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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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted October 31, 2022 through November 3, 2022. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Seven complaints were investigated during the survey; VA00052905 (substantiated with deficiency), VA00054480 (substantiated without deficiency), VA00053035 (substantiated without deficiency), VA00055892 (substantiated with deficiency), VA00054481 (unsubstantiated), VA00053513 (unsubstantiated), VA00056499 (unsubstantiated). The census in this 120 bed certified facility was 104 at the time of the survey. The survey sample consisted of 42 current resident reviews and ten closed record review.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		12/18/22

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

Electronically Signed | 12/06/2022

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, it was determined that facility staff failed to promote resident's dignity for three of 52 residents in the survey sample, Resident #26 (R26), #217(R217) and #309 (R309). The findings include: 1. For (R26), the facility staff failed to serve their meal at the same time as another resident seated at the same table.	F 550	Criteria 1 Resident # 217 foley catheter was covered and removed from the floor. Resident # 309 Received her pain medicine and had relief after identified. Resident #26 did receive her meals with others after identified alleged deficiency. Criteria 2 All residents with catheters have the potential to be affected with the same deficient practice. All residents on pain management programs have the potential	

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F 550	Continued From page 2 (R26) was admitted to the facility with diagnoses that included but were not limited to: quadriplegia (1). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/22/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section G "Activities of Daily Living (ADL) Assessment" coded (R26) as requiring extensive assistance of one staff member for eating. On 10/31/2022, an observation of lunch meal being served in the second floor resident dining room, revealed (R26) received their meal approximately five minutes after another resident seated at the same table was served and eating their meal. On 10/31/2022 at approximately 1:45 p.m., an interview was conducted with CNA (certified nursing assistant) #1. When informed of the observation regarding (R26) having to wait for their meal while another resident sitting at the same table had been served and was eating their meal, CNA #1 stated that it was not proper. When asked if it was dignified for a resident to wait for their meal while another resident was sitting at the same table had been served and was eating their meal, CNA #1 stated no. On 11/01/2022 at approximately 11:10 a.m., an interview was conducted with (R26). When asked how they felt about waiting for their meal during lunch the day before, (on 10/31/2022) while another resident sitting at the same table had been served and was eating their meal,	F 550	to be affected by the alleged deficient practice. All residents have the potential to be affected by alleged deficient practice during meal times. Criteria 3 Licensed nurses and C.N.As were re-educated on the covering and placement of foley catheters. Staff were educated on residents being served meals at the same time. Licensed Nurses were re-educated on the pain Management Program. Criteria 4 The DON/Designee will audit foley catheters three times a week for one month. Then weekly for one month and monthly times one month. Pain management will be audited 3x weekly for one-month, weekly x one month, then monthly x1 month. Audits of dining will be conducted 3 x week for one month and then weekly for one month and monthly x one month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action.	

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(R26) stated, "I don't like it but I have to deal with it." When asked if they thought it was dignified (R26) stated no.

On 11/02/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, regional clinical coordinator were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) The loss of muscle function in part of your body. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

2. For (R217), the facility staff failed to provide privacy bag or cover for an indwelling catheter urine collection bag.

(R217) was admitted to the facility with diagnoses that included but were not limited to: neuromuscular dysfunction of the bladder (1).

The admission MDS (minimum data set) was not due at the time of the survey.

The facility's "Nursing Comprehensive Evaluation" for (R217) dated 10/21/2022 documented in part, "Neurological. Oriented To: person; Genitourinary (relating to the genital and urinary organs). Appliances: Indwelling Catheter."

On 10/31/22 at 2:22 p.m., an observation of

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(R217's) room from the hallway revealed the catheter collection bag and the urine contents could be seen. Further observation failed to evidence a privacy cover or privacy bag to the catheter collection bag.

On 10/31/22 at 4:28 p.m., an observation of (R217's) room from the hallway revealed the catheter collection bag and the contents could be seen. Further observation failed to evidence a privacy cover or privacy bag to the catheter collection bag.

On 11/01/2022 at 8:20 a.m., an observation of (R217's) room from the hallway revealed the catheter collection bag and the urine contents could be seen. Further observation failed to evidence a privacy cover or privacy bag to the catheter collection bag.

On 11/01/22 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #1 at the nurse's station. When asked if the contents of a catheter collection bag should be visible to others LPN #1 stated, "No and that it should be placed in a privacy bag for discretion." LPN # 1 was then asked to look at (R217's) room. When asked if they could clearly view (R217's) catheter collection bag and the contents LPN # 1 stated yes.

The facility's policy "Guest/resident Dignity & Personal Privacy" documented in part, "4. Maintain guest/resident privacy during toileting, bathing, and other activities of personal hygiene."

On 11/02/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4,

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regional clinical coordinator were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from the website: https://medlineplus.gov/ency/article/000754.htm.

3. For Resident #309 (R309), the facility staff failed to administer medications in a timely manner in response to the resident's ringing the call bell.

R309 was admitted to the facility on 10/22/22. The admission MDS (minimum data set) had not been completed at the time of survey entrance. A review of the Nursing Comprehensive Evaluation dated 10/22/22 revealed R309 was oriented to person, place, and time.

On 10/31/22 at 2:08 p.m., R309 was sitting in a chair beside their bed. At 2:11 p.m., R309 rang the call bell. At 2:14 p.m., CNA (certified nursing assistant) #9 entered R309's room and turned off the call bell. CNA #9 asked R309 what they needed. R309 told CNA #9 they needed pain medication for their leg. CNA #9 stated: "The nurse will be here in a minute." CNA #9 went to the nurse station where LPN (licensed practical nurse) #11 was sitting. CNA #9 informed LPN #11 that R309 had rung the bell, and needed pain medication. LPN #11 nodded her head, said, "Okay," and continued to sit at the nurse station, talking with another staff member. LPN #11 was not working on the computer. LPN #11 continued

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to sit at the nurse station, talking to other staff members until 2:29 p.m. At 2:29 p.m., LPN #11 stood up and went around the desk to a medication cart. LPN #11 began opening drawers and removing expired medications from the medication cart. At 2:33 p.m., LPN was interviewed. She stated: "I did not hear the CNA say anything about [R309]. I'll go check." LPN #11 administered pain medication to R309 at 2:42 p.m. She stated: "[R309] wanted me to look at [their] leg. I ended up giving two Tylenol."

A review of R309's clinical record revealed the following order, dated 10/22/22: "Tylenol 650 mg (milligrams) [every six hours] po (by mouth) for pain."

On 10/31/22 at 2:41 p.m., CNA #9 was asked if she was certain LPN #11 had heard her when she informed her about R309's need for pain medication. She stated: "She absolutely heard me."

On 10/31/22 at 2:52 p.m., R309 was interviewed. She stated: "That's what they usually do; they tell me they are coming in a minute, but then they don't come for a long time." She stated she felt like the staff members did not really care about her, and that the staff members were ignoring her. She stated: "I feel like I don't really matter."

On 11/2/22 at 1:13 p.m., CNA #3 was interviewed. She stated if a resident rings the call bell, she responds as soon as possible. She stated if the resident needs the nurse, she reports the need to the nurse assigned to the resident. She stated: "I don't make any promises about when the nurse will come." She stated sometimes nurses are busy and cannot get to the resident right away.

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F 550	Continued From page 7 She stated she would be upset if someone told her the nurse would be there right away, and then did not come for a long while. She stated this is not treating a resident with dignity or respect for their needs. On 11/2/22 at 1:37 p.m., LPN #3 was interviewed. She stated if a CNA informed her of a resident's need, she would go to the resident right away. If she was unable to go right away, she would ask the CNA to inform the resident that the nurse was aware of the need, and would see the resident as soon as possible. She stated to do anything else would not be respectful of the resident's needs. On 11/2/22 at 3:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional clinical coordinator, were informed of these concerns. No further information was provided prior to exit.	F 550		
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 other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, it was determined the facility staff failed to place calls within reach for two of 52 residents in the survey sample, Resident #79 and Resident #15.	F 558	Criteria 1 Resident # 79 and #15 call bells were clipped to the beds by maintenance director.	12/18/22

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F 558	Continued From page 8 The findings include: 1. For Resident #79 (R79), the facility staff failed to ensure the call bell was within the resident's reach; it was observed on the floor. \On the most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 9/15/2022, the resident scored a 10 of out 15 on the BIMS (brief interview for mental status) score, indicating the resident is moderately cognitively impaired for making daily decisions. Observation was made on 10/31/2022 at approximately 12:30 p.m. of R79's room. R79 was in bed, asleep, the call bell was on the floor, out of the reach of the resident. On 11/1/2022 at 8:52 a.m. the resident was observed in his room, in his wheelchair, the call bell was on the floor, out of the reach of the resident. The comprehensive care plan dated, 6/28/2022, documented in part, "Need: [R79] is at risk for fall related injury and falls, R/T (related to) impaired mobility, H/O (history of) falls." The "Interventions" documented in part, "Put the resident's call light within reach and encourage him/her to sue it for assistance as needed." An interview was conducted with CNA (certified nursing assistant) #3, on 11/2/2022 at 10:03 a.m. When asked where are call bells supposed to be, CNA #3 stated, within the reach of the patient. When asked if the call bells should be on the floor, CNA #3 stated, "No, that isn't within reach."	F 558	Criteria 2 All guests that reside in the facility have the potential to be affected by alleged deficient practice. An audit was conducted as a base line and all call bells were within reach. Criteria 3 Staff were educated on call bell placement and assuring call bells are always in reach. Criteria 4 Call bell audits will be conducted 3 x a week for four weeks, then weekly x 1 month and monthly for one month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action.	

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An interview was conducted with LPN (licensed practical nurse) #1, on 11/2/2022 at 10:17 a.m. When asked where are call bells supposed to be, LPN #1 stated within the reach of the resident. When asked if it was okay to be on the floor, LPN #1 stated, no.

The facility policy, "Call Lights" documented in part, "Policy - Call lights will be placed within the guest's/resident's reach and answered in a timely manner...3. When a guest/resident is in bed or confined to a chair be sure the call light is within easy reach of the guest/resident."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional clinical coordinator, were made aware of the above concern on 11/2/2022 at 5:14 p.m.

No further information was provided prior to exit.

2. For Resident #15 (R15), the facility staff failed to keep the call bell within their reach.

(R15) was admitted to the facility with a diagnosis that included by not limited to: muscle weakness and osteoarthritis (1)

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 10/15/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R15) was cognitively intact for making daily decisions.

On 11/01/2022 at 9:00 a.m., an observation of (R15's) call bell revealed it was attached to the

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side of the mattress on the resident's right side of the bed approximately six to eight inches from the corner of the mattress.

11/01/2022 at 9:30 a.m., an observation of (R15's) call bell revealed it was attached to the side of the mattress on the resident's right side of the bed approximately six to eight inches from the corner of the mattress. When asked to locate and activate their call bell, (R15) was observed attempting to reach for the call bell but was unable to locate and grasp it.

The comprehensive care plan for (R15) dated 05/18/2022 documented in part, "Need. (R15) has hip fracture r/t (related to) fall. Date Initiated: 05/18/2022." Under "Interventions" it documented in part, "Anticipate and meets needs. Be sure call light is within reach and respond promptly to all requests for assistance. Date Initiated: 05/18/2022."

On 11/03/22 at 8:14 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When informed of the above observation LPN # 4 stated that they were familiar with (R15) and that (R15) did not have the range of motion to reach where the call bell was located and further stated that the call bell should have been positioned within (R15's) reach.

On 11/03/2022 at approximately 4:02 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, regional clinical coordinator were made aware of the above findings.

No further information was provided prior to exit.

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F 558	Continued From page 11 References: (1) The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive	F 578		12/18/22

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F 578	Continued From page 12 information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to obtain or offer information of an advance directive for one of 52 residents in the survey sample, Resident #96 (R96). The finding include: For (R96), the facility staff failed to evidence an advance directive or documentation of providing information regarding an advance directive. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/05/2022, (R96) scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Review of the facility's "Care Conference Minutes" dated 10/25/2022 for (R96) failed to evidence of having obtain and advance directive or documentation of providing information regarding an advance directive.	F 578	Criteria 1 Resident #96 has been discharged from the facility. Criteria 2 All residents have the potential to be affected by this practice. The Director of Social Services, or designee will complete an audit of all residents to ensure that education was provided on advance directives, and that a copy of the education and/or the advance directive is included in the medical record. Criteria 3 The corporate Director of Social Services, or designee will provide education to the Admissions and Social Services staff on required education of residents on Advance Directives and proper documentation in the medical record. Criteria 4 An audit will be completed on all new admissions 3 times weekly x 4 weeks, then weekly x 4 weeks, then monthly for 1	

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	495394	A. BUILDING _____ B. WING _____	11/03/2022

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F 578	Continued From page 13 The POS (physician's order sheet) for (R96) dated "September 2022" documented in part, "Do Not Resuscitate (DNR). Order Date: 12/06/20." On 11/02/22 at approximately 3:40 p.m., an interview was conducted with OSM (other staff member) #2, director of social services. When asked to describe the process for a resident's advance directive OSM #2 stated that upon admission they (social services) obtains a copy of the resident's advance directive and if they do not have one, the resident and /or the responsible party are asked and /or offered information on how to develop an advance directive. When asked where that information is documented OSM #2 stated that it is documented on the care conference minutes. After reviewing the care conference minutes for (R96) OSM #2 stated that the form was initiated by the facility's other social worker and that they had not completed the form and obtain all the information. When asked to speak with the social worker, OSM #2 stated that they were on leave and could not be reached. On 11/03/2022 at approximately 4:02 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #4, regional clinical coordinator were made aware of the above findings. No further information was provided prior to exit.	F 578	month. Corrections will be made as needed. Continued compliance will be monitored through routine audits and reported to the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
F 580 SS=E	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	F 580		12/18/22

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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, 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

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F 580	Continued From page 15 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 document review, and it was determined that the facility staff failed to notify the physician that a resident's medications were not administered for one of 52 residents in the survey sample, Resident #2 (R2). The findings include: For (R2), the facility staff failed to notify the physician that the physician ordered antibiotic, ceftriaxone [1] was not administered on 10/27/2022, 10/28/2022, 10/31/2022, 11/01/2022 and on 11/02/2022 and vancomycin [2] was not administered on 10/18/2022, 10/19/2022 and 10/28/2022. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 09/20/2022, the resident scored 9 (nine) out of 15 on the BIMS (brief interview for mental status), indicating (R2) was moderately impaired of cognition for making daily decisions. The physician's orders for (R2) documented in part, "Ceftriaxone Sodium Solution Reconstituted 1 (one GM (gram). Inject 1 gram intramuscularly every 12 hours for infection for 5 (five) days. Start Date: 10/27/2022. D/C (discontinue) Date: 10/27/2022."	F 580	Criteria 1 Resident #2 was discharged on 11/4/2022. The were no ill effects noted from his missed doses of antibiotics. Criteria 2 All residents on antibiotics are at risk for the alleged deficient practice. Criteria 3 Nurses were re-educated on notification of MD when medications are not administered. Criteria 4 Audits will be conducted for medications not given and MD notification 3 x weeks for four weeks, then weekly for 1 month and monthly x 1. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action	

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"Ceftriaxone Sodium Solution Reconstituted 1 (one GM (gram). Inject 1 gram intramuscularly every 12 hours for infection for 5 (five) days. Start Date: 10/28/2022."
"Vancomycin HCL (hydrochloride) Solution 50 MG/ML (milligram/milliliter). Give 5 ml by mouth every 6 (six) hours for c-diff (3) for 14 days. Start Date: 10/15/2022."

The comprehensive care plan for (R2) dated 10/27/2022 documented in part, "Need. (R2) is at risk for discomfort for adverse side effects: receives Antibiotic Therapy r/t (related to) for infection CDiff. Vancomycin 10/27/2022, Ceftriaxone until 11/2/22. Date initiated: 10/18/2022.

The eMAR [electronic medication administration record] dated October 2022 for (R2) documented the physician's orders as stated above. For ceftriaxone, the eMAR revealed a number five documented on 10/27/2022 at 9:00 p.m., a blank on 10/28/2022 at 9:00 a.m. and an "X" documented on 10/31/2022 at 9:00 p.m. For the vancomycin, the eMAR revealed a number five documented on 10/18/2022 at 6:00 p.m., number five documented on 10/19/2022 at 12:00 p.m. and at 6:00 p.m., and a blank on 10/28/2022 at 12:00 p.m. Further review of the eMAR revealed a legend that documented in part, "Chart Codes / Follow Up Codes: 5=Hold/See Nurse's Notes."

The eMAR dated November 2022 for (R2) failed to evidence documentation of the physician's order for Ceftriaxone. Further review of the eMAR failed to evidence (R2) received Ceftriaxone on 11/01/2022 or 11/02/2022.

The nurse's "Progress Notes" for (R2) failed to

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evidence documentation for ceftriaxone being held on 10/27/22 at 9:00 p.m. or for the vancomycin being held on 10/18/2022 at 6:00 p.m., 10/19/2022 at 12:00 p.m. and at 6:00 p.m. Further review of the progress notes failed to evidence documentation regarding the blanks for ceftriaxone on 10/28/2022 at 9:00 a.m. and the "X" on 10/31/2022 at 9:00 p.m. and the blank on 10/28/2022 at 12:00 p.m. for vancomycin. Further review of the progress notes failed to evidence documentation of physician notification for the medications not being administer on the dates listed above.

The nurse's "Progress Notes" failed to evidence documentation for ceftriaxone not being administered or the physician being notified.

On 11/03/22 at 9:55 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. After reviewing (R2's) October eMAR, and progress notes dated above ASM #2 stated that (R2) did not receive the medications listed above according to the physician's orders. When asked about the dates coded with a number five ASM #2 stated that the dates coded as a five refer to NN, DON stated that there was no documentation why the medication was held therefore nurse's notes. ASM #2 further stated that the nurse's notes failed to evidence documentation as to why the medications were held on the dated notes above and failed to evidence documentation that the physician was notified of (R2) not receiving their medications on the dates listed above.

On 11/03/2022 at approximately 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked to describe the

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procedure a nurse follows when a medication is not administered to a resident LPN #4 stated that the physician is notified why the medication was not administered. After reviewing the nursing progress notes for (R2) dated in regard to Ceftriaxone on 10/27/2022, 10/28/2022, 10/31/2022, and in regard to Vancomycin on 10/18/2022, 10/19/2022 and on 10/28/2022, LPN #4 stated that there was no documentation that the physician was notified that Ceftriaxone was not administered on 10/27/2022, 10/28/2022 and 10/31/2022 and Vancomycin was not administered on 10/18/2022, 10/19/2022 and on 10/28/2022.

On 11/03/2022 at approximately 4:02 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, regional clinical coordinator were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Used to treat certain infections caused by bacteria such as gonorrhea (a sexually transmitted disease), pelvic inflammatory disease (infection of the female reproductive organs that may cause infertility), meningitis (infection of the membranes that surround the brain and spinal cord), and infections of the lungs, ears, skin, urinary tract, blood, bones, joints, and abdomen. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a685032.html.

