62's August 2021 ADL tracker for bathing failed to evidence that a shower was provided for the month of August. There was no evidence that Resident #62 had refused showers. On 9/1/21 at 9:38 a.m., observation was made of the shower room on the North Unit. There were approximately two shower chairs located in the shower room. On 9/2/21 at 10:07 a.m., an interview was conducted with Licensed Practical Nurse (LPN)	F 677		

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F 677	Continued From page 35	F 677		

#3, the Unit manager. When asked if Resident #62 was able to receive a shower, LPN #3 stated that she was able to go to the shower room. When asked why there was no evidence on her ADL tracker that she had ever received a shower for the month of August, LPN #3 stated that the resident frequently refused showers due to dialysis and feeling tired after dialysis. When asked if it made sense to change her shower schedule so that she could recieve her showers, LPN #3 stated, "Yes." LPN #3 stated that in point in August Resident #62 also had Shingles and was on precautions but that had ended on the 5th or 6th. LPN #3 stated that Resident #62 also refused showers due to residual pain from her shingles. When asked if all shower refusals should be documented, LPN #3 stated that it should. LPN #3 stated that there was an area on the ADL tracker to document refusals. When asked if shower refusals should be care planned if they are frequent, LPN #3 stated that it should be on the care plan. LPN #3 was made aware that there was no evidence of shower refusals in Resident #3's clinical record. When asked if hair can be washed while given a bed bath, LPN #3 stated that the facility utilized no rinse caps that released a cleansing solution to the hair and that the staff should be using those if a resident requests their hair to be washed.

On 9/2/21 at 11:42 a.m., further interview was conducted with LPN #3. LPN #3 that she also did not see anything regarding Resident #62 refusing showers.

On 9/2/21 at 11:51 a.m., an interview was conducted with Certified Nursing Assistant (CNA) #5, a CNA who frequently works with Resident #62. When asked how often showers were

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F 677	Continued From page 36 offered to residents, CNA #5 stated generally twice weekly. When asked the process if a resident refuses a shower, CNA #5 stated that she will document refusals on the assignment sheets. When asked if Resident #62 received showers, CNA #5 stated, "She hasn't been taking them." When asked why Resident #62 has not been taking her showers, CNA #5 stated, "She has been refusing them." When asked if refusals should also be documented on the ADL tracker in the computer system, CNA #5 stated that she only documented on the assignment or the shower sheets. When asked why Resident #5 had been refusing her showers, CNA #5 stated that sometimes Resident #62's showers were also on her dialysis days and that the resident was given bed baths prior to dialysis on the 11 p.m. to 7 a.m. shift and then she felt too weak and tired to take a shower after dialysis. When asked if anyone had thought to change Resident #62's shower schedule around to ensure she recevied showers on non-diaylsis days, CNA #5 stated that there were no changes to her shower schedule. CNA #5 stated that the resident "never voiced ever really wanting a shower." CNA #5 denied using shower caps to wash Resident #62's hair. On 9/2/21 Resident #62's shower skin sheets and shower assignment sheets could not be presented prior to exit. On 9/2/21 at 6:30 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the acting Director of Nursing (DON), ASM #3 the Assistant Director of Nursing (ADON) and ASM #4 the Regional Director of Compliance were made aware of the above concerns.	F 677		

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F 677	Continued From page 37 2. Resident #40 was admitted to the facility on 7/12/21 and have never been discharged from the facility. The current diagnoses included; Cerebrovascular Disease and Chronic Kidney Disease Stage 3. The current Minimum Data Set (MDS), an Admissions assessment with an Assessment Reference Date (ARD) of 07/16/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #40 cognitive abilities for daily decision making were severely impaired. In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of two people with bed mobility, transfers and toilet use. Requires extensive assistance of one person with dressing, eating and personal hygiene. Total dependence of one person with bathing. The care plan dated on 07/28/21 reads: The resident is: independent/dependent on staff for meeting emotional, intellectual, physical, and social needs. Interventions: The resident needs assistance. During the initial tour on 08/31/21 at approximately 2:45 PM Resident #40 was observed resting quietly in bed. A review of the shower assignment schedule for Resident #40 reveals: For the month of August 2021, Resident #40 only received bed baths. No showers were given on her scheduled shower days.	F 677		

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F 677	Continued From page 38	F 677		

On 9/02/21 at approximately 6:55 PM an interview was conducted with CNA (Certified Nursing Assistant) #4 concerning resident showers. She stated, "To be honest, We don't always have the staff available to help."

3. Resident #72 was originally admitted to the facility 07/12/19 and re-admitted on 7/25/19 from an acute care facility. The current diagnoses included; Difficulty in Walking and Muscle weakness.

The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 08/11/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #72 cognitive abilities for daily decision making were intact.

In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of two persons with bed mobility. Requires extensive assistance of one person with dressing. Requiring total dependence of one person with toilet use, personal hygiene and bathing.

The care plan reads: Resident #72 has a self-care performance deficit. Goal: Resident #72 will maintain her current level of function through the review date.

On 09/01/21 at approximately 2:09 PM during the initial tour Resident #72 was observed sitting in her wheel chair in her room. She stated," I get a bath and shower but don't know when." The surveyor reassured her that she would check the shower assignment book and get back with her."

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F 677	Continued From page 39 A review of the shower assignment document reveal that Resident #72 receives showers on Tuesday and Friday evenings. The ADL documentation for the month of August (2021) show that no showers were given. On 9/02/21 at approximately 6:55 PM an interview was conducted with CNA (Certified Nursing Assistant) #4 concerning resident showers. She stated, "To be honest, We don't always have the staff available to help." 4. Resident #86 was admitted to the facility on 07/06/20 and readmitted on 02/03/21. Diagnosis for Resident #86 included but not limited to Muscle Weakness and Schizoaffective Disorder. The current Minimum Data Set (MDS), a Quarterly assessment with an Assessment Reference Date (ARD) of 03/10/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of 15. This indicated Resident #86 cognitive abilities for daily decision making were intact. In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of two persons with bed mobility, transfers and dressing. Requires extensive assistance of one person for toilet use, personal hygiene and bathing. Requires supervision with eating, set-up help only. The care plan reads: Resident #86 has an ADL (Activities of Daily Living) self- care performance deficit r/t (relating/ to) fatigue, impaired balance, limited mobility. Resident #86 will maintain current level of function through the next review date. Intervention: Bathing/Showering avoid scrubbing	F 677		

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F 677	Continued From page 40 and pat dry sensitive skin. A review of the shower assignment document reveal that Resident #86 receives showers on Wednesdays and Saturdays, Day Shift. The ADL documentation for the month of August (2021) show that no showers were given. On 08/31/21 at approximately 2:25 PM during the initial tour Resident #86 stated, "I've had 4 showers since July last year. My shower days are on wednesday and Saturdays. I would rather be in the shower to get my hair washed and conditioned. a Nurse Practitioner was doing my hair until COVID-19 hit." On 09/02/21 at approximately 4:45 PM an interview was conducted with Resident #86 concerning showers. She states that she doesn't get showers because the staff tells her they are short staffed. On 09/02/21 at approximately 2:00 PM an interview was conducted with CNA (Certified Nursing Assistant) #2 concerning Resident #86 receiving showers. She stated, "Resident #86 receives showers on Wednesday and Saturdays and on dialysis days she will get a shower in the evening. If they refuse anything we always let the nurse no about it. She does refuse showers sometimes." 5. Resident #191 was admitted to the facility on 07/15/19 and readmitted on 09/12/20. Diagnosis for Resident #191 included but not limited to Adult Failure to Thrive and Anxiety Disorder. The current Minimum Data Set (MDS), a	F 677		

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F 677	Continued From page 41	F 677		

Quarterly assessment with an Assessment Reference Date (ARD) of 03/17/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 99 out of a possible 15. This indicated Resident #191 cognitive abilities for daily decision making were severely impaired.

