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	495085	A. BUILDING _____ B. WING _____	C 12/08/2022

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RIVER VIEW ON THE APPOMATTOX HEALTH & REHAB CENTER	201 EPPS STREET HOPEWELL, VA 23860

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 12/5/22 through 12/8/22. The facility was in substantial compliance with 42 CFR Part 483.73(b)(6) emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 124 certified bed facility was 108 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Focused Infection Control and Abbreviated survey was conducted 12/5/22 through 12/8/22. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements of Nursing Facilities. The census in this 124 bed certified bed facility was 108 at the time of the survey. The survey sample consisted of 27 resident reviews. Seven complaints were investigated while onsite. VA00057066 - substantiated with deficiency. VA00056421 - substantiated with no deficiency. VA00055873 - substantiated with deficiency. VA00054766 - substantiated with deficiency. VA00054693 - substantiated with deficiency. VA00054444 - substantiated with deficiency. VA00053800 - substantiated with deficiency.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5)	F 552		1/22/23

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

Electronically Signed | 01/05/2023

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

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F 552	Continued From page 1 §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, facility documentation, and in the course of an investigation, the facility staff failed to allow Residents to chose treatment option they prefer for 2 Residents (# 1 and #5) in a survey sample of 27 Residents. The findings included 1. For Resident #1 the facility staff refused the Resident's wishes to go to the Emergency Room when the Resident felt he needed to after a fall at the facility A review of the clinical record revealed the most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/23/21 coded	F 552	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility has taken or will take the actions set fort him the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. 1) Resident #1 no longer resides in the center and resident #5 no corrective action needed; any future change in condition will be addressed per policy. 2) All residents are at risk, if staff fail to allow resident to choose treatment option they prefer.	

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F 552	Continued From page 2 Resident #1 as having an BIMS (Brief Interview of Mental Status) score of 13 out of 15 indicating mild cognitive impairment. Resident #1 was documented as his own Responsible Party. On 12/6/22 at approximately 3:55 PM a review of the clinical record revealed the following progress notes: "1/1/2022 7:44 PM-Fall Note- Data: Resident call bell light on and hollering out. When staff entered room,resident noted to be laying on floor bedside bed. Wound to right hip open and bleeding. Pressure applied and bleeding stopped. Per resident he did hit his head, small hematoma noted to forehead. Per resident he was reaching for remote and fell out of bed on floor. Action: Assessed for injury, ROM, Vitals obtained, MD updated. Assisted staff back to bed. Resident is his own RP. Response: Encouraged resident to ring for assistance as needed." "1/1/2022 10:09 PM*Transfer Out(Acute/Emergency)-Reason for transfer and requires higher level of care (describe): post fall,wife called 911 from home to send patient to ER to be evaluated. Symptoms exhibited:patient hit head when falling out of bed, neurochecks within normal range and was explained to resident. Current TX (if applicable):neurochecks, vitals SBAR completed: n/a Bed Hold provided: yes Resident/Representative informed of reason for transfer: resident is his own RP. explained to resident we were providing care needed and was monitoring resident post fall, continued to refuse to stay in facility. Comprehensive Care Plan Goals sent: yes Resident/Representative's MD/Designee made aware of transfer: yes Personal property sent	F 552	3) Administrator or designee will re-educate all staff on resident□s rights. 4) The DON or designee will review 24-hour report for change in condition to ensure the resident was offer the preferred level of care 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5) Date of compliance January 22, 2023	

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F 552	Continued From page 3	F 552		

Nursing
with resident: (hearing aids, glasses, cell phone,electronic devices): cell phone and glasses COMMENTS:: NP updated."

Resident #1 went to the ER that night and returned to the facility with no new orders.

On 12/7/22 at approximately 11:00 AM an interview was conducted with the DON and the Corporate Nurse who stated that if a Resident is his or her own Responsible Party and they request to go to the ER then the process is to inform the MD and call for medical transport for non emergency and 911 for emergency situations. When asked if the Resident should be allowed to decide if he or she wants to go to the ER the DON answered, "Yes the choice is up to the Resident and the RP if the Resident cannot make decisions for him or herself"

On 12/7/22 the Administrator was made aware of the concerns and no further information was provided.

2. For Resident #5 the facility staff failed to honor the choice of the Resident to go to the Emergency Room when she felt ill.

A review of the clinical record revealed the most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/27/22 coded Resident #1 as having an BIMS (Brief Interview of Mental Status) score of 15 out of 15 indicating no cognitive impairment. Resident #5 has diagnoses that include but are not limited to COPD (Chronic Obstructive Pulmonary Disease) requiring

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F 552	Continued From page 4	F 552		

oxygen, CHF (Congestive Heart Failure), Hypertension, and is non ambulatory and requires a mechanical lift for transfers. Resident #5 was documented as her own Responsible Party.

On 12/06/2022 at approximately 5:30 P.M., Resident #5 was interviewed with Surveyor C and Surveyor D present. When asked about assistance with ADL's, Resident #5 stated that she would call her daughter so her daughter could tell us how many times she has called her daughter about the care she received. The Resident's daughter spoke about various complaints and among them was the time in August 2022 when Resident #5 felt sick, had shortness of breath, and wanted to go to the ER. The Resident's daughter stated that her mother requested to go to the ER for feeling short of breath and generally unwell. According to the Residents daughter the facility staff told her "We can treat you here you don't need to go to the ER." The Resident stated that she had asked the nurse several times to call 911 but she did not. The Resident stated that she called the emergency squad herself.

A review of the grievance log revealed the following from Resident #5's daughter:

"8/12/22 - Nature of concern: feels that her mother's asking to go to the hospital was ignored- she said the NP (Nurse Practitioner) called her Tues and stated she was shocked [Resident name redacted] hadn't been sent to the hospital . NP stated that she had told the staff if she C/O (complains of) any more chest pain to send her out. She also complained about call bell response times and wants a meeting with staff when [Resident name redacted] returns from the

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F 552	Continued From page 5 hospital." "Investigation of Concerns: I did a follow up call with [daughter's name redacted] on 8/12/22 at 1:35 p.m. She feels that if her mom wants to go to the hospital no matter what it should be followed. Also discussed call bell being answered timely." "Plan of Action - Plan to discuss repeated hospitalization with [Resident name redacted] and team with ways to reduce the need for urgent care." On 12/7/22 at approximately 11:00 AM an interview was conducted with the DON and the Corporate Nurse who stated that if a Resident is his or her own Responsible Party and they request to go to the ER then the process is to inform the MD and call for medical transport for non emergency and 911 for emergency situations. When asked if the Resident should be allowed to decide if he or she wants to go to the ER the DON answered, "Yes the choice is up to the Resident and the RP if the Resident cannot make decisions for him or herself" On 12/7/22 the Administrator was made aware of the concerns and no further information was provided.	F 552		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or	F 558		1/22/23

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F 558	Continued From page 6 other residents. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, facility documentation and in the course of an investigations, facility staff failed to provide the services with reasonable accommodation of resident needs and preferences for 1 Residents (#2) in survey sample of 27 Residents. The findings included: On 12/6/22 at approximately 2:00 PM an interview was conducted with Resident #2's father. The Resident's father explained that the Resident has been in the facility since 2014. Upon admission to the facility Resident #2 had a bed that was both for pressure relief and prevention of wounds but also to keep his head elevated due to the shunt in his head and to prevent the fluid from back-flowing up into the Residents head. The Resident's father stated that during COVID the bed broke and they replaced it with a bed that is an air mattress for wounds however it is not the same as the other one with regards to the head elevation. The Resident's father stated that he has come in and found the side of his son's head swollen where they laid him flat in the bed due to his shunt this is not acceptable practice. According to the Resident's father this was never an issue when he had "the other bed." The Resident's father stated that he has had many conversations over the years about the bed but no one seems to do anything about it. On 12/6/22 an interview was conducted with the DON who stated she had just started this year and was unaware of the issue regarding the bed.	F 558	1) Resident #2 bed re-assessed and meets resident accommodation and need. 2) All residents are at risk for deficient practice of reasonable accommodations of residents needs if preference not met. 3) DON or Designee will educate nursing staff on reasonable accommodations related to bed and mattress preference. 4) The DON or Designee will review 10% of patients who require specialized beds to ensure the bed in place and functioning weekly x 12 weeks and report findings to QAPI committee. 5) Date compliance January 22, 2023	

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F 558	Continued From page 7 She stated that she has since spoken with the father and will be working closely with him to obtain the bed that is preferable and more appropriate for Resident #2. On 12/7/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		1/22/23

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F 580	Continued From page 8 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility documentation review, the facility staff failed to notify the physician and Responsible Party of a Change in Condition for one Resident (Resident #6) in a sample size of 27 Residents. For Resident #6, the Physician and Responsible Party were not notified of a nose abscess on 11/25/2021. The findings included: On 12/06/2022 and 12/07/2022, Resident #6's clinical record was reviewed. An excerpt of a progress note dated 11/26/2021 at 11:00 A.M. documented, "Resident left facility via wheelchair, with daughter. CNA stated daughter said yesterday she would be back today at 11am to	F 580	1) Resident # 6 - no corrective action needed; any future change in condition will be addressed per policy. 2) All residents are at risk for the deficient practice if staff fail to notify responsible party and physician of change of condition. 3) DON or Designee will re-educate licensed nurses on policy for notification of responsible party and physician of change in condition. 4) DON or designee will review 24-hour report 3 x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5) Date compliance January 22, 2023	

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take mom to ER to have nose checked."