(2) Used to treat colitis (inflammation of the intestine caused by certain bacteria) that may

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F 580	Continued From page 19 occur after antibiotic treatment. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a604038.html. (3) A bacterium that causes diarrhea and more serious intestinal conditions such as colitis. Symptoms include watery diarrhea (at least three bowel movements per day for two or more days), fever, loss of appetite, nausea, abdominal pain or tenderness. This information was obtained from the website: https: https://medlineplus.gov/clostridiumdifficileinfections.html.	F 580		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not	F 622		12/18/22

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submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

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F 622	Continued From page 21 (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence that all required information was provided to the hospital staff when three of 52 residents in the survey sample were transferred to the hospital; Residents # 95, #15 and #31. The findings include: 1. The facility staff failed to evidence provision of required resident information to a receiving facility at the time of discharge for Resident #95. Resident #95 was transferred to the hospital on	F 622	Criteria 1 Residents identified were all discharged from the facility. Criteria 2 All current residents have the potential to be affected by the alleged deficient practice upon discharge to the hospital. Criteria 3 Licensed Nurses will be reeducated on the policy for hospital discharges and the required forms that need to be sent to the	

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F 622	Continued From page 22 9/22/22. Resident #95 was admitted to the facility on 8/19/22 with diagnosis that included but were not limited to: anemia, hypertension, and malnutrition. The most recent MDS (minimum data set) assessment, a 5-day Medicare assessment, with an ARD (assessment reference date) of 10/10/22, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as being totally dependent for bed mobility, transfer, dressing, bathing and hygiene; extensive assistance for eating. A review of the comprehensive care plan with a revision date of 9/7/22, revealed, "FOCUS: Resident is at risk for nutritional and/or dehydration risk related to: wounds, severe protein malnutrition, anemia. INTERVENTIONS: Provide supplements as ordered. Document consumption. Provide diet preferences and offer substitutes as needed. There was no evidence of hospital transfer documents sent with the resident to the hospital on 9/22/22. A request for clinical documents sent to the facility with the resident was made on 11/3/22 at 10:00 AM. An interview was conducted on 11/3/22 at 11:15 AM, with RN (registered nurse) #2. When asked what documents are sent with the resident to the hospital, RN #2 stated, "Nursing sends out transfer documents, we are supposed to send out labs, SBAR	F 622	hospital. Criteria 4 The DON or designee will conduct audits of hospital discharges three times a week for four weeks, weekly for one month and monthly for one month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action.	

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(situation/background/assessment/recommendation), vital signs and care plan." When asked how do you evidence what was sent to the hospital, RN #2 stated, "It is documented that I gave the verbal report."

On 11/3/22 at 1:00 PM, ASM (administrative staff member) #1, the administrator stated, "We do not have any of the requested information for this resident."

On 11/3/22 at 3:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the findings.

A review of the facilities "Transfer and Discharge" policy, dated 9/20222, revealed the following: "A transfer form is completed, a list of medications and a copy of the care plan goals is sent to the receiving hospital. Nursing documents the transfer in the medical record."

No further information was provided prior to exit.
2. For (R15), the facility staff failed to evidence required documentation was provided to the receiving facility for a facility-initiated transfer on 06/12/2022.

(R15) was admitted to the facility with diagnoses that included but were not limited to: a history of falling.

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 10/15/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R15) was cognitively intact for making daily decisions.

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The facility's progress noted for (R15) dated 09/23/2022 documented in part, "Situation: The Change in Condition/s (CIC) reported on this CIC Evaluation are/were: Falls Pain ...Outcome of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: Functional Status Evaluation: Fall ...Primary Care Provider Fedback (sic): Recommendations: Send resident to hospital."

Review of the EHR (electronic health record) failed to evidence documentation of required information provided to the hospital on 09/23/2022 for (R15).

On 11/03/22 at approximately 10:30 a.m., ASM (administrative staff member) #1, the administrator stated that the facility did not have evidence that the required documentation was provided to the hospital for (R15's) transfer on 09/23/2022.

On 11/03/22 at approximately 2:24 p.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked to describe the procedure they follow when a resident is transferred to a hospital LPN # 4 stated that they complete a form entitled "E-Interact Transfer Form" that is sent to the hospital and includes the resident's medication, physician's orders, the care plan and goals, bed hold form, the name of the physician and/or the nurse practitioner, name of the hospital and who report was given to. After reviewing the electronic health record for (R15), LPN #4 stated that there was evidence of an E-Interact Transfer Form for (R15's) transfer to the hospital on 09/23/2022. After reviewing the nursing progress notes for (R15) dated

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09/23/2022 LPN #4 stated that there was no documentation of what documents were sent to the hospital for (R15).

On 11/03/2022 at approximately 4:02 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #4, regional clinical coordinator were made aware of the above findings.

No further information was provided prior to exit.

3. For Resident #31 (R31), the facility staff failed to provide evidence that required clinical documents related to the continuity of care were sent to the receiving facility when R31 was transferred to the hospital on 8/24/22 and 9/16/22.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/25/22, R31 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status).

A review of R31's clinical record revealed the following progress notes:

"8/24/22 6:47 a.m. "Spoke with ER (emergency room) nurse at [name of local hospital], [Resident] admitted with dx (diagnosis) of CHF (congestive heart failure) exacerbation, still running some diagnostics at this time."

"9/16/22...This morning at 9:45 a.m., resident requested to go back to the ER, stated he felt off, difficulty breathing, and pain...Called non-emergency number and was taken to [name

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F 622	Continued From page 26 of local hospital]." Further review of the clinical record failed to reveal evidence of any clinical documentation related to the continuity of care for R31 that was sent to the receiving facility for the transfers on 8/24/22 and 9/16/22. On 11/2/22 at 11:50 a.m., ASM (administrative staff member) #1, the administrator, stated the facility could not produce evidence of the clinical documents that were sent to the hospital for R31 on 8/24/22 and 9/16/22. On 11/2/22 at 1:37 p.m., LPN (licensed practical nurse) #3 stated it is the nurse's responsibility to send clinical documentation related to the continuity of care to the hospital when a resident is being transferred. She stated this includes a bed hold notice, care plan goals, medication list, face sheet, advance directive, and recent laboratory test results. She stated the nurse documents which items were sent to the receiving facility in a progress note or on a transfer form. She stated if a resident's family member is present, the nurse usually gives the family member the information about the facility's bed hold policy. On 11/2/22 at 3:55 p.m., ASM #1, ASM #2, the director of nursing, and ASM #4, the regional clinical coordinator, were informed of these concerns. No further information was provided prior to exit.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		12/18/22

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§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30

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days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to

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F 623	Continued From page 29 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence that the RP (responsible party) and/or Long Term Care Ombudsman was notified of a transfer to the hospital for four out of 52 residents in the survey sample; Residents # 95, #15, #31 and #81. The findings include: 1. The facility staff failed to evidence written RP (responsible party) and/or ombudsman notification at the time of discharge for Resident #95. Resident #95 was transferred to the hospital on 9/22/22. Resident #95 was admitted to the facility on 8/19/22 with diagnosis that included but were not limited to: anemia, hypertension, and malnutrition. The resident was transferred to the hospital on 9/22/22.	F 623	Criteria 1 Identified residents were discharged from the facility. Criteria 2 All current residents discharged to the hospital have the potential to be affected by the alleged deficiency. Criteria 3 The corporate Director of Social Services provided education to the facility Social worker on ombudsman and RP notification upon hospital discharge. An audit was completed for November 2022 and Ombudsman received letters about discharges to hospital. Criteria 4 The Administrator will audit RP/ombudsman notification 3 times/week x 4 weeks, weekly for 4 weeks, then	

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F 623	Continued From page 30 A request for written RP or ombudsman notification for the resident was made on 11/3/22 at 10:00 AM. An interview was conducted on 11/3/22 at 11:15 AM, with RN (registered nurse) #2. When asked what notification is provided when the resident is sent to the hospital, RN #2 stated, "Nursing calls the family. I do not know who informs the ombudsman." When asked how do you the RP has been informed, RN #2 stated, it is in the progress note that I called them. On 11/3/22 at 1:00 PM, ASM (administrative staff member) #1, the administrator stated, they did not have any of the requested information for this resident. On 11/3/22 at 3:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the findings. A review of the facilities "Transfer and Discharge" policy, dated 9/20222, revealed the following: "When a guest/resident is transferred on an emergency basis to an acute care facility, notice of the transfer is provided to the guest/resident and the guest/resident representative as soon as practicable. The Ombudsman is notified. A list of guest/residents can be sent to the ombudsman on a monthly basis." No further information was provided prior to exit. 2. For (R15), the facility staff failed to evidence written notification was provided to the ombudsman, (R15) and (R15's) responsible party for a facility-initiated transfer on 09/23/2022.	F 623	monthly x 1 month. Notifications will be made as needed. Continued compliance will be monitored through routine audits and reported to the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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(R81) was admitted to the facility with diagnoses that included but were not limited to: a history of falling.

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 10/15/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R15) was cognitively intact for making daily decisions.

The facility's progress noted for (R15) dated 09/23/2022 documented in part, "Situation: The Change in Condition/s (CIC) reported on this CIC Evaluation are/were: Falls Pain ...Outcome of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: Functional Status Evaluation: Fall ...Primary Care Provider Fedback (sic): Recommendations: Send resident to hospital."

Review of the EHR (electronic health record) for (R15) failed to evidence written notification of transfer was provided to the ombudsman, (R15) and (R15's) representative for the facility-initiated transfer on 09/23/2022.

On 11/02/22 at 10:22 a.m., an interview was conducted with LPN (licensed practical nurse) # 5. When asked if they provide written notification to the resident and/or the resident's responsible party when the resident is transferred to the hospital LPN # 5 stated that they do not provide a written notice of the transfer. LPN # 5 stated that they call the responsible party on the phone.

On 11/2/2022 at approximately 1:04 p.m., an interview was conducted with OSM (other staff member) # 2, director of social services. When

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asked to describe their role and what documentation is completed when a resident is transferred to the hospital OSM # 2 stated that if a resident is discharged to hospital they have no role in written notification to the resident and/or the resident's responsible party. When asked if they notify the Ombudsman of a resident's transfer to the hospital OSM # 2 stated that the facility told them on this day (11/02/2022) today that they were supposed to send a notice to the ombudsman for a resident transfer. OSM # 2 further stated that this was something they were not doing.

On 11/03/2022 at approximately 4:02 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, regional clinical coordinator were made aware of the above findings.

No further information was provided prior to exit.

3. For Resident #31 (R31), the facility staff failed to evidence written notification to the resident/RP (responsible party) and to the ombudsman when R31 was transferred to the hospital on 8/24/22 and 9/16/22.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/25/22, R31 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status).

A review of R31's clinical record revealed the following progress notes:

"8/24/22 6:47 a.m. "Spoke with ER (emergency

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room) nurse at [name of local hospital], [Resident] admitted with dx (diagnosis) of CHR (congestive heart failure) exacerbation, still running some diagnostics at this time."

"9/16/22...This morning at 9:45 a.m., resident requested to go back to the ER, stated he felt off, difficulty breathing, and pain...Called non-emergency number and was taken to [name of local hospital]."

Further review of the clinical record failed to reveal evidence that the resident/RP and ombudsman were notified of R31's discharges to the hospital on 8/24/22 and 9/16/22.

On 11/2/22 at 11:50 a.m., ASM (administrative staff member) #1, the administrator, stated the facility could not produce evidence that the resident/RP and ombudsman were notified for R31's discharges to the hospital on 8/24/22 and 9/16/22.

On 11/2/22 at 1:05 p.m., OSM (other staff member) #2, the social services director, was interviewed regarding written notifications at the time of a resident's discharge to the hospital. She stated she had not previously been aware of her role in providing written notification to the resident/RP and ombudsman when a resident is discharged to the hospital. She stated she had just become aware of this responsibility.

On 11/2/22 at 3:55 p.m., ASM #1, ASM #2, the director of nursing, and ASM #4, the regional clinical coordinator, were informed of these concerns.

No further information was provided prior to exit.

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4. For Resident #81 (R81), the facility staff failed to provide evidence that written notification of transfer was provided to the resident and/or responsible party and the ombudsman for a facility-initiated transfer on 8/10/2022.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/27/2022, R81 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status) assessment.

A review of R81's clinical record revealed the following progress note: "8/10/2022 07:41 (7:41 a.m.) Note Text: resident presented with a worsening wound to the left foot [Name of physician] called his foot doctor and stated to send the resedent [sic] to the ed (emergency department) for eval (evaluation) and treat np (nurse practitioner) [Name of NP] and patient emergency contact, ex wife aware."

Further review of the clinical record failed to reveal evidence that written notification of transfer was provided to the resident and/or responsible party and the long-term care ombudsman for the transfer on 8/10/2022.

On 11/02/2022 at approximately 8:00 a.m., a request was made via written list to ASM (administrative staff member) #1, the administrator, for evidence of written notification of transfer provided to the resident and/or responsible party and notification of the ombudsman for the facility-initiated transfer on 8/10/2022.

On 11/02/2022 at 10:40 a.m., ASM #1 stated that

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F 623	Continued From page 35 they did not have evidence of ombudsman notification for the transfer on 8/10/2022 and provided the progress note documented above which documented verbal notification of the responsible party. On 11/02/2022 at 10:22 a.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that the nursing staff did not provide any written notification of transfer to the resident or the responsible party when they went to the hospital. LPN #5 stated that they spoke with the responsible party over the telephone to notify them that the resident was going to the hospital. On 11/2/2022 at 1:04 p.m., an interview was conducted with OSM (other staff member) #2, the director of social services. OSM #2 stated that they did not have any role in providing a written notification of transfer to the resident or responsible party when they went to the hospital. OSM #2 stated that they had not been notifying the ombudsman of transfers and were not aware that it was their responsibility until 11/2/2022. On 11/02/2022 at approximately 5:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were informed of these concerns. No further information was provided prior to exit.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a	F 625		12/18/22

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F 625	Continued From page 36 nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence that bed hold notifications were provided to four out of 52 residents in the survey sample that were transferred to the hospital; Residents # 95, #15, #31 and #81. The findings include: 1. The facility staff failed to evidence bed hold notification was provided at the time of transfer to	F 625	Criteria 1 Identified residents were discharged to the hospital. Criteria 2 All current residents being discharged to the hospital have the potential to be affected by this alleged deficient practice. Criteria 3 Licensed Nurses will be re-educated on	

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	495394	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(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 625	Continued From page 37 Resident #95 and/or resident responsible party. Resident #95 was transferred to the hospital on 9/22/22. Resident #95 was admitted to the facility on 8/19/22 with diagnosis that included but were not limited to: anemia, hypertension, and malnutrition. The most recent MDS (minimum data set) assessment, a 5-day Medicare assessment, with an ARD (assessment reference date) of 10/10/22, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the comprehensive care plan with a revision date of 9/7/22, revealed, "FOCUS: Resident is at risk for nutritional and/or dehydration risk related to: wounds, severe protein malnutrition, anemia. INTERVENTIONS: Provide supplements as ordered. Document consumption. Provide diet preferences and offer substitutes as needed. There was no evidence of bed hold notification for Resident #95 when sent to the hospital on 9/22/22. A review of the nursing progress note dated 10/3/22 revealed, "82-year-old woman transferred to facility for wound care and rehab. Records indicate significant cognitive issues during her stay in hospital. Since her stay here she has experienced hallucinations and has episodic screaming and yelling. She was treated for urinary tract infection. Visited in her room and found resting in bed. She is clearly confused and talking about playing with children on the floor."	F 625	the bed hold policy and documentation that it was given to resident and or RP. Criteria 4 The DON or designee will conduct audits of discharged residents to assure the bed hold policy was sent to the hospital with them 3 x week for four weeks, weekly for one month then monthly x 1 month. These results will be forwarded to the QAPI committee for review. The QAPI committee will determine the needs for further audits and action.	

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A request for bed hold notification for the resident was made on 11/3/22 at 10:00 AM.

An interview was conducted on 11/3/22 at 11:15 AM, with RN (registered nurse) #2. When asked what notification regarding a bed hold is provided when the resident is sent to the hospital, RN #2 stated, we give them a paper. When asked how do you evidence that a bed hold has been provided, RN #2 stated, there is no documentation.

On 11/3/22 at 1:00 PM, ASM (administrative staff member) #1, the administrator stated, we do not have any of the requested information for this resident.

On 11/3/22 at 3:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the findings.

A review of the facilities "Bed Hold" policy, dated 9/20222, revealed the following: "Within 24 hours of a hospital transfer, the admission director or designee will contact the resident or RP regarding possible length of transfer and possible bed hold. Document bed hold offer and resident or RP decision in the medical record."

No further information was provided prior to exit.
2. For (R15), the facility staff failed to provide evidence that they issued a bed hold notice to the resident/RP (responsible party) when (R15) was sent to the hospital on 09/23/2022.

(R15) was admitted to the facility with diagnoses that included but were not limited to: a history of

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falling.

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 10/15/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R15) was cognitively intact for making daily decisions.

The facility's progress noted for (R15) dated 09/23/2022 documented in part, "Situation: The Change in Condition/s (CIC) reported on this CIC Evaluation are/were: Falls Pain ...Outcome of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: Functional Status Evaluation: Fall ...Primary Care Provider Fedback (sic): Recommendations: Send resident to hospital."

Review of the EHR (electronic health record) for (R15) failed to evidence documentation that the bed hold policy was provided to (R15) or (R15's) responsible party in regard to the transfer to the hospital on 09/23/2022.

On 11/02/2022 at 10:22 a.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that when residents were sent out to the hospital they sent a bed hold policy with the resident. LPN #5 stated that this would be documented in the progress notes.

On 11/2/2022 at 1:04 p.m., an interview was conducted with OSM (other staff member) #2, the director of social services. OSM #2 stated that they were not responsible for providing a bed hold notice.

On 11/03/22 at approximately 10:30 a.m., ASM

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(administrative staff member) # 1, the administrator stated that the facility did not have evidence that a bed hold policy was provided to (R15) or (R15's) responsible party for (R15's) transfer on 09/23/2022.

On 11/03/2022 at approximately 4:02 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, regional clinical coordinator were made aware of the above findings.

No further information was provided prior to exit.
3. For Resident #31 (R31), the facility staff failed to provide evidence that they issued a bed hold notice to the resident/RP (responsible party) when R31 was discharged to the hospital on 8/24/22 and 9/16/22.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/25/22, R31 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status).

A review of R31's clinical record revealed the following progress notes:

"8/24/22 6:47 a.m. "Spoke with ER (emergency room) nurse at [name of local hospital], [Resident] admitted with dx (diagnosis) of CHF (congestive heart failure) exacerbation, still running some diagnostics at this time."

"9/16/22...This morning at 9:45 a.m., resident requested to go back to the ER, stated he felt off, difficulty breathing, and pain...Called non-emergency number and was taken to [name

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of local hospital]."

Further review of the clinical record failed to reveal evidence that R31/RP were provided a bed hold notice for the discharges on 8/24/22 and 9/16/22.

On 11/2/22 at 11:50 a.m., ASM (administrative staff member) #1, the administrator, stated the facility could not produce evidence that bed hold notices were provided to R31/RP when R31 was sent to the hospital on 8/24/22 and 9/16/22.

On 11/2/22 at 1:37 p.m., LPN (licensed practical nurse) #3 stated it is the nurse's responsibility to send clinical documentation related to the continuity of care to the hospital when a resident is being transferred. She stated this includes a bed hold notice, care plan goals, medication list, face sheet, advance directive, and recent laboratory test results. She stated the nurse documents which items were sent to the receiving facility in a progress note or on a transfer form. She stated if a resident's family member is present, the nurse usually gives the family member the information about the facility's bed hold policy.

On 11/2/22 at 3:55 p.m., ASM #1, ASM #2, the director of nursing, and ASM #4, the regional clinical coordinator, were informed of these concerns.

No further information was provided prior to exit.

4. For Resident #81 (R81), the facility staff failed to provide evidence that a bedhold notice was provided to the resident and/or responsible party for a facility-initiated transfer on 8/10/2022.

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On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/27/2022, R81 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status) assessment.

