STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495114	A. BUILDING _____ B. WING _____	C 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE OF ARLINGTON, LLC	1785 SOUTH HAYES STREET ARLINGTON, VA 22202

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8/30/2022 through 8/31/2022. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities. No emergency prepardedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/30/2022 through 8/31/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated during the survey. The census in this 240 certified bed facility was 135 at the time of the survey. The survey sample consisted of 26 current resident reviews and 3 closed record reviews.	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to ensure an accurate MDS (minimum data set) assessment for three of 18 resident's in the survey sample. 1. Resident #82's MDS section B (vision) and section H (Bladder and Bowel) was coded incorrectly.	F 641	Tag F641- 1. The MDS section for resident #82 has been modified in section B with vision and section H with bladder and bowel to reflect the current resident status. The care plan for resident number #82 has been modified and care plan updated to reflect the use of resident needing corrective lenses along with resident not	9/19/22

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

Electronically Signed | 09/09/2022

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F 641	Continued From page 1 2. Resident #133's MDS section A (discharge) was coded incorrectly. 3. Resident #131's MDS section A (discharge) was coded incorrectly. The Findings Include: 1. Diagnoses for Resident #82 included: Malignant neoplasm of bladder, anxiety, adult failure to thrive, and unspecified dementia. The most current MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 7/26/22. Resident #82's cognitive score was a 13 indicating cognitively intact. On 8/30/22 at 10:06 AM an interview was conducted with Resident #82. During the conversation Resident #82 verbalized she liked reading but her glasses were broke and said no one has done anything about it (glasses were sitting on Resident #82's dresser, the ear pieces were broken off). Also during the interview Resident #82 was asked if she had a catheter in place (as documentation indicated Resident #82 had a catheter). Resident #82 verbalized that she has never had a catheter. On 8/30/22 Resident #82's clinical record was reviewed. Section B1000 (Vision) of Resident #82's most recent MDS documented Resident #82's vision was adequate and no corrective lenses were needed. Also, section H0100 (Bladder and Bowel documented Resident #82 had an indwelling catheter. On 8/30/22 at 2:16 PM the MDS coordinator	F 641	having an indwelling catheter to reflect the current resident status. 2. The MDS section for resident # 133 has been modified that resident discharged home vs an acute hospital. 3. The MDS section for resident #131 could not be modified due to the information being correct per DHHS RAI coordinator if a resident expires in the emergency room and has not been admitted then it is to be coded as death in facility because they still belong to the facility at that time. The care plans and MDS for current residents was audited to determine that they were accurate and have been revised by the Quality Assurance Utilization Review Nurse with a completion date of 9/19/22. Any issues found were addressed at that time. MDS will access order listing daily and bring to clinical meeting to be discussed with the interdisciplinary team. Resident discharges for past 90 days were audited by the Quality Assurance Utilization Review Nurse to determine that they were accurate and have been modified with a completion date of 9/19/22. Any issues found were addressed at that time. MDS was educated by the Quality Assurance Utilization Review Nurse on 9/8/22 on accuracy of assessments and revising care plans to meet current resident status. The Quality Assurance Utilization Review Nurse will audit 5 care plans weekly for 3 months, then 3 weekly for 2 months, and	

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F 641	Continued From page 2 (registered nurse, RN #2) was asked about the concerns regarding vision and catheter that were listed on the MDS. RN #2 verbalized that he filled out the sections and gets information from the chart and interviews with family and Resident's, but would look into it. On 8/31/22 at 8:16 AM, RN #2 verbalized after reviewing Resident #82's admission MDS he realized a mistake had been made on the MDS regarding vision and catheter. RN #2 went onto say Resident #82 does need glasses and Resident #82 never had a catheter. On 8/31/22 at 12:15 PM the above information was presented to the administrator and director of nursing (DON). No other information was presented prior to exit conference on 8/31/22. 2. Resident #133 was admitted to the facility with diagnoses that included long-term use of insulin, insomnia, osteoarthritis, GERD, stage 5 chronic kidney disease requiring dialysis, hyperlipidemia, anemia, and muscle weakness. The discharge minimum data set (MDS) dated 08/06/2022 documented Under Section A that Resident #133 discharge to an "acute hospital." On 08/30/2022, Resident #133's closed clinical record was reviewed. Observed in the clinical record was the "Discharge Summary and Discharge Plan/Instructions" dated 08/05/2022, both documented that Resident #133 discharged to home on 08/06/2022. A progress note dated 08/06/2022 documented Resident #133 discharged to home on 08/06/2022 at 11:15 a.m. Resident #133's discharge MDS was reviewed	F 641	then 5 monthly for 1 month and as needed. The results of the audits will be reported to the quarterly QAA committee. The Quality Assurance Utilization Review Nurse will audit 3 MDS weekly for 3 months, then 3 weekly for 2 months, and then 5 monthly for 1 month and as needed. The results of the audits will be reported to the quarterly QAA committee.	