In section "G"(Physical functioning) the resident was coded as being totally dependent of one person with bed mobility, dressing, eating, personal hygiene, toilet use and bathing.

The care plan dated 03/23/21 reads: Resident #191 requires assistance with ADLs. Goal: Resident will be clean and dressed appropriately. Interventions: Assist Resident #191 in ADLs as needed.

On 09/02/21 at approximately 9:10 AM an interview was conducted with LPN (Licensed Practical Nurse) #4 concerning Resident #191. She stated, "According to the shower assignment sheet Resident #191 should have received showers on Saturday and Wednesday. This assignment sheet has since changed."

On 09/02/21 at approximately 9:55 AM an interview was conducted with LPN #4 concerning showers. She stated, "She received very good bed baths."

On 09/02/21 at approximately 3:00 PM a phone call was received from LPN #2 concerning Resident #191. She stated, "We gave her the best care we could give her. She did not want showers. The girls gave her a bed bath at night."

A review of the shower assignment document

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F 677	Continued From page 42 read that Resident #191 receives showers on Wednesdays and Saturdays. The ADL documentation for the month of April (2021) show that no showers were given. On 09/02/21 at approximately 6:15 PM., the above findings were shared with the Administrator, the Director of Nursing and the Acting Director of Nursing. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 677		
F 679 SS=E	Complaint Deficiency Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and facility document review the facility staff failed to ensure that 1 of 44 residents (Resident #32) in the survey sample was provided ongoing resident centered activity services based on the resident's activity preferences from May through August of 2021.	F 679	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be constructed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Resident #32 was reassessed for activity preferences and their care plan was updated. 2. An audit has been performed on all bed bound residents to ensure that their activity preferences are being met as well as updating their activity preferences if there are any new activity preferences. Activity preferences will be updated in their care plan. 3. Administrator/Designee has educated the Activities Director on the importance of offering activities and adhering to residents' activity preferences of all residents and especially ones that are bed bound.	

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F 679	Continued From page 43 The findings included: Resident #32 was admitted to the facility on 1/8/2014 with diagnoses to include but not limited to Dementia, Major Depressive Disorder and Anxiety Disorder. Resident #32's most recent comprehensive Minimum Data Set (MDS) was an annual assessment with an Assessment Reference Date (ARD) of 4/21/21. The Brief Interview for Mental Status (BIMS) was coded as a 15 out of a possible 15 indicating Resident #32 was cognitively intact and capable of daily decision making. Under Section F Preferences for Customary Routine and Activities, F0500 Interview for Activity Preferences Resident #32 was coded as follows: While you are in the facility.....B. how important is it to you to listen to music you like? Coded 2 (somewhat important); C. how important is it to you to be around animals such as pets? Coded 1 (very important); D. how important is it to you to keep up with the news? Coded 1 (very important); F. how important is it to you to do your favorite activities? Coded 2 (somewhat important); H. how important is it to you to participate in religious services and practices? Code 1 (very important). Resident #32's comprehensive Care Plan last revised 7/15/21 was reviewed and is documented in part, as follows: Problems: Name (Resident #32) is at risk for social activity deficit related to loss in physical functioning as exhibited by decreased ability to participate in usual activities, declines to get out of bed, reluctant to participate. Status: Active	F 679	4. Activities Director/Designee will audit bed bound resident satisfaction to activities for four weeks and then quarterly thereafter. The Activities Director/Designee will identify any issues, patterns, or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 09/23/2021	

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F 679	Continued From page 44 Effective 12/20/2016-Present. Goal: Name (Resident #32) will interact with staff, volunteer or other residents by verbalizing 1-2 words and changing expressions during 2 visits a week X 90 days. Date Initiated: 12/20/2016. Interventions: -Ask questions promoting positive responses. Date Initiated: 12/20/2016. -Have volunteer from catholic church visit. Date Initiated: 12/20/2016. -Provide visits by friends, staff or other residents for social contact, offer reading, prayers, talking. Date Initiated: 12/20/2016. -When available use volunteers for additional activity support. Date Initiated: 12/20/2016. Disciplines: Activity Therapist. On 8/31/21 at 1:46 P.M. Resident #32 was observed in her room lying in bed. The window blinds were closed and there was no television on or music playing. I introduced myself to the resident and made her aware we were doing the annual survey for the facility. Resident #32 was asked what types of activities she enjoyed doing or have recently participated in. Resident #32 offered no return verbal response to any questions asked but did make eye contact. On 9/1/21 at 11:00 A.M. Resident #32 was observed lying in bed in her room. The window blinds were closed and the room lights were off. No television was on. The bedside table was inspected and revealed no radio, tape recorder or other form of music producing equipment. Resident #32 was again asked what types of activities she enjoyed doing or have recently	F 679		

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F 679	Continued From page 45	F 679		

participated in. Resident #32 offered no return verbal response to any questions asked but did make eye contact.

On 9/1/21 at 5:00 P.M. Resident #32 was observed lying in bed in her room. Resident #32 was asked if she had participated in any activities today. Resident #32 offered no verbal response, however continued to make eye contact. The window blinds were still closed and there were no room lights on. The television was not on and there was no music playing.

During the survey no staff members were observed providing or engaging Resident #32 in activities based on documented preferences.

On 9/1/21 the Activities Director was asked for the Activity Documentation Records for activities completed with Resident #32 from May through August 2021. The Activity Documentation Records for Resident #32 from May through August 2021 were reviewed. The Activity Documentation Records indicated that in May, July and August 2021 no activities were provided to Resident #32. In June 2021 Resident #32 was provided activities on the 14th and the 28th to include a room visit.

On 9/2/21 at 11:04 A.M. an interview was conducted with the Activities Director regarding Resident #32's Activity Documentation Records, activity preferences and goals referenced in the comprehensive care plan. The Activities Director was asked what were Resident #32's activity preferences. The Activities Director stated, "I just took over as the Activity Director, I was the assistant. I have not done an activities preference interview with her yet." The Activity

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F 679	Continued From page 46 Director was asked what activities were provided to Resident #32 from May through August 2021. The Activities Director stated, "In May there were no visits. In June I did a room visit on the 14th, I read her a bible script and on the 24th I went in to detangle her hair. In July and August I did not do any activities with her." Resident #32's current activity care plan to include goals and interventions was reviewed with the Activities Director. The Activities Director stated, "I was not aware of her care plan interventions for activities. I do plan activities if I am aware. Going forward, I will see her once a week and do a bible study, gospel songs, or just sit and talk to her." On 9/2/21 at 1:10 P.M. an interview was conducted with the Director of Nursing where the above information was shared. The Director of Nursing stated, "She (Resident #32) is not mobile and does not leave her room. The Activities Director should have been doing room visits with the resident at least once a week or more and providing activities based on the resident's preferences." The facility policy titled "Activity Programs" revised June 2018 was reviewed and is documented in part, as follows: Policy Statement: Activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident. Policy Interpretation and Implementation: 2. Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident.	F 679		