A review of R81's clinical record revealed the following progress note: "8/10/2022 07:41 (7:41 a.m.) Note Text: resident presented with a worsening wound to the left foot [Name of physician] called his foot doctor and stated to send the resedent [sic] to the ed (emergency department) for eval (evaluation) and treat np (nurse practitioner) [Name of NP] and patient emergency contact, ex wife aware." The progress notes further documented, "8/14/2022 14:45 (2:45 p.m.) Late Entry: Note Text: readmit from [Name of hospital] A&O X 3 (alert and oriented to person, place and time); observation remains in place r/t (related to) infection and treatments in place to heels; will continue plan of care."

Further review of the clinical record failed to reveal evidence that bedhold notice was provided to the resident and/or responsible party for the transfer on 8/10/2022.

On 11/02/2022 at approximately 8:00 a.m., a request was made via written list to ASM (administrative staff member) #1, the administrator, for evidence of bed hold notice provided to the resident and/or responsible party for the facility-initiated transfer on 8/10/2022.

On 11/02/2022 at 10:40 a.m., ASM #1 stated that they did not have evidence of bed hold notice

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F 625	Continued From page 43 being provided to the resident and/or responsible party for R81's transfer on 8/10/2022. On 11/02/2022 at 10:22 a.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that when residents were sent out to the hospital they sent a bed hold policy with the resident. LPN #5 stated that this would be documented in the progress notes. On 11/2/2022 at 1:04 p.m., an interview was conducted with OSM (other staff member) #2, the director of social services. OSM #2 stated that they were not responsible for providing a bed hold notice. On 11/02/2022 at approximately 5:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were informed of these concerns. No further information was provided prior to exit.	F 625		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental	F 645		12/18/22

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condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual

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F 645	Continued From page 45 is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined the facility staff failed to obtain a PASARR (preadmission screening and resident review) for one of 52 residents in the survey sample, Resident #79 (R79). The findings include: For R79, the facility staff failed to obtain a PASARR upon admission to the facility. On the most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 9/15/2022, the resident scored a 10 of out 15 on the BIMS (brief interview for mental status) score, indicating the resident is moderately cognitively impaired for making daily decisions. R79 was admitted to the facility 10/13/2021. The review of the clinical record failed to evidence documentation of a PASARR. A request for the PASARR was made on	F 645	Criteria 1 The PASARR was obtained for resident #79. Criteria 2 All residents have the potential to be affected by this practice. An audit will be completed to ensure all residents have a PASSAR in place that is appropriate to this setting. Criteria 3 Administrative Nurse, or designee will provide in-service education to Admissions and Social Services staff on the requirement for a PASSAR for each resident. Criteria 4 An audit will be completed on all new admissions 3 times per week x 4 weeks, then weekly for 4 weeks, they monthly for 1 month. Corrections will be made as needed.	

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F 645	Continued From page 46 10/31/2022 at approximately 3:30 p.m. On 11/1/2022 at 3:27 p.m. ASM (administrative staff member) #1, the administrator, stated they did not have a PASARR for R79. An interview was conducted on 11/2/2022 at 8:44 a.m. with OSM (other staff member) #3. When asked the process for obtaining or completing a PASARR, OSM #3 stated they ask the case manager at the hospital for a PASARR on all residents. If there is not one, she asked the hospital to complete one. OSM #3 stated sometimes they can get it through the community portal. OSM #3 stated she had just started at the facility in May. The facility policy, "Pre-Admission Screening and Guest/Resident Review," documented in part, "The process begins with the completion of a screening, Level 1/3877. The screening is generally completed by a hospital or community provider. If the responses to the Level 1/3877 screening indicate the presence of a mental illness and/or intellectually/developmental disability or related condition, the person is referred to the local community mental health program for a comprehensive screening, Level 2." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional clinical coordinator, were made aware of the above concern on 11/2/2022 at 5:14 p.m. No further information was provided prior to exit.	F 645	Continued compliance will be monitored through routine audits and reported to the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
F 655 SS=E	Baseline Care Plan	F 655		12/18/22

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F 655	Continued From page 47 CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and	F 655		

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F 655	Continued From page 48 dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on resident interview, responsible party interview, staff interview, facility document review, clinical record review and in the course of complaint investigations, the facility staff failed to provide residents with a summary of the baseline care plan for five of 52 residents in the survey sample, Residents #162, #309, #72, #111 and #109. The findings include: 1. For Resident #162 (R162), the facility staff failed to provide the responsible party with a summary of the baseline care plan. R162 was admitted to the facility on 6/22/2022. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/29/2022, the resident scored 4 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. The "72 Hour Admission Conference" dated 6/26/2022 for R162 failed to evidence the responsible party being provided a summary of the baseline care plan. A review of R162's clinical record failed to evidence R162's responsible party being provided	F 655	Criteria 1 Residents #162,309,72,111 have been discharged from the facility. Resident # 109 received a copy of her care plan. Criteria 2 All current residents have the potential to be affected by the alleged deficient practice. Criteria 3 Social Workers were re-educated on the 72 hour meeting and giving resident and family copy of baseline care plan. Criteria 4 Social Worker/Designee will audit new admissions 3 x a week for one month, weekly x 4 weeks and monthly x 1 to assure post admission meeting is scheduled and Care Plan is given to resident or RP. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action.	

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a summary of the baseline care plan.

On 11/2/2022 at approximately 8:00 a.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence that the baseline care plan was provided to R162's responsible party.

On 11/2/2022 at 10:40 a.m., ASM #1 stated that they did not have evidence of the responsible party being give a copy of the baseline care plan.

On 11/2/2022 at 12:53 p.m., an interview was conducted with RN (registered nurse) #1, MDS coordinator. RN #1 stated that they started the assessment and care planning process for newly admitted residents. RN #1 stated that they reviewed the nursing evaluations and collected information on the activities of daily living, any wounds, any skin conditions, pain and other things that related to the resident. RN #1 stated that they reviewed the orders, diagnoses and auxiliary documents and then started the care plan process.

On 11/2/2022 at 1:04 p.m., an interview was conducted with OSM (other staff member) #2, the director of social services. OSM #2 stated that the admissions staff scheduled the 72 hour admission conference meeting for newly admitted residents and they or the other social worker documented the conference. OSM #2 stated that the 72 hour admission conference was a welcome meeting where everyone introduced themselves and they discussed discharge plans and any nursing or therapy questions. OSM #2 stated that they did not provide a written summary of the care plan but would provide it if requested by the resident or responsible party. OSM #2

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stated that the conference was normally completed by telephone.

On 11/2/2022 at 1:37 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that the purpose of the care plan was to show the overall care of the resident, what they were doing for them, document their goals, behaviors and falls.

On 11/3/2022 at 8:06 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that the process for care planning at the facility was for the MDS nurse to review the medical record provided from the hospital and the assessment completed upon admission and complete the baseline and comprehensive care plan at that time. ASM #2 stated that they did not wait two weeks to do the comprehensive assessment and they updated it as needed. ASM #2 stated that they had not been providing a copy of the care plan to the responsible parties.

The facility policy, "Care Planning" last revised 6/24/2021 documented in part, "...2. A Baseline Care Plan will be developed within 48 hours identifying any immediate needs, initial goals and interventions needed to provide effective and person-centered care. 3. The facility will provide the resident and their representative with a summary of the baseline care plan that includes the following: Initial goals of the resident; A summary of the resident's medications and dietary instructions; Any services and treatments to be administered by the facility and the personnel acting on behalf of the facility; Any updated information based on the details of the comprehensive care plan as necessary..."

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On 11/3/2022 at 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the above concern.

No further information was presented prior to exit.

Complaint deficiency.
2. For Resident #309 (R309), the facility staff failed to provide the resident and/or RR (resident representative) with a summary of the baseline care plan.

R309 was admitted to the facility on 10/22/22. The admission MDS (minimum data set) had not been completed at the time of survey entrance. A review of the Nursing Comprehensive Evaluation dated 10/22/22 revealed R309 was oriented to person, place, and time.

On 10/31/22 at 2:52 p.m., R309 stated they were not aware that they had received a copy of the baseline care plan summary.

A review of R309's clinical record failed to reveal evidence that the resident or RR ever received a summary of baseline care plan.

On 11/2/22 at 1:05 p.m., OSM (other staff member) #2, the social services director was interviewed. She stated within 72 hours of a resident's admission, a meeting is scheduled with the interdisciplinary team and the resident/RR. She stated the purpose of this meeting is to welcome the resident, to begin a discussion about discharge planning, and to ask questions of nursing, therapy, and other departments. She stated there is nothing she regularly offers to the resident/RR in writing, unless she someone asks

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for something specific. She stated that most of the RRs attend by telephone. She stated she does not ordinarily offer a summary of the baseline care plan to the resident/RR.

On 11/2/22 at 1:52 p.m., OSM #3, the director of marketing was interviewed. She stated the admissions staff sets an admission meeting with the family once the resident is settled into the facility. She stated the family members may either come in to the facility and meet in person, or the meeting occurs by teleconference.

On 11/2/22 at 3:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional clinical coordinator, were informed of these concerns.

On 11/3/22 at 8:06 a.m., ASM #2 stated when a resident is admitted, the MDS coordinator reviews the medical record from the discharging facility, and the facility staff completes an assessment. She stated the facility develops and implements a care plan at that time, and does not distinguish between the baseline care plan and the comprehensive care plan. She stated the facility staff has not been providing the resident/RR with a copy of the care plan.

No further information was provided prior to exit.

3. For Resident #72 (R72), the facility staff failed to provide the resident and/or RR (resident representative) a baseline care plan summary.

R72 was admitted to the facility on 9/27/22. On the most recent MDS (minimum data set), an

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admission assessment with an ARD (assessment reference date) of 10/4/22, R72 was coded as having no cognitive impairment for making daily decisions, having scored 13 out of 15 on the BIMS (brief interview for mental status).

A review of R72's clinical record failed to reveal evidence that the resident or RR ever received a summary of baseline care plan goals.

On 11/2/22 at 1:05 p.m., OSM (other staff member) #2, the social services director was interviewed. She stated within 72 hours of a resident's admission, a meeting is scheduled with the interdisciplinary team and the resident/RR. She stated the purpose of this meeting is to welcome the resident, to begin a discussion about discharge planning, and to ask questions of nursing, therapy, and other departments. She stated there is nothing she regularly offers to the resident/RR in writing, unless she someone asks for something specific. She stated that most of the RRs attend by telephone. She stated she does not ordinarily offer a summary of the baseline care plan to the resident/RR.

On 11/2/22 at 1:52 p.m., OSM #3, the director of marketing was interviewed. She stated the admissions staff sets an admission meeting with the family once the resident is settled into the facility. She stated the family members may either come in to the facility and meet in person, or the meeting occurs by teleconference.

On 11/3/22 at 8:06 a.m., ASM #2 stated when a resident is admitted, the MDS coordinator reviews the medical record from the discharging facility, and the facility staff completes an assessment. She stated the facility develops and implements a

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care plan at that time, and does not distinguish between the baseline care plan and the comprehensive care plan. She stated the facility staff has not been providing the resident/RR with a copy of the care plan.

No further information was provided prior to exit.

4. For Resident #111 (R111), the facility staff failed to provide the resident and/or RR (resident representative) with a summary of the baseline care plan.

R111 was admitted to the facility on 10/25/22. An admission MDS (minimum data set) had not yet been completed at the time of survey entrance. A review of the Nursing Comprehensive Evaluation dated 10/25/22 revealed the resident was oriented to time and person only.

On 11/1/22 at 11:58 a.m., R111's spouse was interviewed. R111's spouse stated they were not aware of R111's care plan goals, and had never received a summary of the resident's baseline care plan.

A review of R111's clinical record failed to reveal evidence that the resident or RR ever received a summary of baseline care plan goals.

On 11/2/22 at 1:05 p.m., OSM (other staff member) #2, the social services director was interviewed. She stated within 72 hours of a resident's admission, a meeting is scheduled with the interdisciplinary team and the resident/RR. She stated the purpose of this meeting is to welcome the resident, to begin a discussion about discharge planning, and to ask questions of nursing, therapy, and other departments. She

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stated there is nothing she regularly offers to the resident/RR in writing, unless she someone asks for something specific. She stated that most of the RRs attend by telephone. She stated she does not ordinarily offer a summary of the baseline care plan to the resident/RR.

On 11/2/22 at 1:52 p.m., OSM #3, the director of marketing was interviewed. She stated the admissions staff sets an admission meeting with the family once the resident is settled into the facility. She stated the family members may either come in to the facility and meet in person, or the meeting occurs by teleconference.

On 11/3/22 at 8:06 a.m., ASM #2 stated when a resident is admitted, the MDS coordinator reviews the medical record from the discharging facility, and the facility staff completes an assessment. She stated the facility develops and implements a care plan at that time, and does not distinguish between the baseline care plan and the comprehensive care plan. She stated the facility staff has not been providing the resident/RR with a copy of the care plan.

No further information was provided prior to exit.

5. For Resident #103 (R103), the facility staff failed to provide the resident and/or RR (resident representative) with a summary of the baseline care plan.

R103 was admitted to the facility on 10/14/22. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/21/22, R103 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the

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BIMS.

On 11/1/22 at 10:00 a.m., R103 was interviewed. The resident stated they did not remember having received a copy of a summary of the baseline care plan.

A review of R103's clinical record failed to reveal evidence that the resident or RR ever received a summary of baseline care plan goals.

On 11/2/22 at 1:05 p.m., OSM (other staff member) #2, the social services director was interviewed. She stated within 72 hours of a resident's admission, a meeting is scheduled with the interdisciplinary team and the resident/RR. She stated the purpose of this meeting is to welcome the resident, to begin a discussion about discharge planning, and to ask questions of nursing, therapy, and other departments. She stated there is nothing she regularly offers to the resident/RR in writing, unless she someone asks for something specific. She stated that most of the RRs attend by telephone. She stated she does not ordinarily offer a summary of the baseline care plan to the resident/RR.

On 11/2/22 at 1:52 p.m., OSM #3, the director of marketing was interviewed. She stated the admissions staff sets an admission meeting with the family once the resident is settled into the facility. She stated the family members may either come in to the facility and meet in person, or the meeting occurs by teleconference.

On 11/3/22 at 8:06 a.m., ASM #2 stated when a resident is admitted, the MDS coordinator reviews the medical record from the discharging facility, and the facility staff completes an assessment.

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F 655	Continued From page 57 She stated the facility develops and implements a care plan at that time, and does not distinguish between the baseline care plan and the comprehensive care plan. She stated the facility staff has not been providing the resident/RR with a copy of the care plan. No further information was provided prior to exit.	F 655		
F 656 SS=E	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	F 656		12/18/22

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F 656	Continued From page 58 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 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, clinical record review and facility document review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for six of 52 residents in the survey sample, Residents #15 (R15), #21 (R21), #2 (R2), #23 (R23), #19 (R19), and #13 (R13). The findings include: 1a. For (R15), the facility staff failed to implement the comprehensive care plan for the placement of a fall mat. (R15) was admitted to the facility with a diagnosis that included but was not limited to: muscle weakness and a history of falling. On the most recent MDS (minimum data set), a	F 656	Criteria 1 Resident #15 fall mat was placed by her bed. Resident# 15 pain scale was corrected to reflect correct numerical pain scales. Resident #15 call bell was put back in place and clipped to the bed. Resident #15's MAR was corrected to reflect and include non-pharmacological interventions. Resident#21was discharged from the facility. Resident #2 suffered no ill effects from medication not being administered. He was discharged from the facility. Resident #23 had care plan updated to reflect use of side rails. Resident #19 and #13 was seen by the wound physician, measurements were taken, and treatments implemented.	

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F 656	Continued From page 59 significant change assessment with an ARD (assessment reference date) of 10/15/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R15) was cognitively intact for making daily decisions. On 11/01/2022 at approximately 9:00 a.m. and 9:30 a.m., (R15) was observed lying in the bed. Further observation failed to evidence a fall mat on the floor next to the bed. The physician's orders for (R15) documented in part, "Fall mat to right side of bed every shift. Order Date: 09/30/2022. Start Date: 09/30/2022." The comprehensive care plan for (R15 dated 09/18/2022 documented in part, "Need: (R15) is at risk for fall related injury and falls R/T (related to): orthostatic hypotension, hx (history) falls, peripheral neuropathy. Date Initiated: 09/18/2022." Under "Interventions" it documented in part, "Fall mat to right side of bed. Date Initiated: 10/04/2022." The facility's policy "care Planning" documented in part, "Every resident in the facility will have a person-centered Care Plan developed and implemented that is consistent with resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a resident medical, nursing, and mental and psychosocial needs identified in the comprehensive assessments and prepared by an interdisciplinary team...." On 11/03/2022 at approximately 4:02 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, regional clinical coordinator were made aware of	F 656	Criteria 2 All residents have the potential to be affected by the alleged deficient practices. Criteria 3 The DON/designee will re-educate licensed nurses on pain management, non-pharmacological interventions, notification of medications not administered, side rail policy and procedure, call bell placement, and fall interventions. Nurse Aides will receive in-service education on fall interventions and call bell placement. Criteria 4 The DON/designee will audit the following: Random audits of residents receiving pain medications will be conducted for use of non-pharmacological interventions. Random MAR audits will be conducted for physician notification of medications not administered. Side rail use and consent requirements will be audited to ensure use is properly documented. Random call bell placement audits will be conducted through room rounds. Random audits will be conducted for fall mat placement. All audits will be completed 3 times/week x 4 weeks, weekly x 4 weeks, then monthly x 1 month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action.	

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the above findings.

No further information was provided prior to exit.

1b. For (R15), the facility staff failed to implement the comprehensive care plan to prevent the administration of unnecessary medications.

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 10/15/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R15) was cognitively intact for making daily decisions. Section J0400 "Pain Frequency" coded (R15) as "Occasionally." Under "J0600. Pain Intensity" it documented, "A. Numeric Rating Scale (00-10)." (R15) was coded a "4 (four)."

The physician's order for (R15) documented in part, "Roxicodone Tablet 5 (five) MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 09/30/2022. Start Date: 09/30/2022."

The "(Name of Pharmacy) Admission Medication Regimen Review Report" for (R15) dated "September 30, 2022 through October 7, 2022" documented in part, "Roxicodone Tablet 5 mg 1 tab (tablet) po (by mouth) every 6 hours as needed for pain discharge summary states for pain 6-10 (should be 7-10) since ibuprofen (2) is for pain 4-6)." Further review of the medication regimen review revealed the signature by the nurse practitioner dated "10-10-22 (October 10, 2022)."

The eMAR (electronic medication administration record) for (R15) dated October 2022

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documented the physician order as stated above. Further review of the eMAR revealed that (R15) received five milligrams of roxicodone for a pain level of five on 10/18/2022.

The comprehensive care plan for (R15) dated 09/18/2022 documented in part "Need: (R15) is at risk for pain and has pain related to neuropathy, C2 fracture (fracture of the second cervical vertebra) with fusion, post concussion headache with Odontaoid fracture (a toothlike upward projection at the back of the second vertebra of the neck), OA, (osteoarthritis) fracture of femur (leg). Date Initiated: 09/18/2022." Under "Interventions" it documented in part, "Administer medications as ordered. Date Initiated: 06/30/2021."

On 11/03/22 at approximately 8:19 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. After reviewing (R15's) medication regimen review, the October 2022 eMAR LPN # 4 stated that (R15) should have not received the roxicodone on 10/18/2022. After reviewing the care plan LPN # 4 stated that the care plan was not being followed.

On 11/03/2022 at approximately 4:02 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, regional clinical coordinator were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Are an immediate-release oral formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain where

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the use of an opioid analgesic is appropriate. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d48c22ff-bbb4-4a93-a35b-6eebff7b8e53 .