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F 641	Continued From page 3	F 641		

and documented that the resident discharged on 08/06/2022. The MDS documented the discharged was planned and the resident's return was not anticipated. The discharge MDS documented that the resident discharge to an "acute care hospital".

On 08/30/2022 at 6:10 p.m., the MDS Coordinator (RN #2) was interviewed regarding Resident #133's discharge location. RN #2 stated the resident discharged to home. RN #2 was asked to review the MDS for accuracy of the resident's discharge location. RN #2 reviewed the discharge MDS and stated it was coded in error, that Resident #133 did not discharge to the hospital, and the resident was planned discharge to home.

On 08/31/2022 at 12:14 p.m., the above findings were reviewed during a meeting with the administrator & DON.

3. Resident #131 was admitted to the facility with the following diagnoses including but not limited to: Chronic respiratory failure, heart failure, diabetes mellitus, gastrostomy, tracheostomy, dependence on ventilator, mediastinal b-cell lymphoma, heart failure, rib fractures and COPD.

The admission MDS with an ARD of 07/08/2022, assessed Resident #131 as cognitively intact with a summary score of "13". Resident #131 was added to the survey sample a closed record with a discharge disposition of "Death in Facility".

The clinical record was reviewed on 08/30/2022 at approximately 3:00 p.m. The following note was written 07/18/2022:
7/18/2022 01:22 (a.m.) Respiratory Therapy

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F 641	Continued From page 4	F 641		

Progress Not...Called to pt's room at approximately 2310 (11:10 p.m.) by CNA (certified nursing assistant) who said pt was requesting to see respiratory. Pt indicated that he was having trouble breathing. Airway assessed, and trach noted to be partially out of stoma. Before I could advance the trach tube further into place, the resident reached up and pulled his trach tube out. Attempted several times unsuccessfully to reinsert trach using obturator and correct position. 9-1-1 was immediately called after several unsuccessful attempts of reinsertion of trach tube. Trachea appeared to have blockage which would not allow for insertion. Began bagging pt with stoma mask. Additional attempts made to pass tracheostomy tube, but again unsuccessfully. Began bagging pt with stoma mask again. Pt became unresponsive during this process, and CPR (cardio pulmonary resuscitation) was initiated. CPR was continued until the EMTs (emergency medical transports) arrived and took over the resuscitation process."

During a meeting with the DON (director of nursing) and the administrator on 08/31/2022 at approximately 12:15 p.m. Resident #131's death in the facility was discussed. The administrator stated, "He didn't die here...he died at the hospital." The administrator was informed that since the patient was transferred out to the hospital his MDS discharge status should have been, "Acute hospital", not "Deceased". She agreed.

The discharge documentation from the hospital was presented at approximately 1:00 p.m. and included: "...Patient presented in cardiac arrest...bedside ultrasound showed no organized cardiac activity. Patient was declared dead at

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F 641	Continued From page 5 12:42 (a.m.)" No further information was obtained prior to the exit conference on 08/31/2022.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		9/19/22

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F 656	Continued From page 6 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview and clinical record review, the facility failed to develop a care plan for one of 29 resident's. Resident #82 did not have a care plan for vision. The Findings Include: Diagnoses for Resident #82 included: Malignant neoplasm of bladder, anxiety, adult failure to thrive, and unspecified dementia. The most current MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 7/26/22. Resident #82's cognitive score was a 13 indicating cognitively intact. On 8/30/22 at 10:06 AM an interview was conducted with Resident #82. During the conversation Resident #82 verbalized she liked reading but her glasses were broke and said no one has done anything about it (glasses were sitting on Resident #82's dresser, the ear pieces were broken off). On 8/30/22 Resident #82's clinical record was reviewed. Section B1000 (Vision) of Resident #82's most recent MDS documented Resident #82's vision was adequate and no corrective	F 656	Tag 656 #2 1. The MDS and care plan for resident number #82 has been modified and care plan updated to reflect the use of resident needing corrective lenses. 2. The care plans and MDS for current residents were audited to determine that they were accurate and have been revised. Any issues found were addressed at that time. MDS will access order listing daily and bring to clinical meeting to be discussed with the interdisciplinary team. 3. MDS was educated on 9/8/22 by the Quality Assurance Utilization Review Nurse on accuracy of assessments and revising care plans to meet current resident status. Completion date of 9/19/22. 4. The Quality Assurance Utilization Review Nurse will audit 5 care plans weekly for 3 months, then 3 weekly for 2 months, and then 5 monthly for 1 month and as needed. The results of the audits will be reported to the quarterly QAA	