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F 679	Continued From page 47 On 9/2/21 at 6:10 P.M. a pre-exit debriefing was conducted with the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Regional Director of Compliance where the above information was shared. No further information was provided prior to exit.	F 679		
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, it was determined that facility staff failed to clarify orders for the use of oxygen AND failed to follow oxygen orders for one of 49 residents in the survey sample, Resident #1. The findings included: Resident #1 was admitted to the facility on 8/13/21 with diagnoses that included but were not limited to chronic respiratory failure with hypoxia (1), alcoholic cirrhosis of the liver with out ascites, anemia, chronic diastolic heart failure, and generalized edema. Resident #1's most recent Minimum Data Set (MDS) assessment was an admission assessment with an Assessment Reference Date (ARD) of 8/24/21. Resident #1	F 695	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Oxygen orders for resident #1 have been reviewed and clarified and the resident is receiving the correct amount of oxygen per the provider's orders. The resident's plan of care was reviewed and updated to include resident-specific needs. 2. An observation audit of resident oxygen administration amounts was performed on all residents receiving oxygen and the amounts were compared to the provider's orders. Any discrepancies were immediately corrected and orders were verified or clarified with the provider. 3. The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) regarding oxygen amounts administered to residents. The in-service includes, but is not limited to, the importance of administering oxygen per provider's orders and clarifying oxygen orders if there is any variance between what is ordered and what is stated elsewhere in the medical record.	

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F 695	Continued From page 48 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status (BIMS) exam. Resident #1 was coded in Section O (Special Treatments, Procedures and Programs) as receiving oxygen therapy. Review of Resident #1's clinical record revealed the following oxygen orders: 1) "Oxygen at 3 lpm (liters per minute) via nasal cannula. Check oxygen setting every shift for accuracy. 2) Change and label oxygen tubing, humidifier bottle, and masks weekly every night shift every Sat (Saturday) for infection control." Review of Resident #1's oxygen care plan dated 8/18/21 documented the following: "(Name of Resident #1) has oxygen therapy r/t (related to) Respiratory failure, Chronic Obstructive Pulmonary Disease (COPD), and asthma...Oxygen settings: 02 via (nasal cannula) @ (at) (4) L (liters) (cont.) (continuous)." Review of a note from the Nurse Practitioner dated 8/31/21 documented in part, the following: "...Continue 2 L (liters) nasal cannula." On 8/31/21 at 3:18 p.m., an observation was made of Resident #1. Resident #1 was on 2 liters of oxygen via nasal cannula. Resident #1's oxygen tubing and humidifier bottle was labeled "8/22" (changed over a week ago). On 9/1/21 at 8:17 a.m., an observation was made of Resident #1. Resident #1 remained on 2 liters of oxygen via nasal cannula. Resident #1's oxygen tubing and humidifier bottle was labeled	F 695	4. The Director of Nursing/designee will perform an observation audit of oxygen orders compared to amounts administered weekly for six weeks to ensure that oxygen is being administered as per the provider orders. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 10/15/2021	

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F 695	Continued From page 49 "8/22" (changed over a week ago). On 9/2/21 at 10:07 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #3, the unit manager. When asked how often oxygen tubing and the humidifier bottle was to be changed, LPN #3 stated, "Weekly." When asked the purpose for changing oxygen tubing and the humidifier bottle on a weekly basis, LPN #3 stated, "For Infection Control. Bacteria breeds in warm, moist environments." When asked the last time Resident #1's oxygen tubing and humidifier bottle was changed, LPN #3 stated it would be the date that is documented on the tubing and bottle. When asked if "8/22" was over a week ago, LPN #3 stated that it was, that the bottle and tubing should have been changed over the past weekend. When asked how many liters of oxygen Resident #1 was supposed to be on, LPN #3 stated, "2 liters." When asked why Resident #1's orders documented 3 liters and her care plan documented 4 liters, LPN #3 stated that she wasn't sure, that 4 liters definitely was not appropriate for Resident #1 as she had COPD. LPN #3 then stated that 3 liters was even too high for Resident #1 due to her COPD diagnosis. When asked if it was possible that a nurse could bump up Resident #1's oxygen to 3 liters being that there was an order for 3 liters, LPN #3 stated that it was possible. When asked if it was important for Resident #1's oxygen orders to be clarified, LPN #3 stated that it was. On 9/2/21 at 11:24 a.m., further interview was conducted with LPN #3. LPN #3 confirmed that Resident #1 was to receive 2 liters of oxygen. LPN #3 presented this writer an admission report sheet dated 8/13/21 documenting that Resident #1 was to receive 2 liters of oxygen via nasal	F 695		

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F 695	Continued From page 50 cannula. LPN #3 also stated that the 4 liters on Resident #1's care plan was an error, that she had found out that a dietary aide had completed the oxygen care plan for Resident #1. When asked why a dietary aide was completing an oxygen care plan, LPN #3 stated that she was not sure. When asked if a dietary aide should be completing oxygen therapy care plans on any resident, LPN #3 stated no. On 9/2/21 at 12:00 p.m., a third observation was made of Resident #1. Her oxygen tubing and humidifier bottle still read "8/22." On 9/2/21 at 6:30 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the acting Director of Nursing (DON), ASM #3 the Assistant Director of Nursing (ADON) and ASM #4 the Regional Director of Compliance were made aware of the above concerns. Facility policy titled, "Oxygen Administration" documents in part, the following: "The purpose of this procedure is to provide safe oxygen administration...Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident..." (1) Hypoxia- Exists when there is a reduced amount of oxygen in the tissues of the body. This information was obtained from The National Institutes of Health. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=hypoxia.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		

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F 698	Continued From page 51 §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, facility document review and clinical record review, it was determined that the facility staff failed to coordinate care with the dialysis center for one of 49 sampled residents, Resident #62. The findings included: Resident #62 was admitted to the facility on 7/9/21 with diagnoses that included but were not limited to stroke, atrial fibrillation, heart failure, diabetes mellitus, and renal insufficiency requiring hemodialysis (1). Resident #62's most recent Minimum Data Set (MDS) assessment was an admission assessment with an assessment reference date (ARD) of 7/14/21. Resident #62 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the Brief Interview For Mental Status (BIMS) exam. Review of Resident #62's August 2021 Physician Order Summary (POS) documented the following order: "Dialysis - M,W,F...chair time 6 a.m." Review of Resident #62's care plan dated 7/27/21 documented in part, the following: "(Name of Resident #62) needs hemodialysis r/t (related to) renal failure. (Name of Resident #62) will have no s/sx (signs/symptoms) of complications from	F 698	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Dialysis assessments and communication with the dialysis center has been established for resident #62. The resident's plan of care was reviewed and updated to reflect their resident-specific needs. 2. The Director of Nursing/designee has identified all current residents receiving hemodialysis and has established resident assessments and communication with the dialysis center. Nursing staff has ensured that care plan interventions are appropriate and address resident specific care needs. 3. The Director of Nursing/designee has educated licensed clinical staff regarding dialysis assessment and communication with dialysis centers. The education includes, but is not limited to, the importance of assessing residents pre and post-dialysis, and the importance of sending and receiving resident information to and from the dialysis center. 4. The Director of Nursing/designee will review residents receiving hemodialysis weekly for six weeks to ensure that proper assessments were performed, and that communication has been sent to and received from dialysis centers. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of	