An excerpt of a progress note dated 11/26/2022 at 8:00 P.M. documented, ": Resident return with daughter from ER [emergency room]. Resident in good spirits. No complaints voiced upon return at this time. resident new orders entered by treatment nurse. Bactrim DS 800/160mg [antibiotic] po [by mouth] twice daily for 10 days, Mupirocin (Bactroban 2%of oint [antibiotic ointment]) twice a day for 10 days r/t [related to] abscess incision done at ER. Warm compress every 3-4 hours for 10-15mins to place on nose area per ER MD [emergency room medical doctor] orders."

There was no evidence in the clinical record that facility staff identified, assessed, monitored, or notified physician and Responsible Party of the nose abscess prior to the Responsible Party recognizing it and taking Resident #6 to the emergency room for treatment.

On 12/07/2022 at 4:15 P.M., Licensed Practical Nurse B (LPN B), unit manager, was interviewed. When asked about Resident #6's emergency room visit for the nose abscess dated 11/26/2021, LPN B referred to Resident #6's clinical record and verified there was no evidence the nose abscess was identified, assessed, or monitored.

On 12/07/2022 at 4:45 P.M., the Corporate Nurse Consultant was notified of findings.

The facility staff provided a copy of their policy entitled, "Notification of Changes." Under the header entitled, "Policy", it was documented, "The purpose of this policy is to ensure the Center promptly informs the patient, consults the

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F 580	Continued From page 10 patient's physician/physician extender; and notifies, consistent with his or her authority, the patient's legal representative when there is a change requiring notification."	F 580		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to protect 3 Residents from abuse (Confidential Informant, Resident #16, Resident #5) in a sample size of 27 Residents. 1. A Confidential Informant experienced the Administrator being rude to them and did not want to be identified for fear of retaliation. 2. Resident #16 experienced harassment and bullying from the Administrator.	F 600	1)Resident #16, no untoward effect noted, FRI Submitted 12/7/22 investigation concluded on 12/13/22, #5, no untoward effect noted, FRI Submitted 12/7/22 investigation concluded on 12/13/22 2) All patients have the potential to be affected by deficient practice. 3) Corporate Designee will re-educate all facility staff on abuse, neglect, and report policy. 4) The DON or Designee will conduct 5 random patient interviews regarding abuse and neglect 3x a week for 2 weeks,	1/22/23

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F 600	Continued From page 11 3. Resident #5 experienced verbal/mental abuse from the Administrator. The findings included: On 12/06/2022 at approximately 3:30 P.M., a Confidential Resident interview was conducted. During the course of the conversation, the Resident stated that staff were rude to them. When asked for names of staff that were rude to them, the Resident stated that they did not want to provide names for fear of retaliation. When asked if it was reported to the Administrator, the Resident stated that the Administrator was also rude to them. The Resident did not want to talk about it further and wanted the information to remain confidential. A review of the Confidential Informant's most recent Minimum Data Set revealed that the Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition. On 12/06/2022 at approximately 4:15 P.M., Resident #16 requested to speak with this surveyor. Resident #16 stated that they have "an issue with the Administrator." Resident #16 stated that her significant other put a criticism of the facility on a social media post and "the Administrator bullied me and my family to take it down." Resident #16 also stated that the Administrator "asked me if I knew the login and password so I could go in and remove the post." Resident #16 also stated that the Administrator "doesn't want to talk with you but talks down to you." Resident #16 stated that the Administrator had a meeting with them and their family in the Administrator's office and Resident #16 felt	F 600	then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5)Date compliance January 22, 2023	

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"cornered."

A review of Resident #16's most recent quarterly Minimum Data Set with an Assessment Reference Date of 10/23/2022 revealed that the Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition.

On 12/06/2022 at approximately 5:30 P.M., Resident #5 was interviewed. When asked about any interactions with the Administrator, Resident #5 went on to explain an exchange that occurred between Resident #5 and the Administrator. Resident #5 stated that she told the Administrator that "some of her things were taken out of her room while she was sleeping." Resident #5 stated that she was missing all her bath stuff, clothes, undergarments, socks, and shoes. Resident #5 stated that the Administrator then walked over to her closet and opened it and told Resident #5 all her stuff was there. Resident #5 stated she explained to the Administrator it had happened a few weeks ago and the clothes have since been replaced but was still missing her lotion. Resident #5 stated that the Administrator then said, "Are you sure you didn't get up and get it yourself?" Resident #5 stated the Administrator also said, "Because a lot of people around here imagine things." Resident #5 stated she answered the Administrator by saying "I can't walk, I can't get out of this bed." Resident #5 also reported that in the course of her conversation with the Administrator, the Administrator stated, "You can leave if you want; do you want to stay here?" When asked about how this encounter with the Administrator made her feel, Resident #5 stated that "It upset me the way she was talking to me." Resident #5 stated, "She made me feel like I was

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nothing." Resident #5 stated that the Administrator was "giving me body language - rolling her eyes, looking at the ceiling, tapping her feet." Resident #5 stated that the Administrator "made me feel like a liar" and "I was crying and couldn't sleep." Resident #5 also stated that some of the aides didn't treat her right but refused to name them for fear of retaliation. Resident #5 stated "They'll come back at me." Resident #5 stated that they would do "petty things like take food off my tray; close my room door."

A review of Resident #5's most recent annual Minimum Data Set with an Assessment Reference Date of 10/27/2022 revealed that the Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition. Functional status for bed mobility, dressing, and personal hygiene were coded as requiring extensive assistance from staff. Transferring did not occur and toileting was coded as total dependence on staff.

On 12/06/2022 at approximately 5:45 P.M., the Corporate Nurse Consultant was notified 3 Residents (Confidential Informant, Resident #16, and Resident #5) reported experiencing abuse by the Administrator. The Corporate Nurse Consultant stated they would immediately remove the Administrator from the building pending an investigation.

On 12/07/2022 at approximately 2:50 P.M., the Regional Nurse Consultant and the Regional Director of Operations met with the survey team in the conference room. When asked about the investigation, the Regional Director of Operations stated that the investigation was still ongoing. The Regional Director of Operations stated that a

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random sweep of Residents was conducted and 7 Residents were interviewed screening for abuse. The Regional Nurse Consultant stated that Resident #16 and Resident #5 were also interviewed. When asked about this, the Regional Nurse Consultant stated that Resident #5 just "spoke about missing items and reported it to [The Administrator]." Pertaining to Resident #16, the Regional Nurse Consultant stated that it was about a social media post and (the Administrator) "approached her to ask if she would be willing to remove the post-had a family meeting and her [Significant Other name] agreed to take it down and she felt harassed by the Administrator." When asked how the Administrator would know about the social media post, the Regional Nurse Consultant stated that the corporate legal department notified the Administrator about the social media post.

On 12/08/2022, the facility staff provided a copy of the Facility-Reported Incident and supporting documents of the ongoing investigation which included the following:

Excerpts of an interview with Resident #5 by the Corporate Nurse Consultant dated 12/06/2022 at 8:30 P.M. documented the following: "Interview resident regarding allegation of abuse reported. [Resident #5] stated that [name] the Administrator was walking by her room she called out [name of Administrator] to come to her room due to dropping item on the floor. At that time, she [Resident #5] realized that [name] was the Administrator she began express concern [sic] regarding missing items. She reports that she was missing clothes, shoes, and toiletries item [sic] specifically bath and body lotion. She stated that [the Administrator] just looks at her like she

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was crazy. Specifically asked resident if the center replace [sic] her items, she stated yes [name of Regional Director of Operations] the man her [sic] before replacing all my items except my shoe."

An interview with Resident #16 by the Corporate Nurse Consultant dated 12/06/2022 at 9:00 P.M. documented the following: "Report that [name] the Administrator and her as altercation regarding social media post that her significant other [name] posted. [Administrator name] requested that [name] her significant other take the post down. [Administrator name] as [sic] if [Resident #16] could obtain her significant other password to assist with removing the social media post. Stated that [Administrator name] request to get this corrected felt harassed. During visit with her significant [sic] and family {Administrator name] call them into the office and [Significant Other name] agreed to take the social media post down. Resident stated that as resident council present [sic] that she feels [Administrator name] talks down to her and other resident [sic] that she feels like she can address concerns with her as the resident council president."