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F 656	Continued From page 7 lenses were needed. Resident #82's care plan was also reviewed and revealed no documentation of a care plan for vision. On 8/30/22 at 2:16 PM the MDS coordinator (registered nurse, RN #2) was asked about the concern regarding vision listed on the MDS as not needing glasses and vision was adequate. RN #2 verbalized that he filled out the sections and gets information from the chart and interviews with family and Resident's, but would look into it. On 8/31/22 at 8:16 AM, RN #2 verbalized after reviewing Resident #82's admission MDS he realized a mistake had been made on the MDS regarding vision and that resident #82 needed glasses. RN #2 was asked, if vision would have been triggered on the MDS as needing glasses and vision was inadequate, should a care plan be developed. RN #2 verbalized a care plan would have been put in place for a resident needing glasses. On 8/31/22 at 12:15 PM the above information was presented to the administrator and director of nursing (DON). No other information was presented prior to exit conference on 8/31/22.	F 656	committee. 5. The Quality Assurance Utilization Review Nurse will audit 3 MDS weekly for 3 months, then 3 weekly for 2 months, and then 5 monthly for 1 month and as needed. The results of the audits will be reported to the quarterly QAA committee.	
F 657 SS=E	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	F 657		9/19/22

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F 657	Continued From page 8 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to review and revise the CCP (comprehensive care plan) for six of 29 residents in the survey sample, Resident #47, #97, #118, #131, #107 and #8. 1.) The facility staff failed to update Resident #47's care plan related to snacks and an AV (arteriovenous) fistula (no longer in use). 2.) The facility failed to update Resident #97's care plan related to trach care interventions for dislodgement of a tracheotomy tube.	F 657	Tag F657#1 1. The care plan for resident #47 has been updated to reflect the added snacks and the nonuse of the AV fistula. 2. The care plan for resident #91 has been updated to reflect the trach care interventions for dislodgement of a tracheostomy tube for the current resident status. 3. The care plan for resident #118 has been resolved and updated to reflect the resident current status.	

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F 657	Continued From page 9 3.) Resident #118's care plan was not reviewed and revised to remove the focus area, "Resident is a smoker". 4.) Resident #131's care plan was not reviewed and revised to include his "repositioning" of his tracheotomy tube, nor was the care plan revised to delete the use of hemostats to open up the stoma in the event the tube was coughed out. 5). Resident #107's CCP was not reviewed & revised for code status change. 6.) Resident #8's CCP was not reviewed & revised for discontinuation of anticoagulant medication. Findings include: 1.) Resident #47's diagnoses included, but were not limited to: end stage renal disease (recent kidney transplant), metabolic encephalopathy, cardiovascular and coagulation disease, high blood pressure, enlarged prostate, constipation, reflux disease, dementia without behaviors, insomnia, major depression, and arteriovenous fistula (no longer used). The resident's most recent full MDS (minimum data set) was a significant change assessment dated 06/30/22. This MDS assessed the resident with a cognitive score of 15, indicating the resident was intact for daily decision making skills. The resident triggered in the CAAS (care area assessment summary) section of this MDS for nutrition.	F 657	4. The care plan for resident #131 has been updated to reflect the deletion of the hemostats along with adding the turning and repositioning of the tracheostomy tube. 5. The care plan for resident #107 has been updated to reflect current code status. 6. The care plan for resident #8 has been updated to reflect discontinuation of anticoagulant medication The care plans for current residents were audited to determine that they were accurate and have been revised by the Quality Assurance Review Nurse with a completion date of 9/19/22. Any issues found were addressed at that time. MDS will access order listing daily and bring to clinical meeting to be discussed with the interdisciplinary team. MDS was educated on 9/8/22 by the Quality Assurance Review Nurse on accuracy of assessments and revising care plans to meet current resident status. The Quality Assurance Utilization Review Nurse will audit 5 care plans weekly for 3 months, then 3 weekly for 2 months, and then 5 monthly for 1 month and as needed. The results of the audits will be reported to the quarterly QAA committee. Tag F657#2 1. The care plan for resident # 47 has been updated to reflect physician order of resident receiving snacks TID to reflect current status.	