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F 698	Continued From page 52 dialysis through next review date..,Resident receives dialysis Mon, Wed, Friday at (Name of Company)..." Review of Resident #62's "Dialysis communication book" revealed that on two occasions only: 8/16/21 and 8/30/21 staff had filled out the "Pre-Dialysis Facility Assessment" on her "Dialysis Information Sheet" recording Resident #62's vital signs pre dialysis and the appearance of her right Central Venous Line (CVL). The "Dialysis Assessment" section (to be completed by the nurses at the dialysis center) was left blank. The "Post dialysis Assessment-upon return to the facility" (to be completed by the nursing facility nurses) was also left blank. Resident #62 was also missing "Dialysis Information Sheets" for the following dates that she had been to dialysis: "8/20/21, 8/23/21, 8/28/21, 8/30/21 and 9/1/21." Dialysis pre-assessments from facility staff could not be found for Resident #62 on 8/20/21, 8/23/21, 8/28/21, and 9/1/21 in her clinical record. Further review of Resident #62's clinical record revealed that facility staff were monitoring Resident #62's vital signs and access site post dialysis- upon return the facility but were not recording that information on the "Dialysis Information Sheets." The facility could not provide any assessments of Resident #62's vitals signs and weights while at Dialysis for the above dates. On 9/2/21 at 12:15 p.m., an interview was	F 698	Nursing/designee will identify any trends and/or patterns, and provide education as needed on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 10/15/2021	

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F 698	Continued From page 53	F 698		

conducted with Licensed Practical Nurse (LPN) #3, the unit manager. When asked the process for communicating vital signs, weights, assessments for residents receiving dialysis with the dialysis provider, LPN #3 stated that each resident is sent to dialysis with a "Dialysis Communication Book." LPN #3 stated that first, facility nurses should be filling out a pre-dialysis assessment including vital signs and an assessment of the access site. LPN #3 stated that the nurses at the dialysis center are also requested to fill out pre-dialysis and post dialysis assessments, including weights. LPN #3 stated that upon return to the nursing facility, the facility nurses are also required to fill out a post dialysis assessment. When asked the process if the resident is sent back to the nursing facility with nothing documenting from the dialysis center on the "Dialysis Information Sheet," LPN #3 stated, "They never do." LPN #3 stated, "We do our part." LPN #3 then stated that sometimes the "Dialysis Communication Book" is also not sent back with the resident to the nursing facility. When asked what she expected her nurses to do to obtain that information, LPN #3 stated, "I mean they could call." When asked if nurses should be calling the dialysis center to obtain the resident's assessments from dialysis, LPN #3 stated that they should be. When asked why it was important to know the status of each dialysis resident while at dialysis, LPN #3 stated that it was important because dialysis residents were very fragile and that dialysis not only flushes out toxins but vital nutrients in the resident's body. LPN #3 was also made aware that pre-dialysis assessments for Resident #62 could not be found in her clinical record for the above dates prior to dialysis.

On 9/2/21 at approximately 2:00 p.m., further

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F 698	Continued From page 54 Interview was conducted with LPN #3. LPN #3 stated that she was just made aware that the 11 p.m. to 7 a.m. shift nurse was not sending the "Dialysis Communication Book" with the resident to Dialysis. LPN #3 stated that she needed to investigate further to determine why that was not occurring. On 9/2/21 at 6:30 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the acting Director of Nursing (DON), ASM #3 the Assistant Director of Nursing (ADON) and ASM #4 the Regional Director of Compliance were made aware of the above concerns. A policy could not be provided regarding the above concerns. No further information was presented prior to exit.	F 698		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents'	F 726	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Calibration was immediately performed on the glucometer used on resident #18 and the glucometer was found to be within manufacturer specifications for calibration. A blood glucose reading was taken on resident #18 and the resident's reading was recorded in the medical record. 2. Calibration was performed on all facility glucometers and all glucometers were found to be within manufacturer specifications for calibration. A system was developed within the facility to	

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F 726	Continued From page 55 needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and facility document review it was determined that the facility staff failed to ensure nurses were competent in calibrating their recently acquired Blood Glucose Monitoring System (1) (glucose meter) per policy and manufacturers recommendations. The findings included: On 8/31/21 at approximately 4:30 p.m., an interview was conducted with Resident #18, a current sampled resident. Resident #18 had stated that the glucometer machines were cheap and not accurate. Resident #18 stated that approximately one month ago, a nurse was taking her blood sugar reading (2) when it read at a level of 200 (milligrams per deciliter (mg/dL). Resident #18 stated that she did not eat that much that day and her blood sugar never ran that high. Resident #18 asked the nurse to go get a different glucometer (glucose meter). Resident #18 stated that her second reading with the new glucometer	F 726	ensure that daily calibrations are being performed on all glucometers in use. 3. Licensed staff were educated on calibration of the Assure Platinum Glucometer utilizing the manufacturer's guidelines and on the facility's system for calibrating glucometers. The training included a demonstration of glucometer calibration per manufacturer's guidelines and the employee's responsibilities in performing daily glucometer calibration. 4. The Director of Nursing/Designee will perform an audit of glucometer calibration logs five times weekly for six weeks to assure that all facility glucometers are cleaned per manufacturer's guidelines. The Director of Nursing/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. Date of Compliance: 10/15/21	

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read at a level of 97 mg/dL. Resident #18 could not recall the day or the nurse who had obtained her blood sugar levels. Resident #18 stated that she asked the nurse how often the glucometers were calibrated and the nurse told her once on the 11 p.m. to 7 a.m. shift. Resident #18 stated that she believed this was not happening. Resident #18's most recent Minimum Data Set (MDS) Assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 6/25/21. Resident #18 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status Exam (BIMS).

On 9/2/21 at 2:54 p.m., an interview was conducted with Licensed Practical Nurse #6, an 11 p.m. to 7 a.m. shift nurse that happened to be in the facility at the time. LPN #6 was a nurse of the 100 hall unit. When asked if she could show this writer her logs of each time the glucometer controls were checked on the 11-7 shift; LPN #6 stated that the nurses haven't been calibrating or checking the controls. When asked why this was not being done, LPN #6 stated that they didn't have the solution to check the controls on the glucometer. LPN #6 stated that when the facility changed companies back in February, the old company took all their glucometers that were able to be updated or calibrated electronically on the 11-7 shift. LPN #6 stated that the facility Administrator had to run out to the local drug store to buy the "(Brand Name)" glucometers. LPN #6 stated that she never recalled solution being available to run controls on the glucometers. LPN #6 also denied ever asking if they could obtain solution or if they as nurses should be calibrating the machine. When clarified that the current glucometers have not been

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F 726	Continued From page 57 calibrated or checked since February 1st, 2021; then the company changed over, LPN #6 confirmed that was the case. LPN #6 could not provide any logs for both medication carts and machines on the 100 hall unit. On 9/2/21 at approximately 3:00 p.m., several surveyors checked the glucometer control logs for the 200 hall and the North unit. Staff could not show evidence that the controls were being checked on the 11-7 shifts for the glucometers on these units. On 9/2/21 at 3:29 p.m., an interview was conducted with Other Staff Member (OSM) #3, the Assistant Director of Nursing. OSM #3 stated that the glucometer control checks should be done nightly by the 11-7 shift nurses. OSM #3 stated that it was not being done and that she could not provide any evidence that these checks were being done. When asked why the glucometer control checks were not being completed, OSM #3 stated that before the company change over, the facility had docking stations for the glucometers that would do automatic updates to the glucometers. OSM #3 stated that when the company changed over, the old company came in and took all the old glucometers and that the facility administrator went out and bought six glucometers "(brand name)" brand from the local drug store. OSM #3 stated that this occurred on 2/1/21. OSM #3 stated that when you buy glucometers from the local drug store, they usually come with solution. OSM #3 stated that she would expect to see some control checks. OSM #3 then stated that she could not find the original boxes that the glucometers came in to see if the solution was in there.	F 726		