A typewritten, undated, unsigned statement by the Administrator documented the following: "On the evening of 10/6 it was reported to me by [corporate nurse consultant] that a surveyor was stating there were alleged allegations of abuse against me by three residents. Per conversation with surveyors, they provided names of those who are alleging "abuse" but were unable to provide any context to what abuse they were alleging against me. Protocol was followed and I left the center. The statements that follow are my response to interviews during the investigation.

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Since surveyors have not provided anyone with what the allegations are the statements are purely recalled encounters I have had with each of the residents. The safety of both residents and employees of my center is of the utmost importance to me.

I was asked to recall any situations or encounter with [Resident #5]. It is important to note that [Resident #5] has never been able to recall my name and additionally has a history of calling me the doctor or even confusing me as a nurse. Our interactions are typically pleasant and she usually tells me about some medication she wants ordered and I often remind her that I am not the physician but that I will relay the information to her medical team. On a recent visit to her room, she told me that her deodorant was missing. I asked if I could help her look for it, she said yes, but that it was gone. I opened her cabinet and was able to locate the deodorant and so I also showed it to her. She then started cussing and becoming angry. [Resident #5] has had these types of outbursts from time to time.

Additionally I was asked to recall any social media interactions with [Resident #16]. In response to all social media posts, the concerns are forwarded to me and I am asked to follow up on the post. The post in which I am assuming she is referring to was vague and said something of the nature that everyone was lazy in the center and no one cared, it was posted under her boyfriend's name [name]. I attempted to gain more information about what was shared and reached out to [Significant Other name], whom I thought posted the information, he stated he would be at the center and that they ([Resident #5] and he) would like to chat with me. I welcome

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dialogue with my residence and their families, if they choose, at any time. During this meeting I asked [Resident #16] and the family to please feel free to express any concerns to me directly as social media may have filters and does not always get to me quickly in order for me to address and to resolve. [Residence #16] apologized and said that she knew all staff were not lazy but that she was just having a bad day and she would remove the post. Additionally she said that if it wasn't removed would I please I let her know because she didn't really know how to work Google reviews well. She also told me that she was the one who had posted the review on her boyfriend's account. I did not ask or tell [Resident #16] to take the post down, this was something she offered to do herself. I later saw her during rounds check in with her as normal. I did let her know that the post was still on the Google reviews. She said she thought she had taken it down but that again she didn't really know how to use the reviews well, but that she would try again. There were no further comments in regards to this social media post. This event occurred approximately 7 months ago. My interactions following have been pleasant with both [Resident #16] and her family."

On 12/08/2022, Resident #5's care plan was reviewed. There was no evidence on the care plan Resident #5 had a known behavior of cussing, becoming angry, or having outbursts as the Administrator indicated in her above written statement. The progress notes from 08/26/2022 through 12/03/2022 were reviewed. There was no evidence in the progress notes that Resident #5 displayed incidents of cussing, becoming angry, or having outbursts as the Administrator indicated in her above written statement.

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F 600	Continued From page 18 On 12/08/2022 at approximately 11:00 A.M., the Regional Director of Operations notified the survey team they brought in other social workers to interview Residents for abuse screening. The Regional Director of Operations confirmed that the Administrator of Record served as both the Abuse Coordinator and Grievance Officer. The facility staff provided a copy of their policy entitled, "Abuse Prevention." Under the header, "Policy", an excerpt documented, "The facility is committed to maintaining a safe and abuse-free environment for all residents and committed to a comprehensive investigation of any allegation of activities or situations that may constitute abuse." Under the header, "Definitions" an excerpt documented, "Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology." "Mental or psychological abuse-causing mental or emotional pain or distress." On 12/08/2022 at 3:30 P.M., the Corporate Nurse Consultant, Director of Nursing, and the Regional Director of Operations were notified of findings. The Corporate Nurse Consultant stated there was no further information or documentation to submit.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and	F 607		1/22/23

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F 607	Continued From page 19 misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to implement their abuse policy for 2 Residents (Resident #18, Resident #22) in a sample size of 27 Residents and one staff member (Staff 9) in a staff sample size of 5 staff members. 1) For Resident #18, the facility staff failed to protect, report, and investigate an allegation of abuse on 11/13/2021. 2) For Resident #22, the facility staff failed to	F 607	1) Resident # 18 □ no longer resides in the facility. Resident # 22 □ no longer resides in the facility. Staff member #9 completed annual abuse training. 2) All residents have the potential to be affected by deficient practice. Resident and staff interview were conducted to determine if any other allegations of abuse existed. 3) The DON or Designee will re-educate all staff on abuse and report policy 4) The DON or Designee will conduct 5 random resident interviews regarding	

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F 607	Continued From page 20 protect, report, and investigate an allegation of abuse/neglect on 11/29/2021. 3) For Staff 9, the facility staff failed to ensure annual abuse prevention training in 2020. The findings included: 1) On 12/06/2022, the facility staff provided a copy of their policy entitled, "Abuse Prevention." In Section 5 entitled, "Investigation" and subpart A, it was documented, "Designated staff will immediately review and investigate all incident reports." In Section 6 entitled, "Protection" subpart A, it was documented, "The facility will immediately assess the resident, notify the physician and resident representative, and protect the resident from further harm or incident." In Section 7 entitled, "Reporting/Response" in subpart A, an excerpt documented, "The Facility Administrator, DON [Director of Nursing] or designee must report all alleged incidents of abuse, neglect ..." The facility staff provided a copy of their policy entitled, "Grievance Policy." In Section 9(b) it was documented, "Report any allegations involving neglect, abuse, injuries of unknown source, and/or misappropriation of patient property immediately to the Administrator and follow procedures for those allegations." On 12/06/2022, the grievance logs from November 2021 through December 2022 were reviewed. A grievance form dated 11/13/2021 concerning Resident #18 under the header "Nature of the Concern" documented, "[Resident #18] stated upon arrival to the facility he was	F 607	abuse, neglect and care provided 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5) Date compliance January 22, 2023	

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taken to his room and he asked nurse for some water and she went off on him and the roommate for asking. They both said it was so rude and it didn't make since [sic]." Under the header "Investigation of Concern", it was documented, "Gave concern to SW [social worker], no water pitcher in room, I gave him one." Under the header "Pertinent Findings/Conclusions", it was documented, "No water pitcher in room." Under the header "Plan of Action", it was documented, "Agency nurse no longer here, educated staff on importance of greeting residents appropriately and professionally."

On 12/07/2022 at approximately 11:45 A.M., a Facility-Reported Incident (FRI) and all supporting documents were requested and the Corporate Nurse Consultant verified she was unable to locate a FRI associated with the above allegation of abuse.

On 12/08/2022, Resident #18's clinical record was reviewed. A review of the progress notes around the date of the incident of 11/13/2021 revealed there were no nurse's notes or social worker notes addressing the above incident.

On 12/08/2022 at approximately 3:30 P.M., the Corporate Nurse Consultant and Regional Director of Operations were notified of findings. The Corporate Nurse Consultant stated that this grievance should have been reported and investigated as an allegation of abuse.

2)
On 12/06/2022, the facility staff provided a copy of their policy entitled, "Abuse Prevention." In Section 5 entitled, "Investigation" and subpart A, it

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was documented, "Designated staff will immediately review and investigate all incident reports." In Section 6 entitled, "Protection" subpart A, it was documented, "The facility will immediately assess the resident, notify the physician and resident representative, and protect the resident from further harm or incident." In Section 7 entitled, "Reporting/Response" in subpart A, an excerpt documented, "The Facility Administrator, DON [Director of Nursing] or designee must report all alleged incidents of abuse, neglect ..."

The facility staff provided a copy of their policy entitled, "Grievance Policy." In Section 9(b) it was documented, "Report any allegations involving neglect, abuse, injuries of unknown source, and/or misappropriation of patient property immediately to the Administrator and follow procedures for those allegations."

On 12/06/2022, the grievance logs from November 2021 through December 2022 were reviewed. A grievance form dated 11/29/2021 concerning Resident #22 under the header "Nature of the Concern" documented, "[Resident #22] Stated he needed to be changed this morning and was told 'you're not wet enough' and closed his brief back up." Under the header "Pertinent Findings/Conclusions", it was documented, "Agency CNA [certified nursing assistant] not available to speak with; spoke with resident and encouraged resident if assistance with ADL's [activities of daily living] is not met ask to speak with myself or any member of management."

On 12/07/2022 at approximately 11:45 A.M., a Facility-Reported Incident (FRI) and all supporting

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documents were requested and the Corporate Nurse Consultant verified she was unable to locate a FRI associated with the above allegation of abuse/neglect.

On 12/07/2022 at approximately 4:00 P.M., Certified Nursing Assistant C (CNA C) was interviewed. When asked about the process for providing incontinence care, CNA C stated that every 2-3 hours, she checks to see if the brief needs to be changed. CNA C stated that even if the brief is only a little wet, she would change the brief.

On 12/08/2022, Resident #22's clinical record was reviewed. According to the progress notes, Resident #22 was discharged from the facility on 12/14/2021. There was no evidence in the notes of the above incident. According to Resident #22's admission Minimum Data Set with an Assessment Reference Date of 11/22/2021, the Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition.