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F 657	Continued From page 10 On 08/30/22 at approximately 9:30 AM, the resident was interviewed and stated that he has lost weight, but has a good appetite. The resident was eating corn flakes and stated that he likes to 'indulge' in eating them, he really enjoyed them. The resident stated that staff do not bring him snacks and that he wants to eat. The resident stated that his brother had brought the corn flakes to him. The resident also stated that he had just had a kidney transplant, which may have contributed to some of the weight loss that he was in the hospital for 2 weeks. The resident stated that he was happy and doing well, was no longer receiving dialysis, and was hoping to be able to get rid of his fistula (AV fistula located in the resident's left arm) and eventually go home. The resident's physician's orders were reviewed and documented, "SNACKS TID [three times a day] three times a day @ 10AM, 2PM, & 8PM..Active 08/05/2022..." The physician orders did not document any information regarding the AV fistula. The resident's CCP was then reviewed and the physician ordered TID snacks (intervention for weight loss) was not located on the care plan. The resident's CCP did not mention and/or address the resident's AV fistula that was still in place, but no longer in use. The resident's TARS (treatment administration records) were reviewed, it was documented by staff initials that the resident was getting the snacks TID.	F 657	The care plan for resident #47 has been updated to reflect the nonuse of the AV fistula to reflect current status. 2. The care plan for resident #97 has been updated to reflect the individualized resident current status for trach/vent care and the deletion of the hemostats. 3. The care plan for resident #118 has been updated to reflect resident is no longer a smoker to reflect current resident current status. 4. The care plan for resident #131 has been modified to reflect deletion of hemostats. 5. The care plan for resident #107 has been updated to reflect the correct code status to reflect resident current status. 6. The care plan for resident #8 has been updated to reflect resident is no longer on anticoagulant therapy to reflect resident current status The care plans for current residents were audited by the Quality Assurance Review Nurse to determine that they were accurate and have been revised with a completion date of 9/19/22. Any issues found were addressed at that time. MDS was educated on 9/8/22 on accuracy of assessments and revising care plans to meet current resident status by the Quality Assurance Utilization Review Nurse. MDS will access order listing daily and bring to	

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F 657	Continued From page 11 There was no information on the resident's MARs/TARs (medication/treatment administration records) regarding the resident's AV fistula. On 08/31/22 at 8:47 AM, the MDS coordinator/care planner (MDSCC) was interviewed regarding the above information. The MDSCC stated that the RD (registered dietitian) is supposed to update the care plans regarding nutrition. The MDSCC did not have an answer regarding the resident's AV fistula. On 08/31/22 at approximately 9:00 AM, the RD was interviewed and stated that she will include interventions, but that is typically added by the MDSCC and stated that the snacks should have been included on the resident's care plan. On 08/31/22 at approximately 11:45 AM, the DON (director of nursing) and the administrator were made aware of above regarding Resident #47's CCP. The administrator stated that 'it doesn't work that way' as far as the RD updating the care plan, that is actually done by the MDSCC. The concern regarding the resident not having a care plan for the AV fistula was also shared. The DON stated that the resident should have a care plan for the fistula that was no longer in use (since the kidney transplant). No further information and/or documentation was provided prior to the exit conference on 08/31/22. 2.) Resident #97's diagnoses included, but were not limited to: atrial fibrillation, diabetes mellitus, and sudden cardiac arrest now with tracheotomy and ventilator dependent.	F 657	clinical meeting to be discussed with the interdisciplinary team. The Quality Assurance Utilization Review Nurse will audit 5 care plans weekly for 3 months, then 3 weekly for 2 months, and then 5 monthly for 1 month and as needed. The results of the audits will be reported to the quarterly QAA committee.	

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The most recent full MDS was a significant change assessment dated 06/30/22. This MDS assessed the resident with a cognitive score of 15 indicating the resident was intact for daily decision making skills. The resident was assessed as having a trach and ventilator on this MDS.