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F 726	Continued From page 58	F 726		

When asked during the above interview if any education was done with the nurses regarding the use of the "(brand name)" glucometers, OSM #3 stated that she would think so but that she was not sure; that she had a nurse educator at that time who is no longer employed. OSM #3 stated that she would try to find any education that was done with the nurses. When asked the consequences if the glucometers controls are not checked every day, OSM #3 stated, "If we don't calibrate, we are not getting an accurate reading of blood sugar." OSM #3 then stated nurses may not be giving the right amount of insulin if the blood sugar readings were inaccurate. When asked if central supply personnel was available, OSM #3 stated that she was on vacation but that she would try to get in touch with her.

On 9/2/21 at 4:00 p.m., OSM #3 was able to present to this writer that solution to check the glucometer controls was available in the building and in the central supply closet. OSM #3 stated that she could not find any evidence that the nurses were ever educated when the glucometers had changed to the "(Brand name)."

On 9/2/21 at 4:15 p.m., blood sugar spot checks of two sampled residents (Resident #90 and #10). Resident #90 was conducted with Licensed Practical Nurse #4 on the 100 hall unit. Resident #90 and Resident #10 was checked on the 200 hall unit. A blood sugar check was first conducted with the glucometer un-calibrated and then taken again calibrated. There were no concerns or major discrepancies between the two readings.

On 9/2/21 at 6:30 p.m., Administrative Staff

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F 726	Continued From page 59 Member (ASM) #1, the Administrator, ASM #2, the acting Director of Nursing (DON), ASM #3 the Assistant Director of Nursing (ADON) and ASM #4 the Regional Director of Compliance were made aware of the above concerns. Review of the "(Brand Name)" Manufacturers Instructions documented in part, the following: "...Use Control Solution Before testing with the meter for the first time. When you open a new bottle of test strips. When you suspect the meter or test strips may not be functioning properly. Each time the batteries are changed...When set to "On", the reminder will prompt you to do a control solution test every 24 hours." Facility policy titled, "Obtaining a Fingerstick Glucose Level" documents in part, the following: "Ensure that the equipment and devices are working properly by performing any calibrations or checks as instructed by the manufacturer or this facility." (1) The "(Brand name)" (Glucose Meter) is intended for the quantitative measurement of glucose in fresh capillary whole blood from the fingertip. Testing is done outside the body. It is indicated for use by healthcare professionals in a clinical setting, or at home by persons with diabetes, as an aid to monitor the effectiveness of diabetes control. This information was obtained from the Manufacture's instructions. (2) Blood Sugar - "Blood sugar, or glucose, is the main sugar found in your blood. It comes from the food you eat, and is your body's main source of energy. Your blood carries glucose to all of your body's cells to use for energy...Diabetes is a	F 726		

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F 726	Continued From page 60 disease in which your blood sugar levels are too high...If you do have diabetes, it is very important to keep your blood sugar numbers in your target range...The American Diabetes Association (ADA) generally recommends the following target blood sugar levels: Between 80 and 130 milligrams per deciliter (mg/dL) or 4.4 to 7.2 millimoles per liter (mmol/L) before meals Less than 180 mg/dL (10.0 mmol/L) two hours after meals." This information was obtained from The National Institutes of Health. https://www.mayoclinic.org/diseases-conditions/diabetes/in-depth/blood-sugar/ART-20046628?p=1.	F 726		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Resident #23 has been assessed by nursing staff and provider with no negative outcomes noted. The resident, resident representative, and provider were notified of missing doses. Plan of care was reviewed and updated for individualized care needs. The missing medications were obtained and were administered to resident #23 per the provider's orders. 2. The Director of Nursing/designee has performed an audit of all medications administered by nursing staff since 9/1/2021. Any resident who has missed an administration of a medication has been assessed by nursing staff and the provider and resident representative have been notified. Plans of care have been reviewed and updated for individualized care needs.	

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F 755	Continued From page 61 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility staff failed to procure medications (hydrocortisone cream and scheduled topical pain relief medication) timely for one resident (Resident #23) in a survey sample of 49 residents. The findings included: Resident #23 was admitted to the facility on 05/10/13 and never discharged from the facility. Diagnosis for Resident #23 included but not limited to; Major Depressive Disorder and Anxiety Disorder. The current Minimum Data Set (MDS), an Annual assessment with an Assessment Reference Date (ARD) of 06/30/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15 indicating resident is cognitively intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of two persons with bed mobility. Requiring extensive assistance of one person with dressing, toilet use and personal hygiene. Requiring limited assistance of one person with eating. Requiring	F 755	3. The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) regarding process for when a medication is not available. The in-service includes, but is not limited to, notification to provider for new orders, accessing the STAT box, using a back-up pharmacy if medications are unavailable from the primary pharmacy, and reporting any concerns to the nursing supervisor. 4. The Director of Nursing/designee will audit the MAR five times weekly for 6 weeks to review medication availability, accurate documentation, and provider notification. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to employees on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 10/15/2021	

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F 755	Continued From page 62 total dependence of one person with bathing. Requiring total dependence of two persons with transfers. The Care Plan reads: Resident #23 has chronic pain r/t (relating/to) neuropathy. Goals: The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date of 9/02/21. The resident will not have discomfort related to side effects of analgesia through the review date of 9/02/21. Interventions: The resident's pain is alleviated/relieved by: ordered medications and repositioning. A review of Resident #23's physician order summary reads: Bengay Ultra Strength Cream 4-10-30%. Apply to affected areas topically two times a day for pain. (Sites: Left Ankle, Left Knee and Lower Back). Order Date: 01/25/2019. Start Date: 02/01/21. Hydrocortisone Cream 1% apply to Bilateral Lower Legs topically one time a day for Eczematic Dermatitis after A.M. care. Order Date: 08/29/18. Start Date: 02/02/21. A review of the MAR (Medication Administration Record) reveal that Resident #23 did not receive the following scheduled medications on 09/02/21 at 9:00 AM: Bengay Ultra Strength Cream 4-10-30% and Hydrocortisone Cream 1%. On 09/02/21 at approximately 9:30 AM during the medication observation pass LPN (Licensed Practical Nurse) #7 stated that she was going to check the treatment cart to see if Resident#23 had more Bengay and Hydrocortisone Cream	F 755		

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F 755	Continued From page 63 because she could not find the medication in her medication cart. Upon inspection of the treatment cart LPN #7 stated, "Resident #23 has between 8:00 AM and 10:00 AM to get his creams. I'm ordering it now. It's not available." LPN #7 also informed Resident #23 that she would have to order more Bengay and Hydrocortisone creams for his legs. He nodded his head in agreement. On 9/02/21 at approximately 9:55 AM an interview was conducted with the unit manager (LPN #4) concerning Resident #23's medications. She stated, "The nurses should be re-ordering the creams before they run out of it." On 09/02/21 at approximately 5:56 PM an interview was conducted with Resident #23 concerning his medications. He stated, "They didn't get it yet." A review of progress notes reveal the Bengay Ultra Strength Cream 4-10-30% and the Hydrocortisone Cream 1% was ordered on 09/02/21 at 10:05 AM. Medication on order, provider notified and hold order was received. On 09/02/21 at approximately 6:15 PM., the above findings were shared with the Administrator, the Director of Nursing and the Acting Director of Nursing. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements.	