(2) Prescription ibuprofen is used to relieve pain, tenderness, swelling, and stiffness caused by osteoarthritis (arthritis caused by a breakdown of the lining of the joints) and rheumatoid arthritis (arthritis caused by swelling of the lining of the joints). It is also used to relieve mild to moderate pain, including menstrual pain (pain that happens before or during a menstrual period). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682159.html.

1c. For (R15), the facility staff failed to implement the comprehensive care plan to maintain the call bell within reach.

On 11/01/2022 at 9:00 a.m., an observation of (R15's) call bell revealed it was attached to the side of the mattress on the resident's right side of the bed approximately six to eight inches from the corner of the mattress.

On 11/01/2022 at 9:30 a.m., an observation of (R15's) call bell revealed it was attached to the side of the mattress on the resident's right side of the bed approximately six to eight inches from the corner of the mattress. When asked to locate and activate their call bell, (R15) was observed attempting to reach for the call bell but was unable to locate and grasp it.

The comprehensive care plan for (R15) dated 05/18/2022 documented in part, "Need. (R15)

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has hip fracture r/t (related to) fall. Date Initiated: 05/18/2022." Under "Interventions" it documented in part, "Anticipate and meets needs. Be sure call light is within reach and respond promptly to all requests for assistance. Date Initiated: 05/18/2022."

On 11/03/22 at 8:14 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When informed of the above observation LPN # 4 stated that they were familiar with (R15) and that (R15) did not have the range of motion to reach where the call bell was located and further stated that the call bell should have been positioned within (R15's) reach. After reviewing the care plan LPN # 4 stated that the care plan was not being followed.

On 11/03/2022 at approximately 4:02 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, regional clinical coordinator were made aware of the above findings.

No further information was provided prior to exit.

1d. For (R15), the facility staff failed to implement the comprehensive care plan for the use non-pharmacological interventions prior to the administration of as needed pain medication.

The physician's order for (R15) documented in part,
"Roxicodone Tablet 5 (five) MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 09/30/2022. Start Date: 09/30/2022."
"Acetaminophen Extra Strength Tablet 500 MG. Give 2 (two) tablets by mouth every 6 hours

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needed for pain 1-5 (one to five). Order Date: 10/10/2022. Start Date: 10/10/2022."

The eMAR (electronic medication administration record) for (R15) dated October 2022 documented the physician's order as stated above. The eMAR revealed that (R15) received 5 mgs of roxicodone on the following dates and times, with no evidence of non-pharmacological interventions being attempted on: 10/01/2022 at 1:12 p.m., 10/02/2022 at 1:44 p.m., 10/06/2022 at 10:00 a.m., and on 10/18/2022 at 8:31 p.m. Further review of the eMAR revealed that (R15) received 1000 mg of acetaminophen on the following dates and times, with no evidence of non-pharmacological interventions being attempted on: 10/26/2022 at 10:29 a.m. and on 10/27/2022 at 7:46 p.m.

The comprehensive care plan for (R15) dated 09/18/2022 documented in part "Need: (R15) is at risk for pain and has pain related to neuropathy, C2 fracture (fracture of the second cervical vertebra) with fusion, post concussion headache with Odontaoid fracture (a toothlike upward projection at the back of the second vertebra of the neck), OA, (osteoarthritis) fracture of femur (leg). Date Initiated: 09/18/2022." Under "Interventions" it documented in part, "Offer Non-Pharmacological Interventions: 1) Massage; 2) Meditation/relaxation; 3) Positioning; 4) Ice/cold pack; 5) Diversional Activity; 6) Guided Imagery; 7) Rest; 8) Social Interaction; 9) Other. Date Initiated: 06/30/2021.

Review of the facility's nurse's notes for (R15) dated 10/01/2022 through 10/31/2022 failed to evidence non-pharmacological interventions being attempted on the dates and times listed

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above.

On 11/02/22 at approximately 2:15 p.m., an interview was conducted with (R15). When asked if the staff attempt to alleviate their pain before administering their as needed pain medication, (R15) stated no and that they give them the pain medication.

On 11/03/22 at approximately 8:19 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. After review of (R15's) eMAR and progress notes dated 10/01/2022 through 10/31/2022 for non-pharmacological interventions prior to the administration of roxicodone and acetaminophen to (R15), LPN # 4 was asked about the missing documentation. LPN # 4 stated that they could not say non-pharmacological interventions were attempted because it was not documented. After reviewing the care plan LPN # 4 stated that the care plan was not being followed.

On 11/03/2022 at approximately 4:02 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, regional clinical coordinator were made aware of the above findings.

No further information was provided prior to exit.

2. For (R21), the facility staff failed to implement the comprehensive care plan for the use non-pharmacological interventions prior to the administration of as needed pain medication.

(R21) was admitted to the facility with a diagnosis that included but was not limited to: low back pain.

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On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 09/19/2022, (R21) scored 14 out of 15 on the BIMS (brief interview for mental status), indicating (R21) was cognitively intact for making daily decisions. Section J0400 "Pain Frequency" coded (R21) as "Frequently." Under "J0600. Pain Intensity" it documented, "A. Numeric Rating Scale (00-10)." (R21) was coded a "5 (five)."

The physician's order for (R21) documented in part, "Oxycodone-Acetaminophen Tablet 5-325 MG (milligram). Give 1 (one) tablet by mouth every 12 hours as needed for pain. Order Date: 09/15/2022. Start Date: 09/15/2022."

The eMAR (electronic medication administration record) for (R21) dated October 2022 documented the physician's order as stated above. The eMAR revealed that (R21) received 5-325 mgs of oxycodone-acetaminophen on the following dates and times, with no evidence of non-pharmacological interventions being attempted on: 10/01/2022 at 9:02 p.m., 10/05/2022 at 7:58 p.m., 10/07/2022 at 3:48 p.m., 10/08/2022 at 2:17 p.m., 10/09/2022 at 4:06 p.m., and on 10/10/2022 at 8:05 p.m.

The comprehensive care plan for (R21) dated 09/14/2022 documented in part "Need: (R21) is at risk for pain and/or has acute/chronic pain r/t (related to) age related changes, recent fall with compression fracture ...Date Initiated: 09/14/2022." Under "Interventions" it documented in part, "Offer Non-Pharmacological Interventions: 1) Massage; 2) Meditation/relaxation; 3) Positioning; 4) Ice/cold

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pack; 5) Diversional Activity; 6) Guided Imagery; 7) Rest; 8) Social Interaction; 9) Other. Date Initiated: 06/30/2021.

Review of the facility's nurse's notes for (R21) dated 10/01/2022 through 10/31/2022 failed to evidence non-pharmacological interventions being attempted on the dates and times listed above.

On 11/02/2022 at approximately 2:25 p.m., an interview was conducted with (R21). When asked if they receive as needed pain medication (R21) stated yes. When asked of the nurse attempts to alleviate their pain by other means before administering their pain medication (R21) stated that the nurses don't always attempt to alleviate their pain by other means.

On 11/03/22 at approximately 8:19 a.m., an interview was conducted with LPN (licensed practical nurse) # 4 regarding the implementation and documentation of non-pharmacological interventions prior to the administration of as needed pain medication to (R21). After review of (R21's) eMAR and progress notes dated 10/01/2022 through 10/31/2022 for non-pharmacological interventions prior to the administration of oxycodone-acetaminophen to (R21), LPN # 4 was asked about the missing documentation. LPN # 4 stated that they could not say non-pharmacological interventions were attempted because it was not documented. After reviewing the care plan LPN # 4 stated that the care plan was not being followed.

On 11/03/2022 at approximately 4:02 p.m., ASM # 1, administrator, ASM # 2, director of nursing and ASM # 4, regional clinical coordinator, were

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made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f2137f1a-b49a-40bd-97ac-cd6b36e295f4.

3. For (R2), the facility staff failed to implement the comprehensive care plan for physician ordered medications.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 09/20/2022, the resident scored 9 (nine) out of 15 on the BIMS (brief interview for mental status), indicating (R2) was moderately impaired of cognition for making daily decisions.

The physician's orders for (R2) documented in part,
"Ceftriaxone Sodium Solution Reconstituted 1 (one GM (gram). Inject 1 gram intramuscularly every 12 hours for infection for 5 (five) days. Start Date: 10/27/2022. D/C (discontinue) Date: 10/27/2022."
"Ceftriaxone Sodium Solution Reconstituted 1 (one GM (gram). Inject 1 gram intramuscularly every 12 hours for infection for 5 (five) days. Start Date: 10/28/2022."
"Vancomycin HCL (hydrochloride) Solution 50 MG/ML (milligram/milliliter). Give 5 ml by mouth every 6 (six) hours for c-diff (3) for 14 days. Start

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Date: 10/15/2022."

The comprehensive care plan for (R2) dated 10/27/2022 documented in part, "Need. (R2) is at risk for discomfort for adverse side effects: receives Antibiotic Therapy r/t (related to) for infection CDiff. Vancomycin 10/27/2022, Ceftriaxone until 11/2/22. Date initiated: 10/18/2022. Under "Interventions" it documented in part, "Administer medications as ordered. Date initiated: 10/18/2022."

The eMAR [electronic medication administration record] dated October 2022 for (R2) documented the physician's orders as stated above. For ceftriaxone, the eMAR revealed a number five documented on 10/27/2022 at 9:00 p.m., a blank on 10/28/2022 at 9:00 a.m. and an "X" documented on 10/31/2022 at 9:00 p.m. For the vancomycin, the eMAR revealed a number five documented on 10/18/2022 at 6:00 p.m., number five documented on 10/19/2022 at 12:00 p.m. and at 6:00 p.m., and a blank on 10/28/2022 at 12:00 p.m. Further review of the eMAR revealed a legend that documented in part, "Chart Codes / Follow Up Codes: 5=Hold/See Nurse's Notes."

The eMAR dated November 2022 for (R2) failed to evidence documentation of the physician's order for Ceftriaxone. Further review of the eMAR failed to evidence (R2) received Ceftriaxone on 11/01/2022 or 11/02/2022.

The nurse's "Progress Notes" failed to evidence documentation for ceftriaxone being held on 10/27/2022 at 9:00 p.m. or for the vancomycin being held on 10/18/2022 at 6:00 p.m., 10/19/2022 at 12:00 p.m. and at 6:00 p.m. Further review of the progress notes failed to

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evidence documentation regarding the blanks for ceftriaxone on 10/28/2022 at 9:00 a.m. and the "X" on 10/31/2022 at 9:000 p.m. and the blank on 10/28/2022 at 12:00 p.m. for vancomycin.

The nurse's "Progress Notes" dated 11/01/2022 through 11/03/2022 for (R2) failed to evidence documentation that ceftriaxone was administered on 11/01/2022 and 11/02/2022.

On 11/03/22 at 9:55 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. After reviewing (R2's) October and November eMAR, and progress notes dated above ASM # 2 stated that (R2) did not receive the medications listed above according to the physician's orders. After reviewing the care plan LPN # 4 stated that the care plan was not being followed.

On 11/03/2022 at approximately 4:02 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, regional clinical coordinator were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Used to treat certain infections caused by bacteria such as gonorrhea (a sexually transmitted disease), pelvic inflammatory disease (infection of the female reproductive organs that may cause infertility), meningitis (infection of the membranes that surround the brain and spinal cord), and infections of the lungs, ears, skin, urinary tract, blood, bones, joints, and abdomen. This information was obtained from the website:

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https://medlineplus.gov/druginfo/meds/a685032.html.

(2) Used to treat colitis (inflammation of the intestine caused by certain bacteria) that may occur after antibiotic treatment. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a604038.html

4. For Resident #23 (R23), the facility staff failed to develop a care plan for the use of side rails.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/11/22, R23 was coded as being moderately cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS (brief interview for mental status. R 23 was coded as requiring the extensive assistance of facility staff for bed mobility.

On the following dates and times, R23 was observed lying in bed with quarter side rails up: 10/31/22 at 8:42 a.m., and 11/1/22 at 8:45 a.m.

A review of R23's care plan dated 10/5/22 revealed no information related to the resident's use of side rails.

On 11/2/22 at 12:53 p.m., RN (registered nurse) #1, the MDS coordinator, was interviewed. She stated she initiates resident care plans on admission. She stated she uses multiple sources of information to develop the care plan, including nursing assessments, physician's orders, ADL (activities of daily living) needs, and other personalized information for each resident. After reviewing R23's care plan, she stated: "There is nothing about side rails here." She stated side

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rails should be included in a resident's care plan.

On 11/2/22 at 1:37 p.m., LPN (licensed practical nurse) #3 was interviewed. She stated if the resident is using the side rails, they should go on the care plan.

On 11/2/22 at 3:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional clinical coordinator, were informed of these concerns.

No further information was provided prior to exit.
5. For Resident #19 (R19), the facility staff failed to implement the comprehensive care plan to provide pressure ulcer treatments as ordered.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/1/2022, the resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. Section M (skin condition) of the assessment documented R19 having a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. It further documented R19 at risk of developing pressure ulcer/injuries and not having any unhealed pressure ulcer/injuries.

The comprehensive care plan for R19 documented in part, "[R19] has the potential for skin breakdown and pressure ulcers related to impaired mobility and urine incontinence. Actual skin impairment: wound to sacrum and blisters to left upper thigh. Date Initiated: 08/08/2019; Revision on: 08/25/2022." Under "Interventions" it documented in part, "...provide treatment as

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ordered. Date Initiated: 08/28/2019..."

A total body skin assessment dated 10/13/2022 at 9:01 a.m. documented one new wound identified. The document failed to identify the location or describe the wound identified. The skin assessment was completed by RN (registered nurse) #4.

The progress notes failed to evidence documentation describing the wound identified on 10/13/2022.

The "Wound Evaluation & Management Summary" for R19 dated 10/26/2022 documented in part, "...Patient presents with a wound on her sacrum. History of Present Illness: At the request of the referring provider, [Name of physician], a thorough wound care assessment and evaluation was performed to day. She has a stage 3 pressure wound (1) sacrum for at least 1 days duration...Wound Size (LxWxD) (length by width by depth): 1.4x1.4x0.2 cm (centimeter)...[Age and sex] w (with) Hx (history) of HIV (human immunodeficiency virus), DM (diabetes mellitus) presents with a new wound over old scar tissue, continue Medihoney (2) as she has done well with this in the past. Dressing Treatment Plan: Primary Dressing(s): Leptospermum honey apply once daily for 30 days. Secondary Dressing(s): Superabsorbent silicone bdr (border) & faced apply once daily for 30 days...This patient's care was discussed with another health provider Nursing Staff Member during this visit..."

The physician's order summary report dated 11/2/2022 documented in part, "Cleanse areas to sacrum w/ (with) ns (normal saline), apply protective cream and a border dressing every

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evening shift. Order Date: 09/22/2022." The physician's order summary for R19 failed to evidence an order for the Medihoney treatment plan documented in the wound evaluation and summary on 10/26/2022.

The TAR (treatment administration record) for R19 dated 10/1/2022-10/31/2022 documented, "Cleanse areas to sacrum w/ ns, apply protective cream and a border dressing every evening shift. Start Date: 09/22/2022 1500 (3:00 p.m.)." The TAR documented R19 receiving the treatment each evening shift during the month of October 2022.

On 11/2/2022 at 1:37 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that the purpose of the care plan was to show the overall care of the resident, what they were doing for them, document their goals, behaviors and falls. LPN #3 stated that it was the whole facilities responsibility for implementing the care plan.

On 11/2/2022 at 3:22 p.m., an interview was conducted with LPN (licensed practical nurse) #6, unit manager. LPN #6 stated that weekly skin assessments were scheduled in the computer system and came up on the medication administration record screen in the computer so the nurse would know that it was due. LPN #6 stated that staging and measurements of wounds were done by the wound physician, the assistant director of nursing or a registered nurse. LPN #6 stated that each morning they printed out a list of weekly skin assessments that were due for the nurses and provided it to them. LPN #6 stated that R19 had a sacral wound previously which had healed and it had reopened either last week

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or the week before that. LPN #6 stated that they had been notified of the wound reopening by a CNA (certified nursing assistant) who reported it to them. LPN #6 stated that they had spoken with the wound physician and had R19 placed back on the list to be followed. LPN #6 stated that when a new would was discovered the nurse should write a progress note describing the wound, notify the responsible party, the resident and the physician. LPN #6 reviewed R19's clinical record and stated that it appeared that 10/13/2022 was the first time the re-opening of the wound was identified.

On 11/02/2022 at 3:55 p.m., an observation was made of ASM (administrative staff member) #6, wound physician and LPN #4 providing care and assessment to R19's sacral pressure ulcer. There were no concerns with wound care observed. ASM #6 measured R19's sacral pressure ulcer as 1.2x1.2x0.2 cm (length by width by depth) and a stage 3 wound. ASM #6 stated that R19's sacral pressure ulcer had improved and gotten smaller. ASM #6 stated that R19 had previously had a wound in the same area that was treated with Medihoney and responded very well to it. ASM #6 stated that they were treating R19's wound with the Medihoney again for this reason since the initial evaluation on 10/26/2022 and would have the staff continue with the treatment. ASM #6 stated that due to R19's previous healed wound in the area, scar tissue and lack of tissue between the skin and bone underneath, the area could open up easily and become a stage 3 pressure ulcer very quickly.

On 11/03/2022 at 7:58 a.m., an interview was conducted with LPN #4. LPN #4 stated that normally the unit manager rounded with the

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wound physician. LPN #4 stated that they had been going with them recently. LPN #4 stated that the wound physician came in on Wednesday and completed his wound notes after rounding. LPN #4 stated that every Thursday morning they printed out the wound notes and gave them to the unit manager to review. LPN #4 stated that the unit manager was responsible for going through the notes and reviewing the wound details to see if there were any changes to the wound treatments. LPN #4 stated that if there were any changes to the wound treatments the unit manager changed the orders to reflect the new treatment. LPN #4 stated that all of the wound notes were reviewed by someone every Thursday morning. LPN #4 reviewed the wound note dated 10/26/2022 written by ASM #6 for R19 and the current physician orders and stated that there was no order in place for the Medihoney. LPN #4 stated that there was only an active order for the protective cream and a border dressing every evening shift. LPN #4 stated that there should have been an order in place for the Medihoney treatment after the 10/26/2022 wound evaluation by the wound physician.

On 11/03/2022 at 10:17 a.m., an interview was conducted with RN (registered nurse) #4. RN #4 stated that they completed the total body skin assessment dated 10/13/2022 for R19. RN #4 stated that they had found the area on the sacrum when they went to do the ordered treatment to the sacral area. RN #4 stated that they had documented the area as a new wound but had not done anything else because there was a treatment already in place. RN #4 stated that there was a small open area with no bleeding at that time. RN #4 stated that they did not complete a change in condition form, contact the

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physician or nurse practitioner or call to get an order. RN #4 stated that if they observe a new wound and did not have a treatment order in place they completed the change in condition form, called the physician or nurse practitioner to get a treatment order, notified the unit manager and wrote a progress note. RN #4 stated that they were not sure how residents got on the wound physicians list that they thought the unit manager was responsible for that.

On 11/3/2022 at 11:00 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that the purpose of the care plan was to have a written plan of care for their guests. ASM #2 stated that the care plan was implemented by being reviewed quarterly, as needed and with any significant change. ASM #2 stated that R19's care plan was not being implemented to provide wound treatment as ordered.

On 11/03/2022 at 1:15 p.m., an interview was conducted with ASM #5, nurse practitioner. ASM #5 stated that they had not examined R19 after their pressure ulcer reopened. ASM #5 stated that they saw R19 on 10/12/2022 and they were not aware of the sacral wound reopening at that point. ASM #5 stated that they did not see R19 again until after the wound physician had examined them.