The resident was observed on 08/30/22 and 08/31/22. The resident was not interviewable. The resident's trach care was observed on 08/30/22 at approximately 10:00 AM with RT (respiratory therapist) #2. RT #2 explained the procedure during the observation of Resident #97's care for suctioning, inner canula change and total care of the tracheotomy tube and what should happen if the resident's tube is dislodged. There was no mention of hemostats and no hemostats were observed at the bedside.

The resident's physician orders and CCP were then reviewed. The resident's physician's orders did not have any information regarding hemostats. The resident's CCP was reviewed for trach/ventilator care and documented, "...TUBE OUT PROCEDURES: Keep extra trach tube and obturator at bedside. If tube is coughed out, open stoma with hemostat. If tube cannot be reinserted, monitor/document for signs of respiratory distress. If able to breathe spontaneously, elevate HOB 45 degrees and stay with resident. Obtain medical help IMMEDIATELY..."

On 08/30/22 at approximately 5:30 PM RT #2 was interviewed with the survey team. RT #2 explained that they do not use hemostats and wasn't sure why that information was on the resident's care plan.

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On 08/31/22 at approximately 8:45 AM, the MDSCC was interviewed regarding Resident # 97's care plan for trach/vent care. The MDSCC could not provide an answer to where that particular intervention came from and then stated that he has a library to pick interventions from for trach/vent care and that must have been selected for this resident (even though hemostats are not used at this facility and did not apply to this resident). The MDSCC was made aware that the care plan was not specific to this resident and was generalized, not customized for this particular resident.

On 08/31/22 at approximately 11:45 AM, the DON and administrator were made aware of the above information and findings. The DON and administrator both stated that they are aware they have a problems with MDS and care plans.

No further information and/or documentation was provided prior to the exit conference on 08/31/22.
3. Resident #118 was admitted to the facility with the following diagnoses, including but not limited to: Unspecified convulsions, chronic pain, left above knee amputation, peripheral vascular disease and COPD (chronic obstructive pulmonary disease)

A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 08/11/2022, assessed Resident #118 as cognitively intact with a summary score of "15".

Resident #118's clinical record was reviewed on 08/30/2022 at approximately 10:00 a.m. A focus area, "Resident is a smoker" was observed with interventions that included, but were not limited

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to: Instruct resident about smoking risks, Instruct resident about facility policy on smoking, observe clothing and skin for signs of cigarette burns."

At approximately 10:30 a.m., the administrator was asked if any residents in the facility were allowed to smoke. She stated, "No, we do not allow smoking here." She was informed that Resident #118's care plan listed him as a smoker. She stated, "That is incorrect."

Resident #118 was interviewed on 08/30/2022 at approximately 10:45 a.m. He was asked about smoking. He stated, "I don't smoke anymore, I have COPD and had to quit. I did the patch...smoking is a hard habit to break."

The above information was discussed during a meeting with the DON (director of nursing) and the administrator on 08/31/2022 at approximately 12:15 p.m. They were asked who updates the care plans. The administrator stated, "(Name of MDS)..we meet every morning for an IDT (interdisciplinary team) meeting....we discuss everything, that is the time for MDS to update the care plan." She was asked if the nurses also updated the care plans. She stated, "No, it should be done in real time by MDS in the morning meeting." She was told about the interventions for smoking on Resident #118's care plan. She stated, "We know we have a problem with care plans...that should have been updated."

No further information was obtained prior to the exit conference on 08/31/2022.

4. Resident #131 was admitted to the facility with the following diagnoses including but not limited

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to: Chronic respiratory failure, heart failure, diabetes mellitus, gastrostomy, tracheostomy, dependence on ventilator, mediastinal b-cell lymphoma, heart failure, rib fractures and COPD.

The admission MDS with an ARD of 07/08/2022, assessed Resident #131 as cognitively intact with a summary score of "13".

The clinical record was reviewed on 08/30/2022 at approximately 3:00 p.m. The following note was written 07/18/2022:
7/18/2022 01:22 (a.m.) Respiratory Therapy Progress Not...Called to pt's room at approximately 2310 (11:10 p.m.) by CNA (certified nursing assistant) who said pt was requesting to see respiratory. Pt indicated that he was having trouble breathing. Airway assessed, and trach noted to be partially out of stoma. Before I could advance the trach tube further into place, the resident reached up and pulled his trach tube out. Attempted several times unsuccessfully to reinsert trach using obturator and correct position. 9-1-1 was immediately called after several unsuccessful attempts of reinsertion of trach tube. Trachea appeared to have blockage which would not allow for insertion. Began bagging pt with stoma mask. Additional attempts made to pass tracheostomy tube, but again unsuccessfully. Began bagging pt with stoma mask again. Pt became unresponsive during this process, and CPR (cardio pulmonary resuscitation) was initiated. CPR was continued until the EMTs (emergency medical transports) arrived and took over the resuscitation process."