On 12/08/2022 at approximately 3:30 P.M., the Corporate Nurse Consultant and Regional Director of Operations were notified of findings. The Corporate Nurse Consultant stated that this grievance should have been reported and investigated as an allegation of abuse.

3)
On 12/06/2022, the facility staff provided a copy of their policy entitled, "Abuse Prevention." In Section 2(D), it was documented, "Annual in-services on the steps to report allegations of abuse or observations of abuse, neglect,

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F 607	Continued From page 24 mistreatment or exploitation, resident rights, care of the aging population, behavior interventions, and other topics as mandated by state and federal regulation will be provided for staff." On 12/08/2022 at approximately 12:45 P.M., the facility staff provided the abuse prevention training transcripts for 5 employees as requested. A review of the transcripts revealed the following: Staff 9, a certified nursing assistant with a hire date of 08/29/2017, did not receive abuse prevention training in 2020. On 12/08/2022 at approximately 3:45 P.M., the Corporate Nurse Consultant and Regional Director of Operations were notified of findings.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		1/22/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 25 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to report allegations of abuse/neglect for 2 Residents (Resident #18, Resident #22) in a sample size of 27 Residents. 1) For Resident #18, the facility staff failed to report an allegation of abuse on 11/13/2021. 2) For Resident #22, the facility staff failed to report an allegation of abuse/neglect on 11/29/2021. The findings included: 1) On 12/06/2022, the facility staff provided a copy of their policy entitled, "Abuse Prevention." In Section 7 entitled, "Reporting/Response" in subpart A, an excerpt documented, "The Facility Administrator, DON [Director of Nursing] or designee must report all alleged incidents of abuse, neglect ..." On 12/06/2022, the grievance logs from November 2021 through December 2022 were	F 609	1. Resident # 18 □ no longer resides in the facility, late FRI submitted on 12/8/22. Resident # 22 □ no longer resides in the facility, late FRI submitted on 12/8/22. 2. All residents have the potential to be affected by deficient practice. Resident and staff interviews were conducted to determine if any other allegations of abuse existed. 3. The DON or Designee will re-educate all staff on abuse and report policy 4. The DON or Designee will conduct 5 random resident interviews regarding abuse, neglect and care provided 3 x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5. Date compliance January 22, 2023	

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F 609	Continued From page 26	F 609		

reviewed. A grievance form dated 11/13/2021 concerning Resident #18 under the header "Nature of the Concern" documented, "[Resident #18] stated upon arrival to the facility he was taken to his room and he asked nurse for some water and she went off on him and the roommate for asking. They both said it was so rude and it didn't make since [sic]." Under the header "Investigation of Concern", it was documented, "Gave concern to SW [social worker], no water pitcher in room, I gave him one." Under the header "Pertinent Findings/Conclusions", it was documented, "No water pitcher in room." Under the header "Plan of Action", it was documented, "Agency nurse no longer here, educated staff on importance of greeting residents appropriately and professionally."

On 12/07/2022 at approximately 11:45 A.M., a Facility-Reported Incident (FRI) and all supporting documents were requested and the Corporate Nurse Consultant verified she was unable to locate a FRI associated with the above allegation of abuse.

On 12/08/2022 at approximately 3:30 P.M., the Corporate Nurse Consultant and Regional Director of Operations were notified of findings. The Corporate Nurse Consultant stated that this grievance should have been reported as an allegation of abuse.

2)
On 12/06/2022, the facility staff provided a copy of their policy entitled, "Abuse Prevention." In Section 7 entitled, "Reporting/Response" in subpart A, an excerpt documented, "The Facility Administrator, DON [Director of Nursing] or

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F 609	Continued From page 27 designee must report all alleged incidents of abuse, neglect ..." On 12/06/2022, the grievance logs from November 2021 through December 2022 were reviewed. A grievance form dated 11/29/2021 concerning Resident #22 under the header "Nature of the Concern" documented, "[Resident #22] Stated he needed to be changed this morning and was told 'you're not wet enough' and closed his brief back up." Under the header "Pertinent Findings/Conclusions", it was documented, "Agency CNA [certified nursing assistant] not available to speak with; spoke with resident and encouraged resident if assistance with ADL's [activities of daily living] is not met ask to speak with myself or any member of management." On 12/07/2022 at approximately 11:45 A.M., a Facility-Reported Incident (FRI) and all supporting documents were requested and the Corporate Nurse Consultant verified she was unable to locate a FRI associated with the above allegation of abuse/neglect. On 12/08/2022 at approximately 3:30 P.M., the Corporate Nurse Consultant and Regional Director of Operations were notified of findings. The Corporate Nurse Consultant stated that this grievance should have been reported and investigated as an allegation of abuse.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		1/22/23

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F 610	Continued From page 28 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to investigate allegations of abuse for 2 Residents (Resident #18, Resident #22) in a sample size of 27 Residents. 1) For Resident #18, the facility staff failed to investigate an allegation of abuse on 11/13/2021. 2) For Resident #22, the facility staff failed to investigate an allegation of abuse/neglect on 11/29/2021. The findings included: 1) On 12/06/2022, the facility staff provided a copy of their policy entitled, "Abuse Prevention." In Section 5 entitled, "Investigation" and subpart A, it was documented, "Designated staff will immediately review and investigate all incident	F 610	1. Resident # 18 □ no longer resides in the facility, late FRI submitted on 12/8/22. Resident # 22 □ no longer resides in the facility, late FRI submitted on 12/8/22. 2. All residents have the potential to be affected by deficient practice. Resident and staff interviews were conducted to determine if any other allegations of abuse existed. 3. The DON or Designee will re-educate all staff on abuse and report policy 4. The DON or Designee will conduct 5 random resident interviews regarding abuse, neglect and care provided 3 x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5. Date compliance January 22, 2023	

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F 610	Continued From page 29	F 610		

reports."

On 12/06/2022, the grievance logs from November 2021 through December 2022 were reviewed. A grievance form dated 11/13/2021 concerning Resident #18 under the header "Nature of the Concern" documented, "[Resident #18] stated upon arrival to the facility he was taken to his room and he asked nurse for some water and she went off on him and the roommate for asking. They both said it was so rude and it didn't make since [sic]." Under the header "Investigation of Concern", it was documented, "Gave concern to SW [social worker], no water pitcher in room, I gave him one." Under the header "Pertinent Findings/Conclusions", it was documented, "No water pitcher in room." Under the header "Plan of Action", it was documented, "Agency nurse no longer here, educated staff on importance of greeting residents appropriately and professionally."

On 12/07/2022 at approximately 11:45 A.M., a Facility-Reported Incident (FRI) and all supporting documents were requested and the Corporate Nurse Consultant verified she was unable to locate a FRI associated with the above allegation of abuse.

On 12/08/2022, Resident #18's clinical record was reviewed. A review of the progress notes around the date of the incident of 11/13/2021 revealed there were no nurse's notes or social worker notes addressing the above incident.

On 12/08/2022 at approximately 3:30 P.M., the Corporate Nurse Consultant and Regional Director of Operations were notified of findings. The Corporate Nurse Consultant stated that this

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F 610	Continued From page 30	F 610		

grievance should have been investigated as an allegation of abuse.

2)
On 12/06/2022, the facility staff provided a copy of their policy entitled, "Abuse Prevention." In Section 5 entitled, "Investigation" and subpart A, it was documented, "Designated staff will immediately review and investigate all incident reports."

On 12/06/2022, the grievance logs from November 2021 through December 2022 were reviewed. A grievance form dated 11/29/2021 concerning Resident #22 under the header "Nature of the Concern" documented, "[Resident #22] Stated he needed to be changed this morning and was told 'you're not wet enough' and closed his brief back up." Under the header "Pertinent Findings/Conclusions", it was documented, "Agency CNA [certified nursing assistant] not available to speak with; spoke with resident and encouraged resident if assistance with ADL's [activities of daily living] is not met ask to speak with myself or any member of management."

On 12/07/2022 at approximately 11:45 A.M., a Facility-Reported Incident (FRI) and all supporting documents were requested and the Corporate Nurse Consultant verified she was unable to locate a FRI associated with the above allegation of abuse/neglect.