On 11/3/2022 at 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the above concern.

No further information was presented prior to exit.

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Reference:
(1) Pressure Ulcer
A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm.

(2) Medihoney
Applying honey preparations directly to wounds or using dressings containing honey seems to improve healing. Honey seems to reduce odors and pus, help clean the wound, reduce infection, reduce pain, and decrease time to healing. This information was obtained from the website: https://medlineplus.gov/druginfo/natural/738.html
6. For Resident #13 (R13), The facility staff failed to implement the comprehensive care plan for the preventions and treatment of a pressure injury.

On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 10/11/2022, the resident scored a zero out of 15 on the BIMS

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(brief interview for mental status) score, indicating the resident was severely cognitively impaired for making daily decisions. In Section M - Skin Conditions, the resident was coded as not having any pressure injuries.

The comprehensive care plan dated, 9/21/2022 and revised on 10/6/2022 documented in part, "Need: [R13] is at risk for impaired skin integrity/pressure injury R/T (related to): impaired mobility, gout, recent UTI (urinary tract infection), right hip fracture." The "Interventions" documented in part, "9/21/2022 - Braden scare per protocol. Conduct weekly head to toe skin assessment, document and record abnormal findings to the physician. Cue to reposition self as needed. Follow facility policies/protocols for the prevention/treatment of impaired skin integrity. 10/6/2022 - Observe finer and toes nails on shower days to see if they need to be trimmed. Observe skin with showers/care. Notify nurse immediately of any new areas of skin breakdown. Redness, blisters, bruises, discoloration noted during bath or daily care. Pressure reduction cushion to w/c (wheelchair). Pressure reduction mattress to bed or specialty bed: air mattress, check placement and function every shift. 9/21/2022 - Provide diet as ordered. Observed and document food acceptance and offer substitutes as needed. 10/6/2022 - Provided incontinence care with each incontinent episode and as needed and apply moisture barrier cream/ointment per facility policy/orders. Provide therapy and encourage participation as ordered. 9/21/2022 - Turn/reposition resident during rounds and PRN (as needed)." The comprehensive care plan dated 9/21/2022 and revised on 10/23/2022, documented in part, "[R13] has actual skin impairment to skin integrity

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r/t reddened area. 10/5/2022 fractured right hip, 10/20/2022, open area to sacrum." The "Interventions" documented, " 9/21/2022 - Encourage good nutrition and hydration in order to promote healthier skin. Provide dietary supplements as ordered. Observe location, size, and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to physician. Treatment to skin impairment per order. Turn and reposition during rounds and PRN (as needed). 10/7/2022 - WBAT (weight bearing as tolerated).

The "Braden Scale for Predicting Pressure Sore Risk" dated 9/22/2022, documented in part, "Scoring: At Risk: 15-18." The resident was documented as having a score of "15."

The "Braden Scale for Predicting Pressure Sore Risk" dated 9/29/2022, documented in part, "Scoring: Moderate Risk: 13-14." The resident was documented as having a score of "14." There were no further "Braden Scale for Predicting Pressure Sore Risk" in the clinical record.

The "Nursing Comprehensive Evaluation" dated 10/5/2022 documented in part, "Section K - Skin - category - no risk. Score 0.0. Does resident have any skin conditions - yes. Actual Skin breakdown Care Plan - [R13] has actual skin impairment to skin integrity r/t (related to) reddened area...Site: R(right) hip fracture had surgery, incision dry and intact a bandage is on. Buttocks have a dressing on but no open wound on (their) buttock, it on for precaution."

The "Skin & Wound - Total Body Skin

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Assessment" dated, 10/20/2022, documented in part, "Turgor - poor elasticity; Skin color - normal for ethnic group; Temperature - warm (normal); Moisture - moist; Condition - Normal. Enter # of New Wounds - 1.

There were no "Skin & Wound - Total Body Skin Assessments" documented between 10/5/2022 and 10/20/2022.

Review of the nurse's notes between 10/5/2022 and 10/20/2022, failed to evidence any documentation related to the skin.

The nurse's note dated 10/27/2022 at 9:26 a.m. documented, "PT (physical therapy) asked this writer if she could observe this guest rt (right) heel, noted lg (large) darken harden purple area, no drainage noted, skin prepped, ankle edematous, tender to touch, informed NP."

The nurse practitioner's note dated 10/28/2022 documented in part, "R (right) heel - DTI (deep tissue injury) - acute - betadine to heel, monitor.

Review of the physician orders failed to evidence any orders for protective foot devices or treatments for the feet. The physician order dated 10/30/2022, documented, "Air Mattress, check placement and function qs (every shift)." The physician order dated, 10/28/2022, documented, "Clean right heel with NS (normal saline), apply betadine-soaked gauze, cover with abd (abdominal) and wrap with Kling every day shift. The October TAR (treatment administration record) documented the above order. The treatment was documented as having been done on 10/29/2022 through 10/31/2022.

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Observations were made of R13 on 10/31/2022 at approximately 1:00 p.m. The resident was in bed, with the head of the bed elevated, lying on her back, heel boots in place. A second observation was made on 11/1/2022 at 8:57 a.m. R13 was in bed, on her back, with their heel boots in place.

Observation was made of the R13's right heel on 11/1/2022 at 11:39 a.m. with LPN (licensed practical nurse) #4. The right heel had a large necrotic area on the inner aspect of the right heel, the outer aspect of the heel had deep purple tissue. LPN #4 applied the physician ordered treatment. The resident was in their bed on their back with green puffy heel boots on both feet.

An interview was conducted with LPN #5 on 11/2/2022 at 3:11 p.m. LPN #5 was asked to review her nurse's note of 10/27/2022 at 9:26 a.m. Once reviewed, LPN #5 was asked to describe what she saw, LPN #5 stated it was a darkened area on the heel with dead skin around it. LPN #5 stated she let the unit manager of the wound. She (unit manager) would inform the nurse practitioner and get treatment orders for it. When asked the process when a resident has a new wound, LPN #5 stated she lets the unit manager know. When who does the measurements of a new wound, LPN #5 stated she was told LPNs could not measure wounds, only the wound care nurse. When asked if they had a wound care nurse, LPN #5 stated, not now. Did the unit manager look at the wound, LPN #5 stated at that time, she (LPN #5) left her at the nurse's station. When asked if she had ever done a skin assessment on R13, LPN #5 stated - no. When asked how often skin assessments are done, LPN #5 stated she tries to look at them

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daily but if not daily at least three to four times a week. LPN #5 stated 10/27/2022 was the first day she had cared for R13.

An interview was conducted with LPN # 6, the unit manager, on 11/2/2022 at 3:37 p.m. When asked what she did when LPN #5 informed her of the wound on R13's heel, did she look at it, did she measure it, where is your documentation, LPN #6 stated, we are not allowed to measure wounds, only an RN (registered nurse) and (name of ASM #6 - wound doctor) can measure. When asked if she notified the RN, LPN #6 stated ASM #3, the assistant director of nursing (ADON), was in a meeting. (Name of ASM #2) the director of nursing was in a meeting. LPN #6 stated she talked about it in clinical meeting. When asked if any RN in the building looked at it, LPN #6 stated she contacted the nurse practitioner, who was not in the building and told her she would see it the next day. LPN #6 further stated, she asked LPN #4 to look at it, and she looked at it on the 27th (10/27/2022) and treatment was not initiated until the 28th. When asked to explain the process when a staff person finds an unusual skin observation, LPN #6 stated it is reported to the nurse practitioner, the RP (responsible party), the unit manager, and the ADON. The nurse practitioner gives an order to refer to (name of wound doctor). If she doesn't refer to wound doctor, them she puts a treatment in place. Had LPN #6 read LPN #5's nurse's note of 10/27/2022 and the TAR for October. When asked where a treatment was put in place on 10/27/2022, LPN #6 stated LPN #5 told me she put a treatment in place. I was at home. When I spoke with nurse practitioner, she told me she would see it in the morning. LPN #6 restated only an RN and (name of wound care doctor) cam

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measure wounds in this facility. When asked if the staff were elevating R13's heels, LPN #6 stated R13 had elevating boots.

An interview was conducted with ASM #2, the director of nursing, on 11/3/2022 at 11:11 a.m. When asked the purpose of the care plan, ASM #2 stated it is to have a written plan of care for each guest. When asked if it should be followed, ASM #2 stated, yes.

An interview was conducted with ASM # 5, the nurse practitioner, on 11/3/2022 at 12:57 p.m. When asked if she looks at resident's skin, ASM #5 stated usually if I am told there is a problem, mostly on recertifications. When were you made aware of the heel on R13, ASM #5 stated late in the afternoon the day before I saw it. I told the nurse to but skin prep on it until the next day. ASM #5 was asked to describe the wound when she saw it on 10/28/2022, ASM #5 stated the left heel was intact. The right heel was black, not necrotic, more pressure, it was a deep purple to black. When asked if it had any necrotic tissue when she saw it, ASM #5 stated there was no necrosis nor drainage. ASM #5 stated she saw it on 11/1/2022 and saw some necrosis that was starting to peel off. When asked if she had looked at R13's skin prior to 10/28/2022, ASM #5 stated she had not looked at the leg until they told me to. ASM #5 stated R13 didn't want to move. I told them to put the boots on her on Friday to ensure they had the boots on while she was in bed. When asked if R13 had the boots on when she went to look at the heel on 10/28/2022, ASM #5 stated R13 did not have the boots on, only her socks were on. ASM #5 stated she told the nurse to get those boots put on. When asked if she measured the wound, ASM #5 stated, no.

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F 656	Continued From page 85 ASM #1, the administrator, ASM #2, and ASM #4, the regional clinical coordinator, were made aware of the above concern on 11/3/2022 at 4:30 p.m. No further information was provided prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		12/18/22

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F 657	Continued From page 86 by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to review and revise the comprehensive care plan for two of 52 residents in the survey sample, Resident #160 and Resident #23. The findings include: 1. For Resident #160, the facility staff failed to review and revise the comprehensive care plan after four falls. On the most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 7/27/2021, the resident scored a 4 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired for making daily decisions. In Section G - Functional Status, R160 was coded as requiring extensive assistance of two or more staff members for all of her activities of daily living. In Section J - Health Conditions, the resident was coded as having had two falls with no injury during the lookback period. The care plan initiated on 10/15/2020 documented in part, "Need: [R160] is at risk for fall related injury and falls R/T (related to) abnormality of gait, cervical radicular pain, anxiety, depression, use of anti-depressant mediations, takes Melatonin for insomnia." The "Goal" documented, "Will be free from injury related to falls through the next review date." The "Interventions" documented in part, "Administer meds (medications) as ordered. Anticipate and meet needs PRN (as needed). Assess the risk	F 657	Criteria 1 Resident #23 had his care plan updated with O2 and order obtained for O2. Resident # 160 was discharged from the facility prior to survey. Criteria 2 All current residents have the potential to be affected by the alleged deficient practice. Criteria 3 MDS nurses were re-inserviced on updating care plans from the regional MDS nurse. Licensed nurses were re-inserviced on the requirement of obtaining an order prior to the administration of oxygen. Criteria 4 DON/Designee will conduct audit on care plan updates and oxygen order audits 3 x week for four weeks, weekly x4 and monthly x1. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action	

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level for falls on admission and as needed. Complete fall risk per protocol. Do no leave resident unattended in bathroom. Encourage resident to wear non-skid foot ware when out of bed. Encourage resident to wear appropriate footwear as needed. Follow facility fall protocol. Keep resident's environment as safe as possible with: even floors free from spills and/or clutter; adequate lighting, call light within reach, commonly used items within reach, avoid repositioning furniture and keep the bed in the appropriate position. Labs (laboratory test) and diagnostics as ordered. Lock wheels on wheelchair prior to transfers. Observe for ineffectiveness and side effects R/T psychotropic drug use, report abnormal findings to the physician. Observe resident for side effects related to: anti-depressant medication that increases the risk for falls. Provide [R160] with activities that minimize the potential for falls while providing diversion and distraction. PT/OT (physical therapy/occupational therapy) evaluate and treat as ordered PRN. Put the resident's call light within reach and encourage her to use it for assistance as needed. Request dose reduction for hydrocodone and Ativan. will educate guest Re: (regarding) wheelchair safety and reaching.

Review of the clinical record revealed R160 had had 10 falls between 10/14/2020 and the time of their death on 7/28/2021. The falls were on the following dates: 2/10/2021, 2/12/2021, 2/23/2021, 2/25/2021, 3/8/2021, 4/19/2021, 6/4/2021, 6/22/2021, 6/24/2021 and 7/13/2021.

Review of the care plan and the falls documented, the following dates of falls did not have a new intervention on the care plan and no evidence the care plan had been reviewed:

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7/13/2021, 6/24/2021, 6/22/2021, and 2/23/2021.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 11/3/2022 at 3:13 p.m. When asked about the above dates of falls and interventions, ASM #2 stated for 6/22/2021 and 7/13/2021, the previous director of nursing, said if the resident is found on the fall mat, then the goal was met because the resident had no injury. For the falls of 2/23/2021 and 6/24/2021, ASM #2 stated there was definitely no new interventions put in place. When asked the process for when a resident falls, ASM, #2 stated first you assess the resident, write an incident report, perform a post fall assessment, notify the doctor and responsible party. The nurse then puts in a new intervention on the care plan. The fall and new intervention are reviewed in clinical meeting the next day. For the above falls there were not reviewed or a new intervention initiated.

The facility policy, "Care Planning" documented in part, "Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nursing and mental and psychosocial needs identified in the comprehensive assessments and prepared by an interdisciplinary team....The results of interdisciplinary assessments will be used to develop, review and revise the resident's comprehensive care plans."

ASM #1, the administrator, ASM #2, and ASM #4, the regional clinical coordinator, were made aware of the above concern on 11/3/2022 at 4:30

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p.m.

No further information was provided prior to exit.

2. For Resident #23 (R23), the facility staff failed to revise a care plan for the administration of oxygen.

R23 was admitted to the facility on 10/5/22. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/11/22, R23 was coded as being moderately cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS (brief interview for mental status. The resident was coded as having received oxygen prior to admission to the facility, but not since admission to the facility.

On the following dates and times, R23 was lying in bed, with oxygen being delivered by nasal cannula at a rate of 1.5 lpm (liters per minute) by way of an oxygen concentrator: 10/31/22 at 8:42 a.m., and 11/1/22 at 8:45 a.m.

A review of R23's physician's orders revealed no evidence of an order for oxygen.

A review of R23's care plan dated 10/5/22 revealed no information related to the resident's use of oxygen.

On 11/2/22 at 12:53 p.m., RN (registered nurse) #1, the MDS coordinator, was interviewed. She stated she initiates resident care plans on admission. She stated she uses multiple sources of information to develop the care plan, including nursing assessments, physician's orders, ADL (activities of daily living) needs, and other

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F 657	Continued From page 90 personalized information for each resident. After reviewing R23's care plan, she stated: "There's nothing about oxygen. I must have missed it, or there wasn't an order." She stated R23 was not receiving oxygen when he was first admitted to the facility, and the oxygen must have been added since admission. On 11/2/22 at 3:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional clinical coordinator, were informed of these concerns. No further information was provided prior to exit.	F 657		
F 677 SS=D	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 staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to provide ADL (activities of daily living) care to dependent residents for one of 52 residents in the survey sample, Resident #162. The findings include: For Resident #162 (R162), the facility staff failed to provide a shower or bath on 6/23/2022, 6/27/2022, and 7/7/2022. On the most recent MDS (minimum data set), an	F 677	Criteria 1 Resident # 162 was discharged from the facility prior to survey. Criteria 2 All dependent residents have the potential to be affected by the same deficient practice. Criteria 3 License nurses and C.N.As will be reeducated on showers/baths and documentation of refusals.	12/18/22

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F 677	Continued From page 91 admission assessment with an ARD (assessment reference date) of 6/29/2022, the resident scored 4 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. Section G documented R162 requiring extensive assistance of one person for personal hygiene and bathing not occurring during the 7 day assessment period. Review of the ADL (activities of daily living) documentation for R162 dated 6/1/2022-6/30/2022 documented in part, "Shower/Bath." It documented the shower or bath scheduled on day shift 6/23/2022, 6/27/2022 and 6/30/2022. A shower or bath was documented as given on 6/30/2022. The documentation failed to evidence a shower or bath provided on 6/23/2022 or 6/27/2022. Review of the ADL documentation for R162 dated 7/1/2022-7/31/2022 documented in part, "Shower/Bath." It documented the shower or bath scheduled on day shift 7/4/2022, and 7/7/2022. A shower or bath was documented as given on 7/4/2022. The documentation failed to evidence a shower or bath provided on 7/7/2022. The comprehensive care plan for R162 documented in part, "[R162] has an ADL Self Care Performance Deficit and requires assistance with ADL's and mobility r/t (related to): Hip fracture left hip with hemiarthroplasty, Limited Mobility, Pain, bilateral superior and inferior pubic fractures. Date Initiated: 06/23/2022. Revision on: 07/20/2022." Under "Interventions" it documented in part, "...Provide Resident with a sponge bath when a full bath or shower cannot be tolerated. Date Initiated: 06/23/2022. Offer a	F 677	Criteria 4 DON and/or designee will complete shower audits three/week x four weeks, weekly for four weeks and monthly x 1 month. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action.	

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tub bath or shower two times per week and prn (as needed). Date Initiated: 06/23/2022..."

On 11/3/2022 at 10:39 a.m., an interview was conducted with CNA (certified nursing assistant) #8. CNA #8 stated that showers were given twice a week and documented in the computer that they were given or refused. CNA #8 stated that if a resident refused their shower they attempted reported it to the nurse and attempted to offer it later in the shift. CNA #8 stated that all of the care they provided to the residents was documented in the computer to evidence that it was done. CNA #8 stated that if there was no documentation then it meant that the work was not done because you have to document what you do.

The facility policy, "Routine Guest/Resident Care" last revised 6/16/2021 documented in part, "Guests/residents receive the necessary assistance to maintain good grooming and personal/oral hygiene...Showers, tub baths, and/or shampoos are scheduled according to person centered care or state specific guideliens [sic]; bed linens are changed at this time. Additional showers are given as requested...Incontinence care is provided timely according to each guest's/resident's needs..."

On 11/3/2022 at 4:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the above concern.

No further information was presented prior to exit.

Complaint deficiency.