The care plan was reviewed. A focus area: "The resident has a tracheostomy r/t (related to) respiratory failure". One of the interventions

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listed was: "TUBE OUT PROCEDURES: Keep extra trach tube and obturator at bedside. If tube is coughed out, open stoma with hemostat. If tube cannot be reinserted, monitor/document for signs of respiratory distress."

The director of respiratory services was interviewed on 08/30/22 at 5:30 p.m. He was asked about the incident. He stated, "(Name of resident) had mobility in his hands he would reposition the vent and the trach."

OS (other staff) #3 a respiratory therapist that had worked with Resident #131 earlier in the shift of the night his trach tube cam out was interviewed at 6:20 p.m. She stated that Resident #131 "Messed with is trach...he moved it to the right and to the left...we told him the importance of leaving it alone." She was asked if hemostats were used to reopen the stoma if a trach came out as the care plan directed. She stated, "No, we don't do that."

On 08/31/2022 at 07:40 a.m., OS #2 the therapist who attempted to reinsert the trach was interviewed. She stated, "When I got in there he had his hands on his trach...I got his hands down and tried to get it back in but I couldn't get it in, it was blocked...I bagged him and suctioned him, and still couldn't get it in." She was asked if she had used hemostats per the care plan to try to reopen the stoma. She stated, "We don't do that." She was asked if Resident #131 moved his trach around. She stated, "Yes, he was constantly, moving and fiddling with it...we tried to explain to him that it was his lifeline." She was asked what was normally done if residents moved their trachs around or touched them frequently. She stated, "We talk to the nurses, they may need a PRN (as

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needed) to relax them. sometimes a psych consult." She was asked if she had spoken with any of the nurses, she stated, "No."

On 08/31/22 at approximately 8:20 a.m., the MDS nurse who created Resident #131's care plan was interviewed. He was asked about the intervention for the use of hemostats to reopen the stoma in the event the trach tube came out. He explained that he had a "library" of interventions in the computer system to choose from when doing care plans. He stated, that respiratory therapy should review the care plans to make sure they were okay. He was asked why there were no interventions regarding Resident #131 moving his trach around. He stated, "I was unaware of that." He was asked if he had been aware would that have been care planned. He stated, "Yes."

The director of respiratory services was interviewed at approximately 9:00 a.m. and was asked if he had reviewed the care plan. He stated, "Yes." He was asked if hemostats were used to reopen the stoma if the tube was coughed out as the care plan directed. He looked at the intervention and stated, "No, we don't do that. I missed that on the care plan. That part should have been marked out." Concerns were voiced to him that the intervention regarding the use of hemostats had not been reviewed and revised/removed from the care plan, nor had the respiratory therapists communicated to the MDS nurse or documented in the clinical record, that Resident #131 was moving his trach tube around so interventions could be put into place.

The policy on care plans was requested and contained the following: "An interdisciplinary plan of care will be established for every resident and

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updated in accordance with stated and federal regulatory requirements and on an as needed basis..."

The above information was discussed with the DON and the administrator in a meeting on 08/31/2022 at approximately 12:15 p.m. The administrator stated the care plan should have been updated.

No further information was obtained prior to the exit conference on 08/31/2022.

5. Resident #107 was admitted to the facility with diagnoses that included: hyperlipidemia, presence of pacemaker, anemia, stage 5 chronic kidney disease - requiring dialysis, muscle weakness, urinary tract infection, and afib. The most recent minimum data set (MDS) dated 08/08/2022 was the 5-day admission assessment and assessed Resident #107 as moderately impaired for daily decision making with a score of 12 out of 15.

Resident #107's clinical record was reviewed. Observed on the order summary report was the following order: "DNR (do not resuscitate). Order Date 08/18/2022." Resident #107's clinical record included a copy of a DNR form signed on 08/15/2022.

Resident #107's care plans included the following focus area with goals and interventions: "Resident identified Advanced Directives are Full Code. Date Initiated: 08/03/2022."

On 08/30/2022 at 6:10 p.m., the MDS Coordinator (RN #2) was interviewed regarding Resident #107's care plans. RN #2 reviewed Resident #107's clinical record and stated the

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advance directive/code status care plan should have been reviewed and revised to reflect the change from Full Code to DNR.