On 12/08/2022 at approximately 3:30 P.M., the Corporate Nurse Consultant and Regional Director of Operations were notified of findings. The Corporate Nurse Consultant stated that this

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F 610	Continued From page 31 grievance should have been investigated as an allegation of abuse.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		1/22/23

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F 656	Continued From page 32 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review during a complaint investigation, the facility staff failed to develop a comprehensive care plan for one Resident (Resident # 4) in a survey sample of 27 residents. For Resident # 4, the facility staff failed to include the problems and interventions to address issues with the Resident's feet. The findings include: Resident # 4 was admitted to the facility in June 2021. Diagnoses included but were not limited to: Insulin Dependent Diabetes Mellitus, Heart Failure, Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, Diabetic Neuropathy and Chronic Kidney Failure. Resident # 4's most resent MDS (Minimum Data Set) with an Assessment Reference Date of 11/14/2022 was coded as a Quarterly assessment. The Brief Interview for Mental Status was coded as "13" out of possible "15" indicating no cognitive impairment. Functional	F 656	1. Resident #4 care-plan updated to include podiatry care 2. All patients have the potential to be affected by deficient practice. 3. The DON or designee will re-educate the Department of Social Services, MDS Department, and all licensed nurses developing comprehensive care-plan. 4. Administrator or designee will audit 10 resident care plans to ensure podiatry care in care-planned as per physician orders and standard of practice, weekly for 12 weeks and report findings to QAPI committee. 5. Date of compliance January 22, 2023	

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F 656	Continued From page 33	F 656		

status for (ADLs) Activities of Daily Living were coded as requiring limited to extensive assistance from staff. Urinary continence and Bowel continence were coded as frequently incontinent.

On 12/5/2022 through 12/8/2022, the clinical record for Resident # 4 was reviewed.

On initial tour on 12/5/2022 at 3:30 p.m., Resident # 4 was observed sitting in a wheelchair wearing green "Bunny Boots" on both feet. Resident # 4 expressed being upset about a lot of things at the facility. Resident # 4 stated both feet should be elevated when out of bed and that the boots were not to be worn when up in the chair. Resident # 4 stated the feet did not look better and was worried "they might get worse." Both feet appeared swollen. Resident # 4 stated both feet were swollen when questioned.

Review of the Podiatry consult notes from 10/18/2022 revealed documentation of 4 orders including the order for Lac-Hydrin Lotion 12 % (Ammonium Lactate) Apply to Bilateral Feet top and bottom every morning and every evening for dry flaking skin.

The consult note stated a dermatology appointment would be needed to treat the clinical skin conditions of the resident's feet.

Review of the care plan revealed no documentation of the skin issues identified by the Podiatry visit and the need for a Dermatology consult. There was no documentation on the care plan to have feet elevated when up in the wheelchair. There was no documentation of the care plan being updated after the Podiatry visit.

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F 656	Continued From page 34 On 12/8/2022 at 3:10 p.m., an interview was conducted with LPN (Licensed Practical Nurse) C who stated the facility staff should follow the care plans and that care plans should be individualized for each resident. On 12/8/2022 at 3:30 p.m., the Director of Nursing stated care plans should be reflective of the Resident and updated as needed. During the end of day debriefing, the Director of Nursing and Corporate Nurse Consultant were informed of the findings. No further information was provided.	F 656		
F 658 SS=D	COMPLAINT DEFICIENCY 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 clinical record review, staff interview, and facility documentation review, the facility staff failed to provide care and services according to professional standards of practice for One Residents (Resident #4) in a sample size of 27 Residents. 1. For Resident # 4, the facility staff failed to transcribe new orders from the Podiatrist on 10/18/2022, failed to administer medications as ordered by the physician.	F 658	1. Resident #4 physician orders updated to include current podiatry orders. 2. All residents have the potential to be affected by deficient practice. A 7-day review was completed to ensure proper transcription of new provider orders. 3. DON or Designee will re-educate all licensed nurses on proper transcription of provider orders. 4. DON or designee will randomly review 10 resident□s new provider orders to	1/22/23

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F 658	Continued From page 35 The findings included: 1. For Resident # 4, the facility staff failed to transcribe new orders from the Podiatrist on 10/18/2022, failed to administer medications as ordered by the physician Resident # 4, was admitted to the facility in June 2021. Diagnoses included but were not limited to: Insulin Dependent Diabetes Mellitus, Heart Failure, Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, Diabetic Neuropathy and Chronic Kidney Failure. Resident # 4's most resent MDS (Minimum Data Set) with an Assessment Reference Date of 11/14/2022 was coded as a Quarterly assessment. The Brief Interview for Mental Status was coded as "13" out of possible "15" indicating no cognitive impairment. Functional status for (ADLs) Activities of Daily Living were coded as requiring limited to extensive assistance from staff. Urinary continence and Bowel continence were coded as frequently incontinent. On 12/5/2022 through 12/8/2022, the clinical record for Resident # 4 was reviewed. Review of the Active Physicians Orders revealed orders that included: Prevalon Boots to bilateral heels while in bed As tolerated every shift. Voltaren Gel 1 % (Diclofenac Sodium) Apply to both feet topically ... Ordered 11/30/2022 20:00 11/30/2022 Actions apply skin prep to bilateral heels every	F 658	ensure accurate transcription 3 x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through and report findings to QAPI committee. 5. Date compliance January 22, 2023	

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shift for prevention
Lac-Hydrin Lotion 12 % (Ammonium Lactate) Apply to Bilateral Feet top and bottom every morning ... Pharmacy Active 6/8/2021 07:00 11/17/2021

Review of the Podiatry consult notes from 10/18/2022 revealed documentation of 4 orders including the order for Lac-Hydrin Lotion 12 % (Ammonium Lactate) Apply to Bilateral Feet top and bottom every morning and every evening for dry flaking skin. The consult note stated a dermatology appointment would be needed to treat the clinical skin conditions of the resident's feet. The note stated the prescriptions had "been sent to the pharmacy.

Further review of the Active Physicians Orders revealed no documentation of the orders from the Podiatry consult visit on 10/18/2022.

Review of the December 2022 Medication Administration Record on page 18 of 19 revealed documentation of Lac-Hydrin Lotion 12% (Ammonium Lactate) Apply to Bilateral Feet top and bottom every morning - start date 6/8/2021. There was no documentation of the medication being administered to the feet every evening. Further review revealed no documentation of the order being changed on 10/18/2022 as ordered by the Podiatrist to Lac-Hydrin Lotion 12 % (Ammonium Lactate) Apply to Bilateral Feet top and bottom every morning and every evening for dry flaking skin.

On 12/5/2022 at 3:45 p.m., an interview was conducted with a nurse, RN (Registered Nurse) B who stated medications should be administered as ordered by the physician. RN B stated nurses

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should follow doctor's orders. RN B stated she was working 3-11 shift and had just gotten to work.

On 12/8/2022 at 3:10 p.m., an interview was conducted with LPN (Licensed Practical Nurse) C who stated that the Prevalon Boots were supposed to be worn while in bed not while Resident # 4 was up in the chair. LPN C stated that elevating Resident # 4's legs would be helpful due to problems with swelling.

Guidance for nursing standards for the administration of medication was provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:

1. The right medication
5. The right time
6. The right documentation."

Guidance further stated that "Nurses follow health care providers' orders unless they believe the orders are in error or harm patients."

An interview was conducted on 12/8/2022 at 10:30 a.m. with the Director of Nursing who stated nurses should make sure to follow up on consultant visits.

On 12/8/2022 during the end of day debriefing,

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F 658	Continued From page 38 the Director of Nursing and Corporate Nurse Consultant were informed of the findings. No further information was provided.	F 658		
F 677 SS=E	COMPLAINT DEFICIENCY 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 observation, interview, clinical record review, facility documentation and in the course of an investigation the facility staff failed to provide services to maintain good grooming and personal hygiene for 4 Residents (#'s 2, 5, 24, and 4) in a survey sample of 27 Residents. The Findings included: 1. For Resident #2 the facility staff failed to provide adequate bathing and nail care to maintain good hygiene. On 12/5/22 at approximately 1:30 PM, an interview was conducted with Resident #2's father who stated that he was not satisfied with the hygiene of his son. He picked up his sons hand and said, "For example look at his nails they are too long." He stated that his son sometimes scratches himself until he bleeds because his nails are too long. Resident #2 had nails that were at least 1/4 inch over the tip of his fingers. The nails looked dirty there was debris under his	F 677	1. Resident #2 nail care provided and bathing preference/shower preference update in plan of care. Resident #5 bathing preference/shower preference update in plan of care, incontinence care provided 12/8/22. Resident #24 no longer resides in the center. Resident #4 shower preference update in plan of care. 2. All residents have the potential to be affected by deficient practice. 3. DON or designee will re-educate all licensed nurse and certified nursing assistant on the shower, nail care and ADL care policy. 4. a.) DON or designee will randomly audit 10 residents ADL documentation to ensure showers were given and incontinence care was provided timely 3 x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. b.) DON or designee will randomly audit 10 residents to ensure nail care provided	1/22/23

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F 677	Continued From page 39 nails. On 12/6/22 at approximately 4 PM an interview was conducted with CNA C who stated that the nurse aides are supposed to provide nail care on the bath days of the Residents. She stated if there is someone who we cannot do alone we will have someone assist us or let the nurse know. She stated if they are diabetic the aides do not cut the nails but they can file them so they are not sharp or jagged. On 12/7/22 at approximately 10:00 AM an interview was conducted with the DON who stated that CNA's provide nail care during baths and as needed. If a resident is a diabetic or has some other condition such has on blood thinners or has peripheral vascular disease the nurse will provide nail care. Excerpts from the nail care policy as as follows: "6. Principles of Nail Care: a. Nails should be kept smooth to avoid injury. b. Only licensed nurses shall trim or file fingernails of patients with diabetes. Toenails of patients with diabetes or circulation problems will be filed. c. If a patient has a " infection, diabetes mellitus, neurological disorders, renal failure, or PVD, toenail trimming should be performed by a physician or physician extender. d. Patients without complicating disease processes, may have their toenails clipped by employees who have received education and training to provide this service within professional standards of practice.	F 677	3 x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5. Date compliance January 22, 2023	

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e. Patients will have their own nail equipment (e.g., nail clippers, emery boards, files, etc.). Nail equipment is not to be used between patients. Nail equipment is to be cleaned and sanitized after use
and before storing."