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F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to follow professional standards of care for quality resident care for two of 52 residents in the survey sample, Resident #162 and Resident #2. The findings include: 1. For Resident #162 (R162), the facility staff failed to timely act upon critical lab results reported to the facility on 7/8/2022. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/29/2022, the resident scored 4 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. Section I documented R162 having an active diagnosis of anemia. Section O documented R162 receiving transfusions while not a resident of the facility and within the last 14 days. The physician orders for R162 documented in part,	F 684	Criteria 1 Residents # 162 and # 2 were discharged from the facility prior to survey. Criteria 2 All residents with labs and antibiotics have the potential to be affected by the alleged deficient practice. A lab audit and MAR audit will be conducted to ensure timely notification of critical labs and timely physician notification of missed antibiotics. Criteria 3 Licensed nurses were reeducated on stat critical labs and RP physician notification of labs. Licensed nurses were reeducated on physician notification of medications not given. Criteria 4 DON/Designee will audit critical labs and medications not given M-F for4 weeks, weekly x 4 and monthly x1. The results of the audits will be forwarded to the QAPI committee for review. The QAPI	12/18/22

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F 684	Continued From page 94 - "CBC (complete blood count) with diff (differential) and BMP (basic metabolic panel) in the next 3 days one time only for anemia for 3 days. Order Date: 07/07/2022." The progress notes documented in part, - "6/24/2022 12:56 (12:56 a.m.) Physician Note. ...[R162] was admitted to [Name of hospital] on 6/18/2022 following ground-level fall. [R162] was found to have a left femoral neck fracture and underwent a left hip hemiarthroplasty. [R162] required 1 unit of packed red cells transfusion..." - "7/7/2022 18:49 (6:49 p.m.) Nurses Notes. Note Text: Patient and family requesting labs due to patient's history of anemia. Practitioner notified and new order received. Husband, [Name of husband] made aware." - "7/9/2022 08:35 (8:35 a.m.) Nurses Notes. Note Text: daughter [Name of daughter] called looking for results on labs, ...HEMOGLOBIN 5.8 g/dL (grams per deciliter) (R162's test result); 12.0-16.0 (normal range); LL (Critical Low) Final... CALL TO PRIMARY : [Name of physician] reported results awaiting orders." - "7/9/2022 09:06 (9:06 a.m.) Nurses Notes. Late Entry: Note Text: Guest is going to the ER (emergency room) due to critical labs, Hemoglobin was elevated. Daughter requested for [R162] to be sent to [Name of hospital]. Patient was pale in color did not complain of any pain. Will continue to monitor." The laboratory report included in R162's electronic medical record documented a basic metabolic panel and a complete blood count with differential collected on 7/8/2022 at 01:46 (1:46 a.m.), received on 7/8/2022 at 07:25 (7:25 a.m.) and reported on 7/8/2022 at 17:08 (5:08 p.m.). The report documented the critical low	F 684	committee will determine need for further actions or audits.	

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Hemoglobin of 5.8 g/dl highlighted in red text and a red stop sign at the top of the report under Lab information/Flag. The report legend documented the red stop sign meaning the "report contains critical results (results with red text)."

On 11/2/2022 at 8:08 a.m., an interview was conducted with ASM #7, medical doctor. ASM #7 stated that critical lab results were called to the facility by the lab to the nurse. ASM #7 stated that the nurses called the physician or nurse practitioner on call regarding the labs. ASM #7 stated that they did not recall staff contacting them about critical labs but the documentation stated that they did on 7/9/2022.

On 11/2/2022 at approximately 10:40 a.m., ASM (administrative staff member) #2, the director of nursing stated that the LPN (licensed practical nurse) who obtained the lab results after the daughter called for them on 7/9/2022 no longer worked at the facility and could not be interviewed. ASM #2 stated that the LPN who sent R162 to the emergency room on 7/9/2022 was not working and provided a phone number to contact them. Attempts were made to reach the LPN with no answer and the voice mail full.

On 11/2/2022 at 2:57 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated that they had spoken with R162's family member when they requested to have lab work done due to their history of anemia on 7/7/2022. RN #3 stated that they had contacted the physician and relayed the request from the family and received an order for routine lab work. RN #3 stated that the lab work was not ordered as stat (right away) but ordered to be done within the next 3 days. RN #3 stated that R162's lab work

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was ordered on 7/7/2022 and drawn the next day. RN #3 stated that they contracted an outside lab for blood work which sent a phlebotomist in early in the morning to draw the blood. RN #3 stated that the lab called the facility and spoke to the nurse with any critical lab results. RN #3 stated that when the nurse received critical lab results over the telephone from the lab they should verify the lab value with the lab, obtain their name, notify the physician or nurse practitioner, notify the responsible party and document everything in the medical record.

On 11/3/2022 at 8:11 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that an outside lab came to the facility to draw the blood early on the night shift. LPN #7 stated that there was a lab book kept at each nurses station documenting what lab work needed obtaining that the lab staff member used. LPN #7 stated that the nurse assisted the lab member with verifying the resident name and date of birth as needed. LPN #7 stated that the routine lab work was drawn the next draw after the order was placed. LPN #7 stated that if there were any critical lab results that the lab called the facility and notified the nurse who called the doctor or the nurse practitioner to report it.

On 11/3/2022 at 11:00 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that they had received a phone call from the nurse on Saturday, 7/9/2022 saying that R162's daughter was irate because there were labs drawn and the results had not been called to the physician. ASM #2 stated that they had been informed of the critical hemoglobin and advised the nurse to send the resident to the hospital for evaluation and they contacted the

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nurse practitioner. ASM #2 stated that they had investigated and discovered that the labwork had been drawn the day before and resulted the same day around 5:00 p.m. ASM #2 stated that they had found out that a nurse had notified the former ADON (assistant director of nursing) of the critical lab result on 7/8/2022 and the physician or nurse practitioner was not notified. ASM #2 stated that they had educated the nurses on the units regarding prompt physician notification of critical lab results and completed a 30 day audit of labs to ensure that all results had been reviewed by the physician and/or the nurse practitioner.

On 11/3/2022 at 12:23 p.m., an interview was conducted with LPN #8. LPN #8 stated that critical lab results were called to the facility to the nurse. LPN #8 stated that any critical labs were to be called to the physician immediately.

On 11/3/2022 at 12:27 p.m., an interview was conducted with RN #2. RN #2 stated that the lab called any critical results to the facility to the nurse. RN #2 stated that the critical labs should be called to the physician immediately.

On 11/3/2022 at 3:26 p.m., ASM #2 stated that they were unable to find evidence of the education that they had completed regarding the notification of critical lab results.

On 11/3/2022 at 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the above concern.

No further information was presented prior to exit.

Complaint deficiency.

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2. For (R2), the facility staff failed to administer ceftriaxone [1] per physician's orders on 10/27/2022, 10/28/2022 and 10/31/2022, 11/01/2022 and 11/02/2022 and failed to administer vancomycin [2] on 10/18/2022, 10/19/2022 and 10/28/2022 per physician's orders.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 09/20/2022, the resident scored 9 (nine) out of 15 on the BIMS (brief interview for mental status), indicating (R2) was moderately impaired of cognition for making daily decisions.

The physician's orders for (R2) documented in part,
"Ceftriaxone Sodium Solution Reconstituted 1 (one GM (gram). Inject 1 gram intramuscularly every 12 hours for infection for 5 (five) days. Start Date: 10/27/2022. D/C (discontinue) Date: 10/27/2022."
"Ceftriaxone Sodium Solution Reconstituted 1 (one GM (gram). Inject 1 gram intramuscularly every 12 hours for infection for 5 (five) days. Start Date: 10/28/2022."
"Vancomycin HCL (hydrochloride) Solution 50 MG/ML (milligram/milliliter). Give 5 ml by mouth every 6 (six) hours for c-diff (3) for 14 days. Start Date: 10/15/2022."

The comprehensive care plan for (R2) dated 10/27/2022 documented in part, "Need. (R2) is at risk for discomfort for adverse side effects: receives Antibiotic Therapy r/t (related to) for infection CDiff. Vancomycin 10/27/2022, Ceftriaxone until 11/2/22. Date initiated: 10/18/2022. Under "Interventions" it documented

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in part, "Administer medications as ordered. Date initiated: 10/18/2022."

The eMAR [electronic medication administration record] dated October 2022 for (R2) documented the physician's orders as stated above. For ceftriaxone, the eMAR revealed a number five documented on 10/27/2022 at 9:00 p.m., a blank on 10/28/2022 at 9:00 a.m. and an "X" documented on 10/31/2022 at 9:00 p.m. For the vancomycin, the eMAR revealed a number five documented on 10/18/2022 at 6:00 p.m., number five documented on 10/19/2022 at 12:00 p.m. and at 6:00 p.m., and a blank on 10/28/2022 at 12:00 p.m. Further review of the eMAR revealed a legend that documented in part, "Chart Codes / Follow Up Codes: 5=Hold/See Nurse's Notes."

The eMAR dated November 2022 for (R2) failed to evidence documentation of the physician's order for Ceftriaxone. Further review of the eMAR failed to evidence (R2) received Ceftriaxone on 11/01/2022 or 11/02/2022.

The nurse's "Progress Notes" failed to evidence documentation for ceftriaxone being held on 10/27/2022 at 9:00 p.m. or for the vancomycin being held on 10/18/2022 at 6:00 p.m., 10/19/2022 at 12:00 p.m. and at 6:00 p.m. Further review of the progress notes failed to evidence documentation regarding the blanks for ceftriaxone on 10/28/2022 at 9:00 a.m. and the "X" on 10/31/2022 at 9:000 p.m. and the blank on 10/28/2022 at 12:00 p.m. for vancomycin.

The nurse's "Progress Notes" dated 11/01/2022 through 11/03/2022 for (R2) failed to evidence documentation that ceftriaxone was administered on 11/01/2022 and 11/02/2022.

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On 11/03/22 at 9:55 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. After reviewing (R2's) October and November eMAR, and progress notes dated above ASM # 2 stated that (R2) did not receive the medications listed above according to the physician's orders.

On 11/03/2022 at approximately 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) # 4. After reviewing the nursing progress notes for (R2) dated 10/27/2022, 10/28/2022, 10/31/2022, 10/18/2022, 10/19/2022 and on 10/28/2022, 11/01/2022 and 11/02/2022, LPN # 4 stated that there was no documentation that the physician was notified that ceftriaxone was not administered on 10/27/2022, 10/28/2022 and 10/31/2022, 11/01/2022 and 11/02/2022 and vancomycin was not administered on 10/18/2022, 10/19/2022 and on 10/28/2022. When asked if the physician's order was followed for the administration of ceftriaxone and vancomycin LPN # 4 stated no.

On 11/03/2022 at approximately 4:02 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, regional clinical coordinator were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Used to treat certain infections caused by bacteria such as gonorrhea (a sexually transmitted disease), pelvic inflammatory disease (infection of the female reproductive organs that

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F 684	Continued From page 101 may cause infertility), meningitis (infection of the membranes that surround the brain and spinal cord), and infections of the lungs, ears, skin, urinary tract, blood, bones, joints, and abdomen. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a685032.html. (2) Used to treat colitis (inflammation of the intestine caused by certain bacteria) that may occur after antibiotic treatment. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a604038.html. (3) A bacterium that causes diarrhea and more serious intestinal conditions such as colitis. Symptoms include watery diarrhea (at least three bowel movements per day for two or more days), fever, loss of appetite, nausea, abdominal pain or tenderness. This information was obtained from the website: https: https://medlineplus.gov/clostridiumdifficileinfections.html.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		12/18/22

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F 686	Continued From page 102 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services for the assessment and treatment of pressure injuries for three of 52 residents in the survey sample, Residents #13, #19, and #162. The findings include: 1. For Resident #13 (R13) the facility staff failed to complete a full wound assessment of a newly identified wound DTI (deep tissue injury (2)) once identified. The wound was not measured until six days after its discovery. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 10/11/2022, the resident scored a zero out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired for making daily decisions. In Section M - Skin Conditions, the resident was coded as not having any pressure injuries. R13 was readmitted to the facility on 10/5/2022 after a fractured hip repair. The "Nursing Comprehensive Evaluation" dated 10/5/2022 documented in part, "Section K - Skin - category - no risk. Score 0.0. Does resident have any skin conditions - yes. Actual Skin breakdown Care Plan - [R13] has actual skin impairment to	F 686	Criteria 1 Resident #162 was discharged from the facility prior to survey. Resident #13 and resident #19 remain in the facility. All wounds have been assessed, measured and the guests are receiving treatments as ordered by their physician. Criteria 2 All residents with wounds have the potential to be affected by the alleged deficient practice. A skin sweep of the facility has been conducted and all wounds are properly assessed, measured, and receiving treatment. Criteria 3 Licensed nurses will be re-educated on the Skin Management program, change of condition, and hysician notification policy. The wound MD conducted an in-service on measuring and describing wounds for the licensed nurses. Criteria 4 Director of Nursing and/or designee will conduct an audit of the requirements of the Skin Management Program three times per week x 4 weeks, weekly x 4 weeks, then monthly x 1 montth. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action.	

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skin integrity r/t (related to) reddened area...Site: R(right) hip fracture had surgery, incision dry and intact a bandage is on. Buttocks have a dressing on but no open wound on (their) buttock, it on for precaution."

The "Skin & Wound - Total Body Skin Assessment" dated, 10/20/2022, documented in part, "Turgor - poor elasticity; Skin color - normal for ethnic group; Temperature - warm (normal); Moisture - moist; Condition - Normal. Enter # of New Wounds - 1.

There were no "Skin & Wound - Total Body Skin Assessments" documented between 10/5/2022 and 10/20/2022.

Review of the nurse's notes between 10/5/2022 and 10/20/2022, failed to evidence any documentation related to the skin.

The nurse's note dated 10/20/2022 at 3:22 p.m. documented in part, "Resident has an open area to top of sacrum. No bleeding noted. NP (nurse practitioner) made aware. New order for A&D (ointment) to the area. RP (responsible party) made aware of new ordered."

The nurse's note dated 10/27/2022 at 9:26 a.m. documented, "PT (physical therapy) asked this writer if she could observe this guest rt (right) heel, noted lg (large) darken harden purple area, no drainage noted, skin prepped, ankle edematous, tender to touch, informed NP."

The nurse practitioner's note dated 10/28/2022 documented in part, "R (right) heel - DTI (deep tissue injury) - acute - betadine to heel, monitor.

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The comprehensive care plan dated 9/21/2022 and revised on 10/23/2022, documented in part, "[R13] has actual skin impairment to skin integrity r/t reddened area. 10/5/2022 fractured right hip, 10/20/2022, open area to sacrum." The "Interventions" documented, " 9/21/2022 - Encourage good nutrition and hydration in order to promote healthier skin. Provide dietary supplements as ordered. Observe location, size, and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to physician. Treatment to skin impairment per order. Turn and reposition during rounds and PRN (as needed). 10/7/2022 - WBAT (weight bearing as tolerated).

The CNA "ADL (activities of daily living) Care Statement" for October 2022, documented in part, "Question 1 - have you provided routine standard care which includes evaluating skin daily and reporting changes, shaving and nail care as needed, turning and repositioning, oral care, washing face and hands, hair care, clean clothes and linens, ROM (range of motion), offering fluids, utilizing resident specific devices, dignity and respect, universal precautions, observing and reporting changes in behavior, keeping call light within reach, observing and notifying for pain and encouraging and assisting to activities? A yes was documented from 10/5/2022 through 11/2/2022.

The physician order dated 10/30/2022, documented, "Air Mattress, check placement and function qs (every shift)." The physician order dated, 10/28/2022, documented, "Clean right heel with NS (normal saline), apply betadine-soaked gauze, cover with abd (abdominal) and wrap with

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Kling every day shift. The October TAR (treatment administration record) documented the above order. The treatment was documented as having been done on 10/29/2022 through 10/31/2022.

The wound physician notes dated, 11/2/2022, documented in part, "Focused Wound Exam: Unstageable (3) (due to necrosis) of the right heel full thickness. Etiology - pressure; MDS stage - unstageable necrosis; duration > (greater than) 1 day; wound size - 8.2 x 11.1 x 0.1 (centimeters); exudate - light serosanguinous; thick adherent black necrotic tissue (eschar) - 50%; other visible tissues - 50%. An addendum to the above note was documented on 11/3/2022. The addendum documented, "Yesterday, 11/2/2022, was the first time I had seen this patient and her wound. Given the wound's appearance, being a combination of DTI and newly forming eschar, it is my opinion that this wound is at least three days old, but not older than one week. The DTI portion was still soft and pliable and the eschar half was evolving, starting to harden, but not completely dried out/mature."

The physical therapy notes for 10/27/2022 failed to evidence documentation of the wound on the right heel. Review of the occupational therapy notes dated, 10/27/2022, failed to evidence documentation of the wound on the right heel.

Observations were made of R13 on 10/31/2022 at approximately 1:00 p.m. The resident was in bed, with the head of the bed elevated, lying on her back, heel boots in place. A second observation was made on 11/1/2022 at 8:57 a.m. R13 was in bed, on her back, with their heel boots in place.

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Observation was made of the R13's right heel on 11/1/2022 at 11:39 a.m. with LPN (licensed practical nurse) #4. The right heel had a large necrotic area on the inner aspect of the right heel, the outer aspect of the heel had deep purple tissue. LPN #4 applied the physician ordered treatment. The resident was in their bed on their back with green puffy heel boots on both feet.

An interview was conducted with ASM (administrative staff member) #6, the wound doctor, on 11/2/2022 at 1:34 p.m. ASM #6 stated he had not seen this resident. His last visit to the facility was on 10/26/2022.

An interview was conducted with LPN #5 on 11/2/2022 at 3:11 p.m. LPN #5 was asked to review her nurse's note of 10/27/2022 at 9:26 a.m. Once reviewed, LPN #5 was asked to describe what she saw, LPN #5 stated it was a darkened area on the heel with dead skin around it. LPN #5 stated she let the unit manager of the wound. She (unit manager) would inform the nurse practitioner and get treatment orders for it. When asked the process when a resident has a new wound, LPN #5 stated she lets the unit manager know. When/who does the measurements of a new wound, LPN #5 stated she was told LPNs could not measure wounds, only the wound care nurse. When asked if they had a wound care nurse, LPN #5 stated, not now. Did the unit manager look at the wound, LPN #5 stated at that time, she (LPN #5) left her at the nurse's station. When asked if she had ever done a skin assessment on R13, LPN #5 stated - no. When asked how often skin assessments are done, LPN #5 stated she tries to look at them daily but if not daily at least three to four times a week. LPN #5 stated 10/27/2022 was the first day

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she had cared for R13.

An interview was conducted with OSM (other staff member) #8, the occupational therapist who worked with R13 on 10/27/2022. When asked how often she was providing therapy to R13, OSM #8 stated approximately two weeks. OSM #8 stated that with R13's dementia, she was usually seen with physical therapy at the same time. When asked if she had documented the wound in her notes, OSM #8 stated, no. When asked what she saw, OSM #8 stated her heel was darkened, I didn't touch it.

An interview was conducted with OSM #9, the physical therapist, on 11/2/2022 at approximately 3:25 p.m. When asked if she discovered the wound on R13's heel, OSM #9 stated she was getting the resident dressed, R13 had the heel boots on. OSM #9 stated she must have been changing her socks and saw it. When asked if that was the first time, she had seen it, OSM #9 stated, yes, and we went directly to the nurse. When asked if R13 had had the green heel lift boots on while they were treating R13, OSM #9 stated she couldn't recall but they had been there for a while.

An interview was conducted with LPN # 6, the unit manager, on 11/2/2022 at 3:37 p.m. When asked what she did when LPN #5 informed her of the wound on R13's heel, LPN #6 stated, we are not allowed to measure wounds, only an RN (registered nurse) and (name of ASM #6 - wound doctor) can measure. When asked if she notified the RN, LPN #6 stated ASM #3, the assistant director of nursing (ADON), was in a meeting. (Name of ASM #2) the director of nursing was in a meeting. LPN #6 stated she talked about it in

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clinical meeting. When asked if any RN in the building looked at it, LPN #6 stated she contacted the nurse practitioner, who was not in the building and told her she would see it the next day. LPN #6 further stated, she asked LPN #4 to look at it, and she looked at it on the 27th (10/27/2022) and treatment was not initiated until the 28th. LPN #6 stated the process when a staff person finds an unusual skin observation, is it is reported to the nurse practitioner, the RP (responsible party), the unit manager, and the ADON. The nurse practitioner gives an order to refer to (name of wound doctor). If she doesn't refer to wound doctor, them she puts a treatment in place. When asked where a treatment was put in place on 10/27/2022, LPN #6 stated, "[LPN #5] told me she put a treatment in place. I was at home. When I spoke with nurse practitioner, she told me she would see it in the morning." LPN #6 restated only an RN and (name of wound care doctor) can measure wounds in this facility. When asked if the staff were elevating R13's heels, LPN #6 stated R13 had elevating boots.