On 08/31/2022 at 12:14 p.m., the above findings were reviewed during a meeting with the administrator & DON.

6. Resident #8 was admitted to the facility with diagnoses that included: dependence on renal dialysis, anxiety disorder, dysphagia, long-term use of anticoagulant, dysphagia, anemia, hypercalcemia, depression, hypertensive heart, and acute embolism and thrombosis of right internal jugular vein. The most recent readmission assessment dated 07/19/2022 assessed Resident #8 as alert and oriented times 4.

On 08/30/2022, Resident #8 clinical record was reviewed. Observed on the care plans was the following focus area with goals and interventions, "The resident is on anticoagulant therapy r/t (related to) Right internal jugular vein thrombosis (RIJ DVT) and right basilic vein thrombosis. Date Initiated: 05/18/2022. Revised: 05/20/2022."

Resident #8's orders were reviewed and documented the following order: "Heparin Sodium (Porcine) Solution 5000 Unit/ML Inject 5000 unit subcutaneously every 12 hours for clotting prevention for 1 week. Start Date: 06/06/2022. End Date: 06/13/2022." Resident #8's medication administration record (MAR) was reviewed for the period of May 2022 through August 2022. The MARS documented Resident #8 received the Heparin as ordered for one week, ending on 06/13/2022.

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F 657	Continued From page 20 On 08/31/2022 at 8:26 a.m., the MDS Coordinator (RN #2) was interviewed regarding Resident #8's care plans. RN #2 reviewed Resident #8's clinical record and stated the anticoagulant care plan should have been resolved since the Heparin order was completed in June. On 08/31/2022 at 12:14 p.m., the above findings were reviewed during a meeting with the administrator & DON. On 08/31/2022 at 12:14 p.m., during a meeting with the administrator and DON concerns with care plans was discussed. The administrator stated, "the IDT (interdisciplinary team) meets daily and discusses any changes with the residents. The care plans are pulled up at that time and should be reviewed and revised daily at that time instead of waiting until the care plan meeting. This keeps everyone updated on the plan of care..."	F 657		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on facility document review, clinical records review and staff interview, the facility staff	F 881	Tag 881 1. Address how the facility will correct	9/19/22

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F 881	Continued From page 21 failed to ensure the infection prevention and control program (IPCP) antibiotic stewardship included antibiotic use protocols and an accurate system for monitoring antibiotic use. Findings include: On 08/31/22, the facility's antibiotic stewardship book/program was reviewed. The book/program did not consistently identify the type of infection, the antibiotic used, did not identify the specific organism, did not include the date of infection, specific symptoms and/or means of confirming infection prior to the prescribing and/or administering antibiotics. There was not a way to confirm the antibiotic prescribed was for the correct indication, dose, and duration to appropriately treat the resident. The antibiotic stewardship program for antibiotic use protocol(s) did not address antibiotic prescribing practices (i.e., documentation of the indication, dose, and duration of the antibiotic; review of laboratory reports to determine if the antibiotic is indicated or needs to be adjusted; an infection assessment tool or management algorithm is used when prescribing) and a system to monitor antibiotic use (i.e., antibiotic use reports, antibiotic resistance reports) were not found in the information provided by the administrator. The administrator stated that they do not currently have an IPCP preventionist at this time and stated that she has been gone since June 24th and that they recently hired someone for that role, but the person has not actually worked and was	F 881	the deficiency as it relates to the individual The facility will implement and maintain an Antibiotic Stewardship Program as part of the overall infection control program to help optimize the treatment of infections while reducing the adverse events associated with antibiotic use 2. Address how the facility will act to protect residents in similar situation The Infection Preventionist will develop and oversee resident care activities, maintain documentation, serve as a resource for all clinical staff, along with establishing systems for the prevention, identification, reporting investigations, control of infections and communicable diseases of residents. 3. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur. The infection Preventionist has been educated on 9/9/22 by the Administrator of the roles, responsibilities, and the specialized training of the Antibiotic Stewardship Program. The facility will maintain a qualified professional with a license at least part time to maintain the Antibiotic Stewardship program. The Director of Nursing will serve as a backup coordinator for the antibiotic stewardship program and continue to provide and carry oversight to ensure the adequate resources are being carried out. 4. Indicate how the facility will monitor its performance to make sure that solutions are sustained The DON will start 9/19 using the	