A review of the POC (Point of Care) log revealed the following information:
For the month of October 2022 the Resident had a bed bath on 10/5/22, 10/12/22, 10/15/22 and 10/26/22
For the month of November 2022 the Resident had a partial bath on 11/4/22, and a bed bath on 11/16/22 and 11/23/22
For the month of December 2022 the Resident had been given no baths as of 12/5/22.

On 12/6/22 an interview was conducted with CNA B who stated that Residents are to be bathed or showered twice a week if they can't be showered for whatever reason they should have a daily bed bath.

On 12/7/22 an interview was conducted with the DON who was asked if 4 bed baths a month was sufficient to maintain adequate personal hygiene and she stated that it was not.

The facility policy for ADL care read as follows:

"Policy:
It is the policy of this Center to provide ADL care for patients to ensure all ADL needs are met on a daily.
Policy Explanation:
1. Each patient will be provided daily personal attention and care, including skin, nail, hair, and oral hygiene, in addition to any specific care

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ordered by the physician/physician extender. Daily personal care provided will be documented in the patient's medical record.
2. Patients will be dressed in clean clothing and free of odors, to the extent possible. Patients are encouraged to wear their personal clothing when out of bed for the day.
3. Patients will receive a tub/shower bath as often as needed, but not less than twice weekly. Patients whose medical condition(s) prevent tub/shower baths will receive a daily sponge/bed bath.
4. Patients who are incontinent will receive a partial bath, clean clothing and linens each time their clothing or bed linen is soiled/wet with bodily fluids (urine, feces).
5. The care plan will define patient preferences specific to their ADL needs, level of ADL care required, preferred bathing schedule and type of bath, as well as the type of clothing preferred/available when out of the bed for the day."

On 12/7/22 during the end of day conference the Administrator was made aware and no further information was provided.

2. For Resident # 5 the facility staff failed to provide adequate bathing and incontinence care to maintain good hygiene.

On 12/06/2022 at approximately 5:30 P.M., Resident #5 was interviewed with Surveyor C and Surveyor D present. When asked about assistance with ADL's, Resident #5 stated that she would call her daughter so her daughter could tell us how many times she has called her

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daughter crying because she would have to go to the bathroom and have to wait for hours for help. Resident #5 then called her daughter. When the daughter was asked about concerns with ADL care, the daughter stated that staff would leave the brief "saturated" for hours. The daughter stated that her mother would call crying saying she had to "go #2" so the daughter would then try to call the facility to notify them. The daughter stated it is hard to get in touch with someone when she does try to call in so her mom would then soil her brief because it took so long.

A review of Resident #5's most recent annual Minimum Data Set with an Assessment Reference Date of 10/27/2022 revealed that the Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition. Functional status for bed mobility, dressing, and personal hygiene were coded as requiring extensive assistance from staff. Transferring did not occur and toileting was coded as total dependence on staff.

A review of the POC (Point of Care) ADL tracking page revealed the following information:

Resident #2 did not have any baths or bed baths during the month of December 2022. There was no documentation of Bathing, however there was documentation of daily personal hygiene being provided with incontinence care.
Resident #2 received bed baths on 11/3/22, 11/7/22, 11/14/22, and 11/17/22.

On 12/6/22 an interview was conducted with CNA B who stated that Residents are to be bathed or showered twice a week if they can't be showered for whatever reason they should have a daily bed

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bath.

On 12/7/22 an interview was conducted with the DON who was asked if 4 bed baths a month was sufficient to maintain adequate personal hygiene and she stated that it was not.

A review of the ADL policy read as follows:

"Policy:
It is the policy of this Center to provide ADL care for patients to ensure all ADL needs are met on a daily.
Policy Explanation:
1. Each patient will be provided daily personal attention and care, including skin, nail, hair, and oral hygiene, in addition to any specific care ordered by the physician/physician extender. Daily personal care provided will be documented in the patient's medical record.
2. Patients will be dressed in clean clothing and free of odors, to the extent possible. Patients are encouraged to wear their personal clothing when out of bed for the day.
3. Patients will receive a tub/shower bath as often as needed, but not less than twice weekly. Patients whose medical condition(s) prevent tub/shower baths will receive a daily sponge/bed bath.
4. Patients who are incontinent will receive a partial bath, clean clothing and linens each time their clothing or bed linen is soiled/wet with bodily fluids (urine, feces).
5. The care plan will define patient preferences specific to their ADL needs, level of ADL care required, preferred bathing schedule and type of bath, as well as the type of clothing preferred/available when out of the bed for the day."

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On 12/7/22 during the end of day conference the Administrator was made aware and no further information was provided.

3. For Resident #24 the facility staff failed to ensure the Resident was provided incontinence care in a timely manner to ensure good personal hygiene.

During the course of the survey the grievance logs were reviewed and the following grievance was filed with the facility.

"Resident #24's daughter was in visiting on 6/23/22 and at that time she rang the call bell at 5:45 p.m. to alert the staff that her father needed to be changed, that his incontinence brief was wet. Resident #24's daughter reported that the Resident waited 1 full hour before someone came in to change him and he had to eat his meal while sitting in a wet incontinence brief. "

A review of the grievance for this Resident revealed that under the box that read "Investigation of Concern," the Administrator wrote, "Make sure staff is checking on resident and offering frequent incontinence care and and doing rounds in a timely manner."

A review of the grievance log reveals that the Administrator acknowledged grievances (concerning the issues of call bells not answered timely and incontinence care not being provided timely) on 6/6/22 , 7/1/22, 8/12/22 and 10/5/22 and provided training on those topics on 6/15/22 however the problem persisted post training.

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Excerpts from the facility policy on incontinence care read:

"8. Patients that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible."

Excerpts from the ADL policy read as follows:

"4. Patients who are incontinent will receive a partial bath, clean clothing and linens each time their clothing or bed linen is soiled/wet with bodily fluids (urine, feces)."

On 12/6/22 at approximately 3:30 PM an interview was conducted with CNA B who stated that she tries to get to everyone before meals to make sure they don't need incontinence care or toileting. She also stated that rounds are to be made every 2 hours and incontinent care provided every 2 hours and as needed.

On 12/7/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

4. For Resident # 4, the facility staff failed to provide showers per the resident's preference.

On 12/5/2022 on the initial tour, Resident # 4's daughter complained to the surveyor that baths were not given as they were supposed to be given."

Resident # 4 was in the room while the daughter was explaining her concerns. Resident # 4 stated

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baths or showers were "not done twice a week like they are supposed to be."

Resident # 4 required extensive assistance with ADLS (Activities of Daily Living) to include hygiene and bathing. Bowel and bladder continence were coded as frequently incontinent according to the Minimum Data Set Assessment on 11/3/2022.

On 12/5/2022 at 3:50 p.m., an interview was conducted with Certified Nursing Assistant (CNA) D who stated he had just gotten to work but would provide incontinence care as needed. CNA D stated the expectation was that Residents would receive incontinence care as needed and they would be checked at least every 2 hours for incontinence. CNA D did stated they give a partial bath after incontinent episodes that soil the clothes or linens. CNA D stated all residents should have at least two showers per week.

On 12/8/2022 at 2:40 p.m. the Corporate Nurse Consultant presented a copy of the documentation on bathing for Resident # 4. Review of the report revealed the following information on bathing was generated by the Corporate Nurse Consultant on 12/8/2022 at 2:14 p.m.:

The September 2022 bathing report revealed documentation of two bed baths (9/1/22 and 9/5/22) and two partial baths (9/22/22 and 9/29/22). There were no showers given during the month of September 2022.

The October 2022 bathing report revealed documentation of one bed bath on 10/3/2022 and no partial baths during October. There was one

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shower given on October 17, 2022.

The November 2022 bathing report revealed documentation of one bed bath on 11/21/22 and two partial baths (11/3/22 and 11/7/22). There were two showers given during the month of November 2022 on 11/14/22 and 11/17/22.

The December 2022 bathing report revealed documentation of one partial bath on 12/5/22. There were no showers given during the first week of December 2022.

Therefore, there were a total of 12 bathing events including 5 partial baths during the period of 9/1/2022 and 12/8/2022 according to the bathing report that was generated.