Observation was made of R13's heel wound with ASM #6, the wound care doctor, on 11/2/2022 at 4:23 p.m. ASM #6 stated the wound was truly pressure, it was not diabetic wound. ASM #6 stated the resident still had feeling when he started to scrape the wound. The wound was measured at 8.2 x 11.1 x 0.1 centimeters. ASM #6 stated the wound was 1/2 DTI and 1/2 with eschar. The wound was debrided by ASM #6 and stated the inner aspect of the wound was softer and the edges were debrideable. New treatment put in place and applied.

On 11/3/2022 at 12:57 p.m. ASM #1, the administrator, ASM #2, the director of nursing,

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and ASM #4, the regional clinical coordinator, were made aware of the concern for harm.

An interview was conducted with ASM # 5, the nurse practitioner, on 11/3/2022 at 12:57 p.m. When asked if she looks at resident's skin, ASM #5 stated, "Usually if I am told there is a problem, mostly on recertifications." ASM #5 stated she was made aware of the heel wound late in the afternoon the day before she saw it and told the nurse to put skin prep on it until the next day. ASM #5 was asked to describe the wound when she saw it on 10/28/2022, ASM #5 stated the left heel was intact. The right heel was black, not necrotic, more pressure, it was a deep purple to black. When asked if it had any necrotic tissue when she saw it, ASM #5 stated there was no necrosis nor drainage. ASM #5 stated she saw it on 11/1/2022 and saw some necrosis that was starting to peel off. When asked if she had looked at R13's skin prior to 10/28/2022, ASM #5 stated she had not looked at the leg until they told me to. ASM #5 stated R13 didn't want to move. I told them to put the boots on her on Friday to ensure they had the boots on while she was in bed. When asked if R13 had the boots on when she went to look at the heel on 10/28/2022, ASM #5 stated R13 did not have the boots on, only her socks were on. ASM #5 stated she told the nurse to get those boots put on. When asked if she measured the wound, ASM #5 stated, no.

The facility policy, "Skin Management" documented in part, "Policy: It is the policy that the facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries. Overview: Guests/residents with wounds and/or pressure injury and those at risk for skin compromise are

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identified, evaluated and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal guest/resident outcomes. Practice Guidelines: 1. Upon admission/re-admission all guest/residents are evaluated for skin integrity by completing a baseline total body skin evaluation documented in the electronic medical record. 2. The Braden Scale will be completed upon admission/re-admission, weekly for 4 weeks, quarterly, and with a significant change of status by a licensed nurse to determine the risk of pressure injury development. 4. Guests/resident admitted with an skin impairment will have: appropriate interventions implemented to promote healing, a physician's order for treatment, and wound location, measurements, and characteristics documented. 5. The licensed nurse will initiate documentation in the electronic health record, which includes description of the skin impairment as follows: in Electronic Health Record (EHR) facilities, the licensed nurse will document on the skin and wound evaluation for pressure injury and vascular ulcers, document weekly until the areas is resolved, photos may be taken of pressure injury and vascular ulcers. 6. The interdisciplinary team considers whether the guest/resident exhibits conditions or is receiving treatments that may place the guest/resident at high risk of developing pressure injury or complicate their treatment such conditions may include: Cognitive impairments, drugs such as steroids that may affect wound healing., impaired/decreased mobility and decreased functional ability, co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus, impaired, diffuse or localized blood flow; for example, generalized

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atherosclerosis or lower extremity arterial or peripheral insufficiency, bowel/bladder incontinence, abnormal labs, malnutrition, hydration deficits, guest/resident refusal of some aspect of care and/or treatment. and a resolved injury. 7. An initial are plan is developed upon admission/readmission if the guest/resident is at risk or has a pressure injury and the comprehensive care plan may address: identifying the contributing risk factors for breakdown, including history of skin impairment or actual impairment, hydration, nutrition, preventative devices, including recumbent and seated support surfaces, preventatives skin care, pain, physician activity, positioning requirements, proper body alignment, and education - when appropriate. 8. The licensed nurse will document preventative measures on the care plan/kardex. 9. The licensed nurse will monitor evaluate and document changes regarding skin condition (to include - dressing, surrounding skin, possible complication and pain) in the medical record... 11. A weekly total body skin evaluation is completed for each guest/resident by the licensed nurse. The licensed nurse will document findings of the skin evaluation. The CNA's will report any new skin impairment to the licensed nurse that is identified during daily care. 12. If a new area of skin impairment is identified, notify the guest/resident, responsible party, attending physician, DON/designee and treatment team, if applicable. 13. Guest's/resident's with pressure injury and lower extremity ulcers will be evaluated, measured, and staged weekly (pressure injury and vascular ulcers only) in accordance with the practice guidelines until resolved. A photo may be initiated unless the guest/resident refuses.

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No further information was provided prior to exit.

References:
(1) This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.
(2) This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf:
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury

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(Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.
(3) This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf: Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.
2. For Resident #19 (R19), the facility staff failed to document a complete wound assessment of a newly identified wound and failed to follow the wound physician's orders for treatment of the wound.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/1/2022, the resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. Section M (skin condition) of the assessment documented R19 having a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. It further documented R19 at risk of developing pressure ulcer/injuries and not having any unhealed pressure ulcer/injuries.

A total body skin assessment dated 10/13/2022 at 9:01 a.m. documented one new wound identified. The document failed to identify the location or

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describe the wound identified. The skin assessment was completed by RN (registered nurse) #4.

The clinical record failed to evidence documentation describing the wound identified on 10/13/2022.

The "Wound Evaluation & Management Summary" from the wound physician, for R19 dated 10/26/2022 documented in part, "...Patient presents with a wound on her sacrum. History of Present Illness: At the request of the referring provider, [Name of physician], a thorough wound care assessment and evaluation was performed to day. She has a stage 3 pressure wound (1) sacrum for at least 1 days duration...Wound Size (LxWxD) (length by width by depth): 1.4x1.4x0.2 cm (centimeter)...[Age and sex] w (with) Hx (history) of HIV (human immunodeficiency virus), DM (diabetes mellitus) presents with a new wound over old scar tissue, continue Medihoney (2) as she has done well with this in the past. Dressing Treatment Plan: Primary Dressing(s): Leptospermum honey apply once daily for 30 days. Secondary Dressing(s): Superabsorbent silicone bdr (border) & faced apply once daily for 30 days...This patient's care was discussed with another health provider Nursing Staff Member during this visit..."

The physician's order summary report dated 11/2/2022 documented in part, "Cleanse areas to sacrum w/ (with) ns (normal saline), apply protective cream and a border dressing every evening shift. Order Date: 09/22/2022." The physician's order summary for R19 failed to evidence an order for the Medihoney treatment plan documented in the wound evaluation and

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summary on 10/26/2022.

The TAR (treatment administration record) for R19 dated 10/1/2022-10/31/2022 documented, "Cleanse areas to sacrum w/ ns, apply protective cream and a border dressing every evening shift. Start Date: 09/22/2022 1500 (3:00 p.m.)." The TAR documented R19 receiving the treatment each evening shift during the month of October 2022. The TAR failed to evidence the treatment ordered by the wound physician on 10/26/2022.

The comprehensive care plan for R19 documented in part, "[R19] has the potential for skin breakdown and pressure ulcers related to impaired mobility and urine incontinence. Actual skin impairment: wound to sacrum and blisters to left upper thigh. Date Initiated: 08/08/2019; Revision on: 08/25/2022." Under "Interventions" it documented in part, "...provide treatment as ordered. Date Initiated: 08/28/2019..."

On 11/2/2022 at 3:22 p.m., an interview was conducted with LPN (licensed practical nurse) #6, unit manager. LPN #6 stated that weekly skin assessments were scheduled in the computer system and came up on the medication administration record screen in the computer so the nurse would know that it was due. LPN #6 stated that staging and measurements of wounds were done by the wound physician, the assistant director of nursing or a registered nurse. LPN #6 stated that each morning they printed out a list of weekly skin assessments that were due for the nurses and provided it to them. LPN #6 stated that R19 had a sacral wound previously which had healed and it had reopened either last week or the week before that. LPN #6 stated that they had been notified of the wound reopening by a

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CNA (certified nursing assistant) who reported it to them. LPN #6 stated that they had spoken with the wound physician and had R19 placed back on the list to be followed. LPN #6 stated that when a new wound was discovered the nurse should write a progress note describing the wound, notify the responsible party, the resident and the physician. LPN #6 reviewed R19's clinical record and stated that it appeared that 10/13/2022 was the first time the reopening of the wound was identified.

On 11/02/2022 at 3:55 p.m., an observation was made of ASM (administrative staff member) #6, wound physician and LPN #4 providing care and assessment to R19's sacral pressure ulcer. There were no concerns with wound care observed. ASM #6 measured R19's sacral pressure ulcer as 1.2x1.2x0.2 cm (length by width by depth) and a stage 3 pressure ulcer. ASM #6 stated that R19's sacral pressure ulcer had improved and gotten smaller. ASM #6 stated that R19 had previously had a wound in the same area that was treated with Medihoney and responded very well to it. ASM #6 stated that they were treating R19's wound with the Medihoney again for this reason since the initial evaluation on 10/26/2022 and would have the staff continue with the treatment. ASM #6 stated that due to R19's previous healed wound in the area, scar tissue and lack of tissue between the skin and bone underneath, the area could open up easily and become a stage 3 pressure ulcer very quickly.

On 11/03/2022 at 7:58 a.m., an interview was conducted with LPN #4. LPN #4 stated that normally the unit manager rounded with the wound physician. LPN #4 stated that the wound

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physician came in on Wednesday and completed his wound notes after rounding. LPN #4 stated that every Thursday morning they printed out the wound notes and gave them to the unit manager to review. LPN #4 stated that the unit manager was responsible for going through the notes and reviewing the wound details to see if there were any changes to the wound treatments. LPN #4 stated that if there were any changes to the wound treatments the unit manager changed the orders to reflect the new treatment. LPN #4 stated that all of the wound notes were reviewed by someone every Thursday morning. LPN #4 reviewed the wound note dated 10/26/2022 written by ASM #6 for R19 and the current physician orders and stated that there was no order in place for the Medihoney. LPN #4 stated that there was only an active order for the protective cream and a border dressing every evening shift. LPN #4 stated that there should have been an order in place for the Medihoney treatment after the 10/26/2022 wound evaluation by the wound physician.

On 11/03/2022 at 10:17 a.m., an interview was conducted with RN (registered nurse) #4. RN #4 stated that they completed the total body skin assessment dated 10/13/2022 for R19. RN #4 stated that they had found the area on the sacrum when they went to do the ordered treatment to the sacral area. RN #4 stated that they had documented the area as a new wound but had not done anything else because there was a treatment already in place. RN #4 stated that there was a small open area with no bleeding at that time. RN #4 stated that they did not complete a change in condition form, contact the physician or nurse practitioner or call to get an order. RN #4 stated that if they observe a new

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wound and did not have a treatment order in place they completed the change in condition form, called the physician or nurse practitioner to get a treatment order, notified the unit manager and wrote a progress note. RN #4 stated that they were not sure how residents got on the wound physicians list that they thought the unit manager was responsible for that.

On 11/03/2022 at 1:15 p.m., an interview was conducted with ASM #5, nurse practitioner. ASM #5 stated that they had not examined R19 after their pressure ulcer reopened. ASM #5 stated that they saw R19 on 10/12/2022 and they were not aware of the sacral wound reopening at that point. ASM #5 stated that they did not see R19 again until after the wound physician had examined them.

The facility policy, "Skin Management" last revised 7/14/2021 documented in part, "...1. Upon admission/re-admission all guests/residents are evaluated for skin integrity be completing a baseline total body skin evaluation documented in the electronic medical record...4. Guests/residents admitted with any skin impairment will have: Appropriate interventions implemented to promote healing, A physician's order for treatment, and Wound location, measurements and characteristics documented. 5. The licensed nurse will initiate documentation in the electronic health record, which includes a description of the skin impairment as follows: In Electronic Health Record (EHR) facilities, the licensed nurse will document on the skin and wound evaluation for pressure injury and vascular ulcers. Document weekly until the area is resolved...12. If a new area of skin impairment is identified, notify the guest/resident, responsible

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party, attending physician, DON (director of nursing)/designee and treatment team, if applicable...14. The licensed nurse will notify the attending physician with any changes as needed..."

On 11/3/2022 at 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the above concern.

No further information was presented prior to exit.

(1) Pressure Ulcer
A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm.

(2) Medihoney
Applying honey preparations directly to wounds or using dressings containing honey seems to improve healing. Honey seems to reduce odors

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and pus, help clean the wound, reduce infection, reduce pain, and decrease time to healing. This information was obtained from the website: https://medlineplus.gov/druginfo/natural/738.html

3. For Resident #162 (R162), the facility staff failed to complete an accurate skin assessment on admission, document a pressure injury at the time of identification, and obtain a physician order for treatment.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/29/2022, the resident scored 4 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. Section M documented R162 having one Stage 3 pressure ulcer present upon admission/entry or reentry.

The comprehensive care plan for R162 documented in part, "[R162] is at risk for impaired skin integrity/pressure injury R/T (related to): Impaired cognition, impaired mobility, fall with fractures, Left hip hemiarthroplasty, bilateral superior and inferior pubic fractures, Date Initiated: 06/23/2022. Revision on: 07/20/2022." Under "Interventions" it documented in part, "Conduct weekly head to toe skin assessments, document and report abnormal findings to the physician. Date Initiated: 06/23/2022...Observe skin with showers/care. Notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care. Date Initiated: 06/23/2022...Provide incontinence care with each incontinent episode and as needed and apply moisture barrier cream/ointment per facility policy/orders. Date Initiated: 06/23/2022..." The care plan further

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documented, "[R162] has an actual impaired skin integrity related to Pressure injury. Site: coccyx Stage: 3, Date Initiated: 07/06/2022. Revision on: 07/20/2022."

The "Nursing Comprehensive Evaluation" dated 6/22/2022 for R162, documented in part, "...Location of skin conditions/wounds: ...Surgical incision with dermabond; CDI (clean, dry, intact) no bruising and +1 (plus one) edema, scattered bruising to extremities..."

The physician orders for R162 documented in part,
- "Cleanse Coccyx area with normal saline. Apply calcium alginate and dry dressing in the evening for stage 3. Order Date: 06/29/2022. Start Date: 06/29/2022..."
- "Cleanse Coccyx area with normal saline. Apply calcium alginate and dry dressing in the evening for stage 3. Order Date: 06/29/2022. Start Date: 06/30/2022..."
- "Cleanse Coccyx area with normal saline. Apply calcium alginate and dry dressing in the evening for stage 3. Order Date: 07/08/2022. Start Date: 07/09/2022..."

The physician orders failed to evidence an order for the pressure ulcer prior to 6/29/2022.

The TAR (treatment administration record) dated 6/1/2022-6/30/2022 for R162 documented in part, "Cleanse coccyx area with normal saline. Apply calcium alginate and dry dressing in the evening for stage 3. Start Date: 06/29/2022. D/C (discontinue) Date: 06/29/2022." The TAR documented the treatment completed on 6/29/2022. The TAR failed to evidence documentation of a treatment to the pressure ulcer prior to 6/29/2022.

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The TAR dated 7/1/2022-7/31/2022 for R162 documented in part, "Cleanse coccyx area with normal saline. Apply calcium alginate and dry dressing every evening shift for stage 3. Start Date: 06/30/2022. D/C Date: 07/08/2022." The TAR documented the treatment completed on 7/1/2022-7/7/2022. The TAR further documented, "Cleanse coccyx area with normal saline. Apply calcium alginate and dry dressing every day shift for stage 3. Start Date: 07/09/2022. D/C Date: 07/09/2022." The TAR documented the treatment completed on 7/9/2022.

The progress notes for R162 documented in part,
- "6/22/2022 18:35 (6:35 p.m.) Nursing Summary...skin intact with surgical incision to left hip closed with dermabond, denies pain."
- "6/29/2022 16:26 (4:26 p.m.) Nurses Notes. Note Text: new order for woundcare per md (medical doctor). rp (responsible party) notified of new orders."
- "6/29/2022 18:49 (6:49 p.m.) Total Body Skin Assessment... Number of new skin conditions: 0."
- "7/6/2022 18:49 (6:49 p.m.) Total Body Skin Assessment...Number of new skin conditions:1, Comments: skin audit performend [sic], presented with MASD (moisture associated skin damage) to buttocks, treatment placed for alginate and dry dressing..."

Review of the ADL (activities of daily living) documentation for R162 dated 6/1/2022-6/30/2022 documented in part, "ADL Care Statement: 1. Have you provided routine standard care which includes evaluating skin daily and reporting changes..." The report documented skin evaluations by CNA (certified

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nursing assistant) staff 6/23/2022-6/30/2022.

The Skin & Wound Evaluation dated 6/29/2022 for R162 documented in part, "...Type: Pressure; Stage: Stage 3: Full-thickness skin loss; Location: Coccyx; Acquired: Present on Admission; How long has the wound been present? (wound age when first assessed, after that it is auto calculated): Unknown; Wound Measurements: Area: 6.7 cm2 (centimeters squared), Length: 2.7 cm (centimeters), Width: 3.6 cm, Depth: Not applicable, Undermining: Not applicable, Tunneling: Not applicable..."

The "Initial Wound Evaluation & Management Summary" dated 6/29/2022 for R162 completed by the wound physician documented in part, "...Stage 3 Pressure Wound Coccyx Full Thickness...Wound Size (L (length) x W (width) x D (diameter)): 4.2 x 5.3 x 0.1 cm (centimeters)...Treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 06/29/2022 to the patient and health care surrogate; husband, [Name of husband]; who indicated agreement to proceed with the procedure(s)..."

The "Wound Evaluation & Management Summary" dated 7/6/2022 for R162 completed by the wound physician documented in part, "...Stage 3 Pressure Wound Coccyx Full Thickness...Wound Size (L x W x D): 3.8 x 3.2 x 0.1 cm...smaller, spoke w (with) patient, husband [Name of husband] and nursing staff, all at bedside, addressed all questions and concerns about her wound..."

On 11/2/2022 at approximately 10:40 a.m., ASM

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(administrative staff member) #2, the director of nursing stated that the unit manager who completed the Skin & Wound Evaluation on 6/29/2022, the ADON (assistant director of nursing) who completed the admission nursing comprehensive assessment on 6/22/2022, and the unit manager who completed the Total body skin assessment on 7/6/2022, no longer worked at the facility and could not be interviewed.

On 11/2/2022 at 1:46 p.m., an interview was conducted with ASM #6, wound physician. ASM #6 stated that they did not remember R162. After reviewing their wound notes dated 6/29/2022 and 7/6/2022, ASM #6 stated that based on their documentation the Stage 3 pressure injury could have developed quickly due to R162's low weight, co-morbidities and cognitive status. ASM #6 stated that the wound was not deep when first assessed.

On 11/2/2022 at 3:22 p.m., an interview was conducted with LPN (licensed practical nurse) #6, unit manager. LPN #6 stated that all new admission had full skin assessments completed. LPN #6 stated that staging and measurements of wounds were done by the wound physician, the assistant director of nursing or a registered nurse. LPN #6 stated that when a new wound was discovered the nurse should write a progress note describing the wound, notify the responsible party, the resident and the physician.