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F 760	Continued From page 64 medication errors. This REQUIREMENT is not met as evidenced by: Based on observations during medication pour and pass, staff interviews, and clinical record review, the facility's staff failed to ensure a resident didn't experience a significant medication error (blood sugar orders were duplicated and insulin was administered outside of parameters, too close to the next possible dose) for 1 of 44 residents (Resident #10), in the survey sample. The findings included: Resident #10 was originally admitted to the facility 10/13/16 and had never been discharged from the facility. The current diagnoses included; dementia and diabetes. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/9/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired for daily decision making. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bathing, limited assistance of one person with dressing, supervision of one person with on unit locomotion, supervision after set-up with bed mobility, transfers, walking, off-unit locomotion, eating, and personal hygiene. Review of Resident #10's the clinical record revealed the following orders; 6/15/2021 Humalog Solution (Insulin Lispro) Inject as per sliding scale: if 151 - 200 = 2 units	F 760	1. Resident #10 has been assessed by nursing staff and provider with no negative outcomes noted. The resident, responsible party and provider were notified. Resident #10 insulin and blood glucose monitoring orders were clarified with the provider and were corrected. Plan of care was reviewed and updated for individualized care needs. 2. The Director of Nursing/designee has performed an audit of all current sliding scale insulin and blood glucose testing orders. Any incorrect, ambiguous or redundant orders have been clarified with the provider and corrected in the medical record. Plans of care have been reviewed and updated for individualized care needs. 3. The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) regarding process for insulin administration and obtaining blood glucose readings. The in-service includes, but is not limited to, clarification of orders, timely and accurate insulin administration, and administering insulin within parameters. 4. The Director of Nursing/designee will audit the MAR five times weekly for 6 weeks to review insulin orders and administration, including timely and accurate administration and accuracy of insulin and glucometer orders. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional	

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F 760	Continued From page 65 (u); 201 - 250 = 4u; 251 - 300 = 6u; 301 - 350 = 8u; 351 - 400 = 10u greater then 400 call provider, subcutaneously before meals and at bedtime for blood sugar 10/29/19 Metformin 500MG TAB: Give 1 tablet by mouth one time a day related to Other specified diabetes mellitus *WITH BREAKFAST IN THE MORNING* 9/4/2019 Glipizide 5MG TAB; 0.5 mg by mouth in the morning related to diabetes mellitus (HALF TABLET = 2.5 MG) 2/26/21 Blood sugar check, finger-stick blood sugar (FSBS) notify provider for FSBS less than 70 milligrams per deciliter (mg/dl) or greater 400 mg/dl one time a day related to TYPE 2 DIABETES On 9/2/21 at approximately 10:00 a.m., Licensed Practical Nurse (LPN) #5 was observed administering medications to Resident #10. They administered medication included; Magnesium Oxide 400MG Tablet one tablet by mouth, Acetaminophen 325MG Tablet one tablet by mouth, Metformin 500MG Tab 1 tablet by mouth, Preservision Areds two Capsules by mouth, Amlodipine 5MG Tablet one tablet by mouth, Glipizide 5MG Tablet one 0.5 tablet by mouth, Blood sugar reading obtained at 10:00 a.m. The reading was 255 mg/dl. This was ordered for a 7:30 a.m., Six units of Humalog Solution Insulin (Lispro) was given for sliding scale coverage of the blood sugar of 255 mg/dl. An interview was conducted with LPN #5 on 9/2/21 at appoximately 10:10 a.m. LPN #5 stated blood sugars are to be obtained at 6:30 a.m., but	F 760	education and training will be provided to employees on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 10/15/2021	

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F 760	Continued From page 66	F 760		

the nurse didn't give her the results of Resident #10's blood sugar during report and the results were not recorded on the Medication Administration Record (MAR) therefore; she obtained it at 10:00 a.m. LPN #5 stated medication and treatments can be administered one hour before the scheduled time or one hour after the scheduled time.

The above was approximately one hour after the resident had consumed breakfast and one hour before the next scheduled blood sugar was to be obtained.

Further review of Resident #10's MAR and Treatment Administration Record (TAR) for 9/2/21, revealed the resident had two orders for obtaining blood sugar reading one at 6:30 a.m., daily on the TAR and one at 7:30 a.m., daily on the MAR and the off-going nurse had obtained a blood sugar reading at 6:30 a.m., and documented it on the TAR. The 6:30 a.m., blood sugar reading was 121 mg/dl. Also on 9/02/21 at 11:43 a.m., LPN #5 obtained Resident #10's 11:30 a.m., blood sugar reading which was 285 mg/dl and administered another six units of Lispro.

On 9/2/21 at approximately 6:30 p.m., the above findings were shared with the Administrator, Interim Director of Nursing, The Assistant Director of Nursing and Regional Director of Compliance. The Assistant Director of Nursing stated medications and treatments should be administered one hour before or one hour after the scheduled and if this doesn't occur the physician/physician designee should be notified for further orders.

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F 842	Continued From page 67	F 842	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842	1. Resident #18, Resident #1, Resident #391, and Resident #90 have a complete medical record since Hill Valley Healthcare took ownership on 02/01/2021. Complete medical records prior to 2/1/2021 are not available from the facility's previous ownership. 2. All residents residing in the facility have a complete medical record since Hill Valley Healthcare took ownership on 2/1/2021. Complete medical records prior to 2/1/2021 are not available from the facility's previous ownership. 3. The Administrator/Designee has educated the Medical Records Designee to follow the facility retention schedule of medical records after 02/01/2021. The Inservice included, but was not limited to, the importance of maintaining complete and accurate medical records. 4. The Administrator/Designee will audit 25% of current resident medical records weekly for 4 weeks to ensure that the medical records are complete and that they contain adequate information to provide current patient care. Administrator/Medical Record Designee will identify any issues, patterns, or trends and report to the Quality	

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F 842	Continued From page 68 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to maintain a complete and accurate clinical record for four of 49 sampled residents, Resident #18, #1, #391 and #90. The findings included:	F 842	Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 09/23/2021	

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F 842	Continued From page 69 1. For Resident #18, facility staff failed to obtain all after visit summaries from her outside pain management provider and file them in her clinical record. Resident #18 was admitted to the facility on 5/4/19 and readmitted on 6/25/21 with diagnoses that included but not limited to anemia, coronary artery disease, diabetes mellitus, Chronic Obstructive Pulmonary Disease (COPD) and hyperlipemia. Resident #18's most recent Minimum Data Set (MDS) Assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 6/25/21. Resident #18 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status Exam (BIMS). On 8/31/21 at approximately 4:30 p.m., an interview was conducted with Resident #18. Resident #18 had stated that she wanted the facility physician and/or nurse practitioner (NP) to adjust her Percocet (1) from 5 to 10 mg (milligrams) for back pain. Resident #18 stated she had a painful burning sensation to her back. Resident #18 stated that the physician recently only wanted to allow her an additional Fentanyl patch (2) but that she did not feel comfortable receiving fetanyl. Resident #18 stated that the NP would tell her to follow up with her pain management provider and that her pain management provider would tell her to follow up with the facility physician and/or NP. Resident #18 felt that no one was communicating with one another to address her concern. Resident #18 stated that she will be starting botox injections through her pain management provider but that she had injections to her back in the past (not	F 842		