Review of the documentation revealed evidence of a partial bath being provided on 12/5/2022. According to the policy, a partial bath would be provided after incontinence episodes.

According to the facility's policy entitled "ADL Care of Patients, Date Implemented: 6/1/21, Date Reviewed/Revised: 5/17/22 -
Policy stated, "It is the policy of this Center to provide ADL care for patients to ensure all ADL needs are met on a daily."
It also stated:
"3. Patients will receive a tub/shower bath as often as needed, but not less than twice weekly. Patients
whose medical condition(s) prevent tub/shower baths will receive a daily sponge/bed bath.

4. Patients who are incontinent will receive a partial bath, clean clothing and linens each time their

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F 677	Continued From page 48 clothing or bed linen is soiled/wet with bodily fluids (urine, feces)." During the end of the day debriefing on 12/8/2022, the Director of Nursing and Corporate Nurse Consultant were informed of the findings. No further information was provided.	F 677		
F 692 SS=D	COMPLAINT DEFICIENCY Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on Staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to	F 692	1. Resident #24 no longer resides in the center 2. All residents have the potential to be	1/22/23

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F 692	Continued From page 49 provide adequate nutrition, and hydration for one Resident (Resident #24) in a survey sample of 27 residents. For Resident #24 the facility staff knew for several days that the Resident was not eating nor drinking sufficient fluids. The findings included: Resident #24 was first admitted to the facility on 6-16-22, and discharged on 7-1-22 (15 days). Diagnoses included; Prostate Cancer, Bone metastasis, Pneumonia, and malnutrition, with a history of congestive heart failure, and dysphagia. Resident #24's clinical record was reviewed and revealed a 5 day minimum data set assessment (MDS), with an assessment reference date (ARD) of 6-22-22. The document coded the Resident with severe cognitive impairment, unable to walk, unable to feed self, and extensive to total dependence on staff for all activities of daily living. Resident #24 was discharged to the hospital on 7-1-22. The Resident's closed record was reviewed on 12-6-22. Interdisciplinary nursing & physician Progress notes were also reviewed and documented the following chronology of events; 6-23-22 at 12:35 PM, the Resident was ordered to have "Boost Plus mildly thick 1 can every day" for a greater than 5% weight loss since admission (7 days). The recommendation was made by the Registered Dietician (RD). The note goes on to say that the Resident was consuming 50-75% of	F 692	affected by deficient practice. 3. DON or designee will re-educate licensed nurses and certified nursing assistance on hydration policy 4. The DON or designee will randomly audit 5 residents meal intake and hydration documentation to ensure adequate intake 3 x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5. Date compliance January 22, 2023	

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F 692	Continued From page 50	F 692		

meals. The recommendation/order was never written nor implemented by staff. The Resident's weight on admission was 132.4 pounds, and 2 weeks later at discharge the Resident weighed 122.2 pounds for a loss of 10 pounds in 2 weeks. The Resident did receive Lasix medication every day to diurese (remove) fluid. The Resident was dependant on one staff member to feed him, and offer fluids.

6-23-22 through 6-29-22 staff documented "no edema present nor observed". The Residents lungs were clear and no signs of congestive heart failure were present at any time.

On 6-29-22 the Doctor ordered a urinalysis for "increased lethargy", and "Clysis 0.45% Sodium chloride solution fluid for hydration, which continued on 6-30-22. The doctor also ordered Rocephin (antibiotic) Intramuscular injection (IM) on 6-29-22, and on 6-30-22 a different antibiotic, Ceftriaxone IM injection, as no Intravenous access (IV) had been established.

Review of vital signs records and "Skilled observation and assessment" documents, revealed on 6-29-22 a heart rate of 100 beats per minute while the Resident was resting in bed and a blood pressure of 102/63. On 6-30-22 (24 hours later) the Residents blood pressure was 80/40, with a pulse of 111 beats per minute even with some fluid resuscitation. On 7-1-22 the blood pressure was also documented as 80/40, and a heart rate of 111.

On 6-30-22 nursing notes indicated that at 5:49 AM, the Resident had fluids and medications running out of his mouth and that the Resident was now non-verbal. The Resident refused to eat

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or take medications on this day, and by 11:01 PM nurses documented that the Resident was difficult to arouse, blood pressure was low, his fingers were cyanotic (blue) and the Resident was placed on 2 Liters of oxygen which reversed the bluing of his fingers. The note goes on to say an attempt was made to contact the doctor, however, staff was unable to make contact with the doctor.

On 7-1-22 at 8:04 AM nursing notes indicated that "Clysis continues in lower back, unable to swallow meds or liquids, BP (blood pressure) 80/40 this morning."

On 7-1-22 at 8:30 AM a nursing note described "transfer out acute emergency increased lethargy, family request."

On 7-1-22 at 9:49 AM nursing notes document "sent to ER (emergency room)."

No labs were resulted and in the clinical record.

The Resident's doctor was called via telephone and voice messages left requesting a return call on 12-6-22, and on 12-7-22. The facility staff supplied the phone number, and were told that an interview was needed. The doctor for Resident #24 did not answer the calls, and did not call back. The Resident's doctor no longer worked there according to the Administrator and Director of Nursing (DON), and they stated a new medical director had taken over the facility.

Activity of daily living (ADL) records were reviewed and revealed that Resident #24 had consumed the following amounts of liquids listed below for each 24 hour period for the 2 week stay.

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F 692	Continued From page 52 6-16-22 - 660 milliliters (ML) 6-17-22 - 950 ML 6-18-22 - 600 ML 6-19-22 - 960 ML 6-20-22 - 360 ML 6-21-22 - 250 ML 6-22-22 - 540 ML 6-23-22 - 1200 ML 6-24-22 - 600 ML 6-25-22 - 1120 ML 6-26-22 - 500 ML 6-27-22 - 960 ML 6-28-22 - 660 ML 6-29-22 - 940 ML 6-30-22 - 1440 7-01-22 - 0 The Centers for Disease Control (CDC) recommend men aged 60 years or greater should consume 2.92 liters of water per day which is approximately 2900 ML per day. The Resident's only care plan was reviewed and revealed that the Resident had an updated care plan for; nutrition, and hydration. The Administrator and Director of Nursing (DON) were notified of the failure to intervene for several days in the dehydration and malnutrition incident for Resident #24 at the end of day meeting at 4:00 PM on 12-6-22. On 12-7-22 at the end of day meeting at 4:00 PM, The Administrator and DON stated they had no further information to be provided.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		1/22/23

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F 695	Continued From page 53 § 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 documentation review and clinical record review, the facility staff failed to ensure one Resident (Resident # 14) in a survey sample of 27 residents received respiratory care in a manner to prevent the spread of infection. 1. For Resident # 14, the nebulizer tubing was not changed weekly. Findings included: 1. For Resident # 14, the nebulizer tubing was not changed weekly. Resident # 14 was admitted to the facility with the diagnoses of, but not limited to, Chronic Obstructive Pulmonary Disease and Chronic Respiratory Failure. The most recent Minimum Data Set (MDS) was an Admission Assessment with an Assessment Reference Date (ARD) of 11/9/2022. The Brief Interview for Mental Status was coded as "13" out of possible "15" indicative of no cognitive impairment. Functional status for Activities of Daily Living were coded as requiring extensive assistance from staff except for eating which was	F 695	1. Resident #14 nebulizer tubing corrected 12/8/22 2. All residents have the potential to be affected by deficient practice. 3. DON or Designee will re-educate licensed nurses on respiratory policy 4. The DON or Designee will audit 5 random residents with orders for respiratory equipment to ensure proper cleaning and change of tubing 3 x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5. Date compliance January 22, 2023	

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F 695	Continued From page 54	F 695		

coded as supervision only.

Review of the clinical record was conducted on 12/5/2022 - 12/6/2022.

During the initial tour on 12/5/2022 at 3:20 PM, Resident # 26 was observed sitting in bed with a nebulizer mask. Close inspection of the tubing revealed a date of 11/15/2022 written in a black ink on the tubing.

On 12/5/2022 at 3:35 PM, RN (Registered Nurse) B and Surveyor E observed Resident # 26's oxygen equipment. RN B stated the facility staff should change the oxygen tubing weekly. RN B stated not changing the tubing weekly increased the risk for infection control problems.

Review of the Physicians Orders revealed the following orders:

11/16/2022 for Ipratopium Albuterol Solution 0.5-2.5 (3) milligrams/3 milliliters, 3 milliliters inhale orally every 8 hours for wheezing.

On 12/6/2022 at 4:30 PM, an interview was conducted with the Director of Nursing who stated oxygen equipment should be changed every Monday on night shift. The Director of Nursing was informed of the finding of tubing dated 11/15/2022. The Director of Nursing stated the tubing should have been changed on 11/22 and 11/29/2022.

On 12/7/2022, a copy of the Oxygen policy was received and reviewed. The policy stated tubing should be changed, labeled and dated weekly.