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F 881	Continued From page 22 supposed to start on Monday (August 29th), but had not started yet. The administrator stated that the previous DON (director of nursing) had left approximately 2-3 weeks and that the new/current DON has been at the facility for approximately 2 weeks. The administrator stated that she knew the program was lacking as the information was not being input into the system. The administrator was asked for a policy on antibiotic stewardship. The policy was presented and reviewed and documented, "...Antibiotic Stewardship Program...implement an Antibiotic Stewardship Program...optimize treatment of infections while reducing the adverse events associated with antibiotic use...includes antibiotic protocols and a system to monitor antibiotic use...complete an SBAR...lab testing...uses the (CDC's NHSN surveillance definitions) to define infections...Loeb minimum criteria are used to determine whether or not to treat an infection with antibiotics...monitoring...shall be reviewed for appropriateness...random audits...antibiotic use shall be measured by...monthly prevalence, antibiotic starts..." The administrator was made aware that the policy provided does not match the antibiotic stewardship program, that there no evidence of SBAR, lab testing, surveillance, and/or any criteria/algorithm for indications of use/necessity. No further information and/or documentation was provided prior to the exit conference on 08/31/22 to evidence that the facility had an effective and accurate antibiotic stewardship program in place.	F 881	Antibiotic Surveillance tool weekly times 6 months to audit the antibiotic use in the facility and will discuss weekly in the Risk Management meeting with the Interdisciplinary team. The Infection Preventist will participate on the quality assessment and assurance committee (QAA) and will report regularly on the antibiotic stewardship program on a quarterly basis.	

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F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure at least one staff member was designated as the infection preventionist who is responsible for the facility's IPCP (infection prevention and control program). Findings include: On 08/31/22 at approximately 7:30 AM, the	F 882	Tag 882 1. Address how the facility will correct the deficiency as it relates to the individual The facility will maintain a qualified professional with a license at least part time to maintain an infection control and prevention program to prevent transmission of communicable diseases and infections.	9/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495114	A. BUILDING _____ B. WING _____	C 08/31/2022

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F 882	Continued From page 24 facility's IPCP/antibiotic stewardship program was reviewed. The program presented did not consistently identify the type of infection, did not identify the specific organism, did not identify the antibiotic used/prescribed, did not include the date of infection, specific symptoms and/or means of confirming infection prior to the prescribing and/or administering antibiotics to residents. On 08/31/22 at approximately 9:30 AM, the administrator stated that they do not currently have an IPCP preventionist at this time and stated that she (infection preventionist) has been gone since June 24th and that they have not had anyone in that role, but did recently hire someone for that role. The administrator stated that the person has not actually worked yet and was supposed to start on Monday (August 29th), but had not started yet. The administrator stated that the previous DON (director of nursing) had left approximately 2-3 weeks ago and that the new/current DON has been at the facility for approximately 2 weeks. The administrator stated that she knew the program was lacking as the information was not being input into the system for the infection control program. The administrator was asked for a policy on antibiotic stewardship. The policy was presented and reviewed and documented, "...Antibiotic Stewardship Program...implement an Antibiotic Stewardship Program...the infection preventionist, with oversight from the DON, serves as the leader of the...program...DON serves backup..."	F 882	2. Address how the facility will act to protect residents in similar situation The Qualified professional will develop and oversee resident care activities, establish systems for the prevention, identification, reporting investigations, control of infections and communicable diseases of residents. 3. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur. The Infection Preventionist has been educated on 9/9/22 by the Administrator of the roles, responsibilities, and the specialized training in infection prevention and control. The facility will maintain a qualified professional with a license at least part time to maintain an infection control and prevention program to prevent transmission of communicable diseases and infections. The Director of Nursing will serve as a backup coordinator for the antibiotic stewardship program and continue to provide and carry oversight to ensure the adequate resources are being carried out. 4. Indicate how the facility will monitor its performance to make sure that solutions are sustained The Administrator will ensure the facility maintains a qualified nurse professional as the Infection Preventionist. The Qualified nurse professional will start training modules on 9/9/22 with a completion date of 9/19/22 and will participate on the quality assessment and assurance committee (QAA) and will	

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F 882	Continued From page 25 The administrator stated that the current DON had pretty much, just got here to the facility and has not been in that role. No further information and/or documentation was provided prior to the exit conference on 08/31/22 to evidence that the facility had a designated infection control preventionist.	F 882	report regularly on the infection prevention and control program activities on a quarterly basis.	