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F 842	Continued From page 70 botox) and that those didn't cover the pain for too long. Review of Resident #18's clinical record revealed that she was on the following pain medications: Baclofen (3) 10 MG (milligrams) TAB Give 1 tablet orally every 8 hours as needed for Back pain/muscle spasm. Ordered 2/1/21. Bengay Ultra Strength Cream (4) 4-10-30 % Apply to BILATERAL CALVES topically at bedtime for PAIN AND Apply to BILATERAL CALVES topically as needed for PAIN TWO TIMES DAILY. Ordered 2/1/21. Oxycodone-APAP (Percocet) 5-325 mg tablet - Give 1 tablet orally every 4 hours as needed for Pain 6-10 related to Pain, unspecified. Ordered 3/19/21. Acetaminophen Tablet (5) 650 MG Give 1 tablet by mouth every 6 hours as needed for General Discomfort or fever. Ordered 4/13/21. Lidoderm Patch 5 % (Lidocaine) (6) Apply to Back topically every morning and at bedtime for pain (Apply 2 patches in AM-Remove 2 patches at HS (night). Ordered 5/19/21. Further review of Resident #18's clinical record revealed that she had allergies to Tramadol (7), and Gabapentin (8). Review of Resident #18's August 2021 MAR (Medication Administration Record) revealed that Resident #18 received her as needed (PRN) percocet frequently, but rarely received her other PRN medications for pain.	F 842		

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F 842	Continued From page 71 Review of Resident #18's clinical record revealed that the last time the NP had addressed Resident #18's pain was on 8/18/21. The following note was documented in part: "The patient is seen today by the request of patient for pain managemrnt. The patient states her neurpatic (sic) pain has not improved. The patient has increased neuropathy (sic) secondary to diabetes and tumors on her cervical spine that need surgery. The patient is followed by Oncology, and Neurology; has plan for botox injections for pain. Pain currently rated 10/10 on 0-10 pain scale. According to patient, she needs additional therapy, but has been denied multiple times secondary to severe respiratory compromise...Polyneuropathy: FU (follow up) w (with)/pain management and neuropathy." Further review of Resident #18's clinical record revealed that she had gone out to pain management on 3/30/21 and 6/15/21. There was no evidence of any after visit summaries from pain management on her clinical record. Several requests were made by this surveyor for the pain management notes on 9/1/21 at 2:35 p.m. and 9/2/21 at approximately 8 a.m. On 9/2/21 at 2:23 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #4, the unit manager. When asked if she ever found Resident #18's pain management notes, LPN #4 stated that she had put a fax request in that morning to obtain them from pain management. LPN #4 stated that Resident #18 made her own appointments with pain management. When asked if the after visit summaries should be obtained from the resident and/or office, LPN #4 confirmed that her nursing	F 842		

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F 842	Continued From page 72 staff should be getting the after visit summaries in order to coordinate care. On 9/2/21 at 2:30 p.m., an interview was attempted with the Nurse Practitioner. She could not be reached for an interview. The facility staff could not present notes from Resident #18's pain management provider until 9/2/21 (last day of survey) at approximately 4 p.m. The following was documented on the Facsimile Cover Sheet to the pain management provider: "9/2/21 7:23 a.m...State Surveyors are requesting pain management notes...Please send as soon as possible." On 9/2/21 at 6:30 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the acting Director of Nursing (DON), ASM #3 the Assistant Director of Nursing (ADON) and ASM #4 the Regional Director of Compliance were made aware of the above concerns. A facility policy could not provided regarding the above concerns. (1) Percocet - A strong prescription pain medicine that contains an opioid (narcotic) that is used to manage pain, severe enough to require an opioid analgesic and for which alternative treatments are inadequate and when other pain treatments such as non-opioid pain medicines do not treat your pain well enough or you cannot tolerate them. This information was obtained from The National Institutes of Health: https://dailymed.nlm.nih.gov/dailymed/medguide.cfm?setid=4dd36cf5-8f73-404a-8b1d-3bd53bd90c25.	F 842		

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F 842	Continued From page 73 (2) Fetanyl Patch-Fentanyl transdermal system is indicated for management of persistent, moderate to severe chronic pain that: requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means such as non-steroidal analgesics, opioid combination products, or immediate-release opioids. This information is obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b7fe401c-7ddc-4391-9cff-3608da03e86b. (3) Baclofen- is a muscle relaxant and antispastic. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=346af8fe-3816-49de-bfd3-5a7425e728f 9. (4) Bengay Ultra Strength- temporarily relieves the minor aches and pains of muscles and joints associated with: simple backache, arthritis, strains, bruises, sprains. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=0a41ec65-bd0b-4fc6-807d-74f353341cc7. (5) Acetaminophen is a widely used nonprescription analgesic and antipyretic medication for mild-to-moderate pain and fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK548162/. (6) Lidoderm Patch (lidocaine patch 5%) is	F 842		

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F 842	Continued From page 74 comprised of an adhesive material containing 5% lidocaine. Lidocaine is indicated for relief of pain associated with post-herpetic neuralgia. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f1c40164-4626-4290-9012-c00e33420a33. (7) Tramadol- is an opioid analgesic used for the therapy of mild-to-moderate pain. This information was obtained from The National Institutes of Health. https://pubchem.ncbi.nlm.nih.gov/compound/33741. (9) Gabapentin is commonly used to treat neuropathic pain (pain due to nerve damage. This information was obtained from The National Institutes of Health. https://pubmed.ncbi.nlm.nih.gov/28597471/. 2. For Resident #1, the facility staff failed to document daily weights as ordered by the physician. Resident #1 was admitted to the facility on 8/13/21 with diagnoses that included but were not limited to chronic respiratory failure with hypoxia (1), alcoholic cirrhosis of the liver with out ascites, anemia, chronic diastolic heart failure, and generalized edema. Resident #1's most recent Minimum Data Set (MDS) assessment was an admission assessment with an Assessment Reference Date (ARD) of 8/24/21. Resident #1 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status (BIMS) exam.	F 842		

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F 842	Continued From page 75 Review of Resident #1's August 2021 Physician Order Summary (POS) revealed the following order: "Daily Weight." This order was initiated on 8/14/21. This order was discontinued during survey on 9/1/21. Review of Resident #1's "weight summary" log on the electronic medical record revealed missing daily weights for the following dates: "8/16/21, 8/17/21, 8/19/21, 8/20/21, 8/22/21, 8/24/21, 8/27/21, 8/28/21, and 9/1/21." Review of Resident #1's nursing notes failed to evidence any documentation of daily weights or refusals of daily weights. Resident #1's care plan dated 8/18/21 documented in part, the following: "(Name of Resident #1) has altered cardiovascular status r/t(related to) CHF (congestive heart failure, Hypertension)...Monitor/document/report PRN (as needed)...edema and changes in weight." On 9/2/21 at 11:44 a.m., an interview was conducted with Certified Nursing Assistant #6, the restorative aide. When asked if Resident #1 was a daily weight, CNA #6 stated that Resident #1 was a daily weight until yesterday 9/1/21. When asked why Resident #1 was a daily weight, CNA #6 stated that Resident #1 had congestive heart failure. CNA #6 stated that she obtained Resident #1's weight every morning at 8 a.m., or around the time same time every day for a more accurate reading. CNA #6 stated that she would document daily weights in either PCC (Point Click Care) or give the weights to the unit manager who would then document daily weights in PCC. CNA #6 stated that most of the time she would document	F 842		

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F 842	Continued From page 76	F 842		

the weights on the assignment sheets for the unit manager. CNA #6 denied Resident #1 having frequent refusals obtaining her weights. CNA #6 stated that the Resident #1 may have refused a weight on one occasion. CNA #6 was asked to provide all the assignment sheets for the above missing weights.