During the end of day debriefing on 12/7/2022,

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F 695	Continued From page 55 the Corporate Nurse Consultant and Director of Nursing were informed of the failure of the staff to change respiratory tubing weekly. No further information was provided.	F 695		
F 842 SS=D	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;	F 842		1/22/23

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F 842	Continued From page 56 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review and during a complaint investigation, the facility staff failed to ensure a complete and accurate record for two Residents (Resident # 12,	F 842	1. Resident # 12 medical record corrected 2. All residents have the potential to be affected by deficient practice.	

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F 842	Continued From page 57 #23) in a survey sample of 27 residents. For Resident # 12, the facility staff failed to keep an accurate clinical record. For Resident # 23, the facility staff failed to keep information confidential in the clinical record. Findings included: On 12/7/222 while reviewing Resident # 12's Physician's progress notes, a copy of another Resident's Record was discovered uploaded in Resident # 12's record. The other Resident was placed in the survey sample as Resident # 23. Review of Resident # 23's clinical record revealed the Nurse Practitioner's Progress Note dated 3/11/2022 was uploaded accurately in Resident # 23's record. However, the same note was inaccurately uploaded into Resident # 12's clinical record. On 12/8/2022 at 9:30 a.m., an interview was conducted with the Director of Nursing who stated it was very important for clinical records to be complete and accurate. The Director of Nursing stated it was important to protect Resident's information. She also stated there was a risk that the wrong information could cause errors in care. She stated she would emphasize the importance of accurately uploading documents in the correct records. During the end of day debriefing, the Corporate Nurse Consultant and Director of Nursing were informed of the findings. No further information was provided.	F 842	3. Administrator or designee will re-educate medical records on scanning documentation into PCC 4. The administrator or designee will randomly audit 5 resident charts to ensure complete and accurate medical record weekly x 12 weeks and report findings to QAPI committee. 5. Date compliance January 22, 2023	

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F 842	Continued From page 58 COMPLAINT Deficiency	F 842		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative	F 887		1/22/23

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F 887	Continued From page 59 was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide COVID-19 immunization for 64 residents out of 108 residents residing within the facility. The findings included: The facility staff failed to provide COVID-19 immunization for 64 residents whom consented to receive the COVID-19 bivalent vaccine. On 12/8/22, in the course of review with regard to COVID-19 immunization for facility residents, the Infection Preventionist (IP) stated, "I have tried to set up a [COVID-19] booster clinic since the beginning of October [2022], I currently have over	F 887	1. Bivalent clinic scheduled 1/3/23 2. All residents have the potential to be affected by deficient practice. 3. DON or designee will re-educate licensed nurse on completion of covid-19 vaccination policy 4. The DON or designee will randomly audit 10% of resident to ensure covid-19 immunization offered 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5. Date compliance January 22, 2023	

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60 residents who would like to have the bivalent booster vaccine, I do not know why our Pharmacy has not been able to accommodate the request". The facility's policy for COVID-19 immunizations for residents was requested and received.

The IP provided a list of 64 current residents who were consented and eligible to receive a COVID-19 bivalent booster vaccine "when available". The IP confirmed that requests for the COVID-19 bivalent vaccine doses were made directly to the facility's contracted Pharmacy and provided email documents to the facility's pharmacy representative. The emails read as follows:

October 3, 2022
1:27 PM-from IP-"I am reaching out to see when we will have the bivalent booster available to distribute to our residents and staff. How many doses will we initially receive to distribute? Thanks in advance".

2:36 PM-from Pharmacy Rep-"About how many doses total would you need? Depending on the size of the clinic, we may have to outsource it to one of our partner retail pharmacies".

3:11 PM-from IP-"We have about 65 residents that are currently eligible to receive the bivalent dose and I don't have a number on how many employees that are interested in receiving the bivalent".

3:21 PM-from Pharmacy Rep-"Thank you! That would need to be scheduled through our partner pharmacy that will come on site to do the clinic. I will pass this information along, and someone will reach out to you to get this scheduled".

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November 3, 2022
1:52 PM-from IP-"I haven't heard back from anyone in regard to scheduling a booster clinic for the new bivalent booster. I was just wondering if there is any update on when this might happen. Thanks again!".

3:31 PM-from Pharmacy Rep-"I apologize for that! I have reached back out to the corporate team to let them know you were still waiting on follow up. I will set a reminder for myself to reach back out to them next Tuesday if I still have not received a resolution".

December 5, 2022
7:58 PM-from IP-"We are still in need of the bivalent boosters for our residents and staff here at [name redacted]. I have about 60-70 people that are eligible to receive the booster. Are we any closer to getting a clinic scheduled? I would like to have a clinic set-up in the next two weeks. Please let me know what you can do to help me with this. Thanks in advance".

December 6, 2022
10:02 AM-from Pharmacy Rep-"I do apologize. I have been reaching out on your behalf since October as well. I have copied our General Manager, [name redacted], in case there is anything he can do to expedite this".

On 12/8/22, a group telephone interview was conducted with the General Manager (GM) of the facility's contracted pharmaceutical provider, the Regional Director of Operations, and the Corporate Clinical Specialist. The pharmacy GM confirmed supplies of the COVID-19 bivalent booster vaccine were readily available and that

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RIVER VIEW ON THE APPOMATTOX HEALTH & REHAB CENTER	201 EPPS STREET HOPEWELL, VA 23860

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 887	Continued From page 62 there has never been a failure for a "partner" [third party] pharmacy to provide COVID-19 booster vaccines or vaccine clinics upon request. The GM stated that according to documentation from the partner pharmacy, the IP was contacted on 11/9/22 at 8:49 PM by the partner pharmacy to schedule a COVID-19 booster clinic, however "there was no client interest". The IP stated she did not recall any attempt by the facility pharmacy or a partner pharmacy to set up a booster clinic for the facility's residents. Review of the facility's policy titled, "COVID-19 Vaccination--Patients", revised 9/27/22, read, "It is the policy of this Center to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our patients the COVID-19 vaccine" and item 1 read, "In collaboration with the medical director, the center will provide an immunization program against COVID-19 disease in accordance with national standards of practice". No further information was provided.	F 887		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for	F 888		1/22/23

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F 888	Continued From page 63	F 888		

COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to

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F 888	Continued From page 64	F 888		

clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:

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F 888	Continued From page 65 (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to implement their policy and procedure for 1 staff member, CNA E, out of 2 staff members	F 888	1. CNA E file update to include medical exemption. 2. All residents have the potential to be affected by deficient practice.	

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F 888	Continued From page 66 reviewed for medical exemption from COVID-19 immunization. For CNA E, the facility staff failed to provide documentation for medical exemption from COVID-19 immunization. The findings include: On 12/7/22, the facility Infection Preventionist (IP) provided a staff COVID-19 vaccination matrix which indicated CNA E had a pending medical exemption. A request was made for documentation regarding the medical exemption for CNA E and a copy of the facility policy for staff COVID-19 immunization. The facility's policy was provided. On 12/7/22, an interview was conducted with the IP who confirmed CNA E had a pending medical exemption from COVID-19 immunization, however the Human Resources (HR) Department was responsible for handling staff medical exemption requests. On 12/8/22, an interview was conducted with the HR Director who confirmed CNA E was an active employee hired on 9/20/22. The HR Director stated, "I was not aware that there was a process for employees to request a medical exemption from COVID vaccination, I just began my own employment here on September 5th of this year". The HR Director stated, "There is nothing currently in [name redacted, CNA E's] personnel file regarding a medical exemption request for COVID vaccination at this time, I know now that there is a specific policy for these requests, I will need to get started on getting this issue	F 888	3. The Administrator or designee will educate all staff on covid-19 vaccination policy 4. The Administrator or designee will randomly audit 5 employee files weekly x 12 weeks to ensure covid-19 vaccination status is up to date. 5. Date compliance January 22, 2023	

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F 888	Continued From page 67	F 888		

straightened out right away".

Review of the facility policy titled, "Staff Vaccination Policy", revised 10/6/2022, subtitle "COVID-19 Vaccine", read, "...Employees who are not fully vaccinated for COVID-19 and do not have an approved medical or religious exemption on file...will not be eligible for employment" and subtitle "Requests for Exemptions as Accommodations", read, "For any employee who declines a vaccination based upon a qualifying medical condition...the Center will engage in an interactive process...To request an accommodation for one of the above reasons, the employee shall contact the Human Resources Office and submit the Medical or Religious Accommodation Request Form as applicable".

Review of the facility policy titled, "Accommodation Procedure for Vaccines", date implemented 12/3/21, subtitle "Purpose", read, "...Any request for an exemption from COVID-19 vaccination must be submitted and evaluated prior to the potential employee providing care, treatment, or services" and subtitle "Policy", read, "...An employee who wishes to request such an accommodation, should notify the Human Resources Office, and submit the Request for Medical Exemption/Accommodation Form".

On 12/8/22, the Regional Director of Operations, Corporate Clinical Specialist, Director of Nursing, and Infection Preventionist were notified of the findings. No further information was provided.