On 9/2/21 at 11:55 a.m., an interview was conducted with Resident #1. Resident #1 confirmed that staff would obtain her daily weights around the same time every morning. Resident #1 stated that she did not get one that day but that her order for the weights had changed.

Prior to exit, the missing daily weights for above dates could not be provided.

On 9/2/21 at 6:30 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the acting Director of Nursing (DON), ASM #3 the Assistant Director of Nursing (ADON) and ASM #4 the Regional Director of Compliance were made aware of the above concerns.

Facility policy titled, "Weight Assessment and Intervention" documents in part, the following: "...Weights will be recorded in each unit's weight record chart or notebook and in the individual's medical record..."

(1) Hypoxia- Exists when there is a reduced amount of oxygen in the tissues of the body. This information was obtained from The National Institutes of Health. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=hypoxia.

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F 842	Continued From page 77 3. For Resident #391, the facility staff could not provide access to his medical records prior to 2/1/21, when the facility had changed ownership. Resident #391 was admitted to the facility on 11/4/19 and discharged on 11/9/19. Resident #391's most recent Minimum Data Set assessment (MDS) was a discharge assessment with an Assessment Reference Date (ARD) of 11/9/21. Resident #391 was coded as being severely impaired in cognitive function scoring 05 out of possible 15 on the Brief Interview For Mental Status (BIMS) exam. A complaint against the nursing facility regarding resident safety and falls during a therapy session for Resident #391 was submitted to the state agency on 5/1/20. This complaint could not be investigated as the facility did not have access to his medical records prior to 2/1/21 (date of when facility changed ownership). On 9/1/21 at 7:46 a.m., an interview was conducted with Administrative Staff Member #3, the Assistant Director of Nursing (ADON). ASM #3 stated that she could not obtain any information from the previous company for Resident #391 and that the resident was also discharged before the company had changed ownership. On 9/1/21 at 8:30 a.m., an interview was conducted with Resident #391's represenative (RP). She could not provide any additional information on the complaint that was submitted on 5/1/20. The RP had submitted the complaint but stated that she had thought that it was already investigated. There was no evidence that this complaint had been previously investigated by	F 842		

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F 842	Continued From page 78 surveyors. On 9/1/21 at approximately 1:00 P.M., the Administrator provided a letter to the surveyor that is documented in part, as follows: In regards to the patients Name (Resident #391) , I have attempted to access the Name (previous owner) EHR (electronic health record) through the portal that was provided to me by Name (previous owner) during the transition of ownership. After multiple attempts to access the EHR using the log-in information provided, I was unable to access the system. The log-in screen consistently reads, "Invalid Credentials, Access Denied". My ADON (Assistant Director of Nursing), also made multiple attempts to gain access to the Name (previous owner) EHR and was also denied. An agreement between Name (previous owner) and Name (current owner) allowed read only access to all policies, procedures and documents until 8/01/21. The Regional Vice President of Operations, has attempted to work with Name (previous owner) on this and other related concerns with much difficulty. Neither I, nor any of the nursing staff at Name (current owner) have access to the Name (previous owner) medical records system. We are completely blocked from all of Name (previous owner) EHR systems to include running any reports, reading clinical records or accessing any previous or current patient's statements, investigations or data of any kind. Due to lack of access, I am unable to provide the requested information pertinent to Name (Resident #391's)complaint or the allegations therein." On 9/2/21 at 6:30 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2,	F 842		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(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
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the acting Director of Nursing (DON), ASM #3 the Assistant Director of Nursing (ADON) and ASM #4 the Regional Director of Compliance were made aware of the above concerns.

4. The facility staff failed to ensure that a complete and accessible medical record was maintained for Resident #90 prior to 2/1/21. Resident #90 was originally admitted to the nursing facility on 6/6/2014 and readmitted on 5/6/2020 with diagnoses to include but not limited to Left Femur Fracture and Cerebral Palsy.

Resident #90's most recent Minimum Data Set (MDS) was a quarterly with an Assessment Reference Date (ARD) of 8/20/21. The Brief Interview for Mental Status (BIMS) was coded a 9 out of a possible 15, indicating Resident #90 was moderately cognitively impaired. Under Section G Functional Status: G0110 Activities of Daily Living Assistance B. Transfer, Resident #90 was coded 4.3 (total dependence with 2 person physical assist.).

The surveyor was unable to locate Resident #90's clinical record prior to 2/1/21 in the facilities electronic medical record software Point Click Care (PCC).

On 9/1/21 at 9:15 P.M. an interview was conducted with the Administrator and the Director of Nursing regarding Resident #90's clinical record prior to 2/1/21. The Administrator stated, "Name (current owner) took ownership of the facility on 2/1/21 from Name (previous owner) and the previous electronic health record software was not point click care so the resident records did not cross over. We did have an agreement with Name(previous owner) that we

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would have read only access to all documents until 8/1/21. I have attempted numerous times to access the Name (previous owner) electronic health record through the portal that was provided to me during the transition of ownership and each time my access was denied." The Director of Nursing stated, "I do not have access to Name (previous owner's) medical records, therefore I am unable to provide the requested information pertinent to Name (Resident #90's) complaint."

On 9/1/21 at approximately 1:00 P.M., the Administrator provided a letter to the surveyor that is documented in part, as follows:

In regards to the patients Name (Resident #90) , I have attempted to access the Name (previous owner) EHR (electronic health record) through the portal that was provided to me by Name (previous owner) during the transition of ownership. After multiple attempts to access the EHR using the log-in information provided, I was unable to access the system. The log-in screen consistently reads, "Invalid Credentials, Access Denied". My ADON (Assistant Director of Nursing), also made multiple attempts to gain access to the Name (previous owner) EHR and was also denied.. An agreement between Name (previous owner) and Name (current owner) allowed read only access to all policies, procedures and documents until 8/01/21. The Regional Vice President of Operations, has attempted to work with Name (previous owner) on this and other related concerns with much difficulty. Neither I, nor any of the nursing staff at Name (current owner) have access to the Name (previous owner) medical records system. We are completely blocked from all of Name (previous owner) EHR systems to include running

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F 842	Continued From page 81 any reports, reading clinical records or accessing any previous or current patient's statements, investigations or data of any kind. Due to lack of access, I am unable to provide the requested information pertinent to Name (Resident #90's)complaint or the allegations therein. On 9/2/21 at 6:10 P.M. a pre-exit debriefing was conducted with the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Regional Director of Compliance where the above information was shared. No further information was provided prior to exit.	F 842		