On 11/3/2022 at 10:39 a.m., an interview was conducted with CNA (certified nursing assistant) #8. CNA #8 stated that incontinence care was provided every two hours and as needed to residents. CNA #8 stated that barrier cream was applied to residents after each incontinent

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episode and care provided. CNA #8 stated that skin was assessed during resident care including bathing and incontinence care and any new redness or open areas were reported to the nurse immediately for assessment.

On 11/3/2022 at 11:00 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that R162's daughter had called them and was upset about several issues. ASM #2 stated that the former administrator and they had met with the daughter and the daughter had mentioned an area on the resident's buttocks to them. ASM #2 stated that they had gotten another nurse to go with them and had assessed R162's skin. ASM #2 stated that they had found a dressing on the coccyx area covering a small open area which appeared to be a Stage 2 pressure injury at that time. ASM #2 stated that they questioned the staff about the dressing and found that they had been treating the area without an order. ASM #2 stated that they were not sure what the staff were treating the area with. ASM #2 stated at that point, they contacted the physician and obtained a physician's order for wound treatment. ASM #2 stated that they had determined that the area was present on admission and the admitting nurse had not documented it or gotten and order for the area at that time. ASM #2 stated that afterwards they did a skin sweep of all residents in the building and did not find any new open pressure areas. ASM #2 stated that they had put a plan in place for new admissions to have a second person look at skin. ASM #2 stated that the ADON who admitted R162 no longer worked at the facility. ASM #2 stated that LPN (licensed practical nurse) #9 was one of the nurses who had been treating the wound without an order and they still worked at

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F 686	Continued From page 126 the facility. On 11/3/2022 at 11:44 a.m., an interview was conducted with LPN #9. LPN #9 stated that they did not remember R162 or the wound care treatment. On 11/3/2022 at 12:23 p.m., an interview was conducted with LPN #8. LPN #8 stated that skin assessments were completed on newly admitted residents by the nurse admitting the resident. LPN #8 stated that an RN (registered nurse) reviewed the assessment and signed it off also. LPN #8 stated that this process ensured that there were two sets of eyes assessing the skin. On 11/3/2022 at 12:27 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated that the admission nurse completed the skin assessment. RN #2 stated that they took a CNA with them when they completed the skin assessment to have another set of eyes during the assessment. RN #2 stated that the next day, the unit manager conducted a repeat skin assessment to ensure that nothing was missed. On 11/3/2022 at 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the above concern. No further information was presented prior to exit. Complaint deficiency.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F 690		12/18/22

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F 690	Continued From page 127 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to provide care and services for an indwelling catheter for	F 690	Criteria 1 Resident # 217 foley was removed from the floor.	

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F 690	Continued From page 128 one of 52 residents in the survey sample, Residents # 217 (R217). The findings include: For (R217), the facility staff failed to keep the indwelling urinary catheter collection bag off the floor. (R217) was admitted to the facility with diagnoses that included but were not limited to: neuromuscular dysfunction of the bladder (1). The admission MDS (minimum data set) was not due at the time of the survey. The facility's "Nursing Comprehensive Evaluation" for (R217) dated 10/21/2022 documented in part, "Neurological. Oriented To: person; Genitourinary (relating to the genital and urinary organs). Appliances: Indwelling Catheter." The physician's orders for (R217) documented in part, "Routine catheter care every shift. Order date: 10/24/2022. Start Date: 10/24/2022." On 10/31/22 at 4:28 p.m., an observation of (R217's) room from the hallway revealed the indwelling urinary catheter collection bag laying on the floor next to the bed. On 11/01/22 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #1 at the nurse's station. When asked to describe the placement of a resident's catheter collection bag LPN #1 stated that it should be attached to the side of the bed. When the resident is in the bed and not touching the floor. When asked why	F 690	Criteria 2 All residents with Foley catheters have the potential to be affected by the alleged deficient practice. An audit was conducted of all residents with foley catheters to assure compliance. Criteria 3 Licensed Nurses and C.N.As were re educated on care of a foley catheter, specifically assuring the catheter is not touching floor and is below the level of the bladder. Criteria 4 The DON or designee will conduct audits on foley catheters 3 x week for 4 weeks, weekly x 4 and monthly x 1. Results will be reported to the QAPI Committee monthly and the committee will determine need for further audits or actions	

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F 690	Continued From page 129 it was important to keep the catheter collection bag from making contact with the floor LPN #1 stated that it prevented contamination. When informed of the observation stated above LPN #1 stated that the collection bag should not been laying on the floor. The facility's policy "Catheter Associated Urinary Tract Infection (CAUTI) Prevention" documented in part, "9. Keep the collection bag and tubing off the floor." On 11/02/2022 at approximately 5:00 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #4, regional clinical coordinator were made aware of the above findings. No further information was provided prior to exit. References: (1) A problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from the website: https://medlineplus.gov/ency/article/000754.htm.	F 690		
F 692 SS=E	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	F 692		12/18/22

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F 692	Continued From page 130 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 observation, resident interview, facility document review, and clinical record review, it was determined the facility staff failed to monitor a physician ordered fluid restriction for one of 52 residents in the survey sample, Resident #6 (R6). The findings include: For Resident #6 the facility staff failed to evidence documentation of the monitoring of physician ordered fluid restriction. There was no documentation to show the total amount of fluids the resident had daily and no documented review if the fluids amounts were within the physician ordered fluid restriction. On the most recent MDS (minimum data set) assessment, a quarterly assessment with an assessment reference date of 10/4/2022, coded the resident as scoring a 15 out of 15, indicating the resident is not cognitively impaired for making daily decisions. R6 has a diagnosis of congestive heart failure (CHF). Observation was made on 10/31/2022 at 2:31	F 692	Criteria #1 Guest #6 Fluid restrictions were discontinued by the MD due to non-compliance. Criteria #2 All guests on a fluid restriction could be affected by alleged deficient practice. An audit was conducted on all guests on fluid restrictions to maintain compliance. Criteria # 3 Licensed nurses will be re educated on fluid restrictions documentation of intake at the end of 24 hours. Criteria #4 Audits of guests on fluid restriction will be completed three times a week for 4 weeks, then weekly x 4 weeks and monthly x 1. Results will be reported to the QAPI Committee monthly and the committee will determine need for further audits or actions.	

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p.m. The resident was sitting in their wheelchair. On the bedside table was a water container with a straw. The container held 550 cc (cubic centimeters) of fluid. The container was empty. An interview was conducted with R6. When asked how much water they drink a day, R6 stated she was told to drink two of these containers (water container) each day. Observation was made on 10/31/2022 at 4:16 p.m., of a staff member coming into the resident's room and refilled the resident's container with fresh water and ice.

The physician order dated, 9/27/2022, documented, "Fluid restriction - 1800 ml (milliliters) - for nursing - 300 ml 7-3 (7:00 a.m. to 3:00 p.m. shift), 300 ml for 3-11 (3:00 p.m. to 11:00 p.m.) and 120 ml for night (11:00 p.m. to 7:00 a.m.) every shift."

The comprehensive care plan dated, 9/15/2022, documented in part, "Need: [R6] is at nutritional and/or dehydration risk R/T (related to) CHF...potential for weight fluctuations r/t CHF & diuretic tx (treatment). Resident is non-compliant with fluid restriction." The "Interventions" documented in part, "1800 cc fluid restriction."

The TAR (treatment administration record) for September 2022 documented the above order. The following was documented:
9/27/2022 - 11-7 shift = 100 cc
9/28/2022 - 7-3 shift = 300 cc, nothing documented for 3-11 shift, 100 cc for 11-7 shift.
9/29/2022 - 7-3 shift = 300 cc, 3-11 shift = 300 cc, 11-7 = 120 cc.
9/30/2022 - 7-3 shift = 300 cc, 3-11 shift = 300 cc, 11-7 shift = 100 cc.

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The TAR for October 2022 documented the above order. The following was documented:

For all days of October for 7-3 shift, it was documented the resident received 300 cc, except on 10/3/2022 and 10/21/2022, there was no documentation. On 10/4/2022 for 7-3 shift, the resident only received 100 cc. On 10/7/2022, the resident only received 120 cc.

For all the days for October for the 3-11 shift, it was documented the resident received 300 cc, except on 10/5/2022, the resident received 250 cc. On 10/7/2022, it was documented the resident received 240 cc. 10/2/2022, 10/11/2022 and 10/30/2022, nothing was documented for the 3-11 shift.

For all the days in October for the 11-7 shift, it was documented the resident received 100 cc. On 10/17/2033, 10/22/2022, 10/23/2022 and 10/27/2022, it was documented the resident received 120 cc.

The TAR for November 2022, documented the above order. The following was documented:

For 11/1/2022 and 11/2/2022, for 7-3 shift, it was documented the resident received 300 cc.
For 11/1/2022 and 11/2/2022, for the 3-11 shift, it was documented the resident received 300 cc.
For 11/1/2022 and 11/2/2022, for the 11-7 shift, it was documented the resident received 100 cc.

The CNA (certified nursing assistant) Kardex documented in part, "Encourage fluids, offer preferred fluids...Encourage resident to drink fluids of choice. Provide diet as ordered." There was no documentation related to the fluid

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restriction.

The CNA documentation for October 2022, documented in part, "Eating/Fluid Acceptance." The following was documented the amount for each day what the resident received:
10/1/2022 = 940 cc
10/2/2022 = 480 cc - no dinner meal fluids documented
10/3/2022 = nothing was documented for the entire day
10/4/2022 = 440 cc - no dinner meal fluids documented
10/5/2022 = 240 cc - no breakfast or lunch meal documented
10/6/2022 = 240 cc - no breakfast or lunch meal documented
10/7/2022 = 440 cc - no dinner meal fluids documented
10/8/2022 = 1550 cc
10/9/2022 = 420 cc - no breakfast or lunch meal documented
10/10/2022 = 1200 cc - no breakfast or lunch meal documented
10/11/2022 - 240 cc - no breakfast or lunch meal documented
10/12/2022 = nothing documented for the entire day
10/13/2022 = 1200 cc - no breakfast or lunch meal documented.
10/14/2022 = nothing documented for the entire day
10/15/2022 = 160 cc - no breakfast or lunch meal documented
10/16/2022 = nothing documented for the entire day
10/17/2022 = 960 cc
10/18/2022 = 594 cc
10/19/2022 = 346 cc - nothing documented for

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the dinner meal.
10/20/2022 - 1200 - no breakfast or lunch meal documented
10/21/2022 - 210 cc
10/22/2022 = nothing documented for the entire day.
10/23/2022 - nothing documented for the entire day.
10/24/2022 = 360 cc - no breakfast or lunch meal documented
10/25/2022 = 594 cc
10/26/2022 = 236 cc - no lunch or dinner meal documented
10/27/2022 = 175 cc - no breakfast or lunch meal documented
10/28/2022 = nothing documented for the entire day
10/29/2022 = nothing documented for the entire day
10/30/2022 = nothing documented for the entire day
10/31/2022 = nothing documented for the entire day.

The CNA documentation for November 2022, documented in part, "Eating/Fluid Acceptance." The following was documented the amount for each day what the resident received:
11/1/2022 = nothing documented for the entire day
11/2/2022 = nothing documented for the entire day.

If added together, what the kitchen provides, the amount the nurses provide and the amount the resident states she drinks every day, the resident is over their fluid restriction. Kitchen gives 840 cc/day, nursing gives 720 cc/day and the resident states she drinks every day, the resident is

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receiving 2640 cc/day.

Review of the nurse's notes failed to evidence documentation of the resident refusing to follow the physician ordered fluid restriction.

The nurse practitioner notes of 10/20/2922 documented in part, "A/P (Approach/Plan): 1. CHF - ongoing - continue fluid restriction." The nurse practitioner note dated, 10/28/2022 documented in part, "A/P (Approach/Plan): 1. CHF - ongoing - continue fluid restriction." The nurse practitioner notes dated 10/31/2022, documented in part, "A/P (Approach/Plan): 1. CHF - ongoing - continue fluid restriction."

An interview was conducted on 11/03/2022 at 9:19 a.m. with OSM (other staff member) #6, the director of food and nutrition services. When asked if R6 was on a fluid restriction, OSM #6 stated yes. OSM #6 presented a food tray ticket that documented the 1800 cc fluid restriction. OSM #6 explained the kitchen puts the following amounts on the food trays: 360 cc on the breakfast tray, 240 cc on the lunch tray and 240 cc on the dinner tray.

An interview was conducted with R6 on 11/3/2022 at 9:54 a.m. When asked if they are aware of being on a fluid restriction, R6 stated, yes. R6 stated they drink the two containers of water and points to the 18-ounce mark on the container. R6 stated the staff told her she had to drink two of these containers each day. When asked if they get fluids on their meal trays, R6 stated they get two drinks in the morning and iced tea on their lunch and dinner tray. When asked if she follows the fluid restriction prescribed by the physician, R6 stated, I follow what they told me to drink.

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An interview was conducted with LPN (licensed practical nurse) #5 on 11/3/2022 at 10:06 a.m. When asked how she knows what amount of fluids R6 drinks and where is it documented the total amount of fluids the resident has received each day, LPN #5 stated she measures what she gives her. LPN #5 stated the resident has a water pitcher and the family comes in and gets her water. LPN #5 stated the resident receives breakfast and lunch fluids on her tray and the kitchen only gives her what she can have. When asked if anyone totals the amount of fluids the resident drinks in each day? LPN #5 reviewed the TAR, and was then asked if that was the total the resident get for the day, LPN #5 stated, no. LPN #5 stated she mixes one of her medications in 180 cc in the morning and then can also give her 300 cc for the shift. When asked if the 180 cc is counted in the 300 cc she gives the resident, LPN #5 stated, no. When asked who is monitoring the total the resident gets in a day, LPN #5 stated, "I don't know."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 11/3/2022 at 10:52 a.m. When asked the purpose of a fluid restriction, ASM #2 stated [R6] has a history of heart failure. When asked who monitors the 1800 fluid restriction for R6, ASM #2 stated the dietician, the doctor and the nurse on the unit. ASM #2 stated she is aware of the concern. ASM #2 stated they only have documented what the nurse gives the resident. The TARs and CNA documentation was reviewed with ASM #2. When asked if someone should be checking to see if the resident stays within her fluid restriction, ASM #2 stated the documentation speaks for themselves. There is no daily intake

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F 692	Continued From page 137 for the resident. The facility policy, "Fluid Restriction" documented in part, "Purpose: To ensure guests/residents ordered fluid restrictions receive the proper allocation...Guidelines: 1. Upon notification of a fluid restriction via physician order, the Dietary Manager meets with the Charge Nurse to determine the amount of total fluid that will be provided by each department, medication pass, meals, snacks, supplements, and guest/resident beverage preferences are considered in the fluid allocation. 2. The Dietary Manager visits with the guest/resident and adjusts their beverage preferences to adhere to he fluid restriction. The guest/resident and family are education on the fluid restriction and documented in the medical record. The fluid restriction is entered into the dietary software, noted on the tray ticket and snack labels, and clearly identifies the type and amount of fluids to be served. Documentation: None." ASM #1, the administrator, ASM #2, and ASM #4 the regional clinical coordinator, were made aware of the above concern on 11/3/2022 at 4:30 p.m. No further information was provided prior to exit.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		12/18/22

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F 695	Continued From page 138 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to maintain complete respiratory services per professional standards for one of 52 residents in the survey sample, Resident #23. The findings include: For Resident #23 (R23), the facility staff failed to obtain a physician's order to administer oxygen. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/11/22, R23 was coded as being moderately cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS (brief interview for mental status. R23 was coded as not receiving oxygen during the look back period. On 10/31/22 at 8:42 a.m., and 11/1/22 at 8:45 a.m., R23 was observed lying in bed, with oxygen being delivered by nasal cannula at a rate of 1.5 lpm (liters per minute) by way of an oxygen concentrator. A review of R23's physician's orders revealed no evidence of an order for oxygen. A review of R23's care plan dated 10/5/22 revealed no information related to the resident's use of oxygen.	F 695	Criteria 1 Resident # 23 Oxygen order was obtained from MD. Criteria 2 All residents who receive O2 have the potential to be affected by the alleged deficient practice. An audit was conducted for all guests on O2 to assure orders were in place for the O2. Criteria 3 Licensed nurses will be re-educated on obtaining an order when O2 is needed for a resident. Criteria 4 DON/designee will complete audits of residents with O2 three times a week for 4 weeks, weekly x 4 weeks and monthly x 1. The results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action.	

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F 695	Continued From page 139 On 11/2/22 at 1:37 p.m., LPN (licensed practical nurse) #3 was interviewed. She stated oxygen should not be administered to any resident without a physician's order. She stated: "Oxygen is a medication like any other medication." After reviewing R23's physician's orders, she stated: "No, I don't see an order for [oxygen]." On 11/2/22 at 3:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional clinical coordinator, were informed of these concerns. A review of the facility policy, "Use of Oxygen," failed to reveal any information related to obtaining a physician's order for the use of oxygen. No further information was provided prior to exit.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement a complete pain management program for three of 52 residents in the survey sample, Residents # 15 (R15), (R21) and (R96).	F 697	Criteria 1 Resident # 15 pain medications were corrected to reflect appropriate pain scales for administration. Residents #96 and #21 have been discharged from the facility	12/18/22

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F 697	Continued From page 140 The findings include: 1. For (R15) the facility staff failed to attempt non-pharmacological interventions prior to the administration of a prn (as needed) pain medications, roxicodone (1) and acetaminophen (2) (R15) was admitted to the facility with a diagnosis that included but was not limited to: right leg fracture. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 10/15/2022, (R15) scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R15) was cognitively intact for making daily decisions. Section J0400 "Pain Frequency" coded (R15) as "Occasionally." Under "J0600. Pain Intensity" it documented, "A. Numeric Rating Scale (00-10)." (R15) was coded a "4 (four)." The physician's order for (R15) documented in part, "Roxicodone Tablet 5 (five) MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 09/30/2022. Start Date: 09/30/2022." "Acetaminophen Extra Strength Tablet 500 MG. Give 2 (two) tablets by mouth every 6 hours needed for pain 1-5 (one to five). Order Date: 10/10/2022. Start Date: 10/10/2022." The eMAR (electronic medication administration record) for (R15) dated October 2022 documented the physician's order as stated above. The eMAR revealed that (R15) received 5 mgs of roxicodone on the following dates and	F 697	Criteria 2 All residents who have pain medications ordered have the potential to be affected by the alleged deficient practice. Criteria 3 Licensed nurses will be re-educated on the Medication Administration policy and parameters for administering prn pain medications. Criteria 4 DON/designee will complete (5) random audits of residents with prn pain medications 3x week for 4 weeks, weekly x 4 and monthly x 1 to assure appropriate parameters are followed. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits and/or action.	

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times, with no evidence of non-pharmacological interventions being attempted on: 10/01/2022 at 1:12 p.m., 10/02/2022 at 1:44 p.m., 10/06/2022 at 10:00 a.m., and on 10/18/2022 at 8:31 p.m. Further review of the eMAR revealed that (R15) received 1000 mg of acetaminophen on the following dates and times, with no evidence of non-pharmacological interventions being attempted on: 10/26/2022 at 10:29 a.m. and on 10/27/2022 at 7:46 p.m.

The comprehensive care plan for (R15) dated 09/18/2022 documented in part "Need: (R15) is at risk for pain and has pain related to neuropathy, C2 fracture (fracture of the second cervical vertebra) with fusion, post concussion headache with Odontaoid fracture (a toothlike upward projection at the back of the second vertebra of the neck), OA, (osteoarthritis) fracture of femur (leg). Date Initiated: 09/18/2022." Under "Interventions" it documented in part, "Offer Non-Pharmacological Interventions: 1) Massage; 2) Meditation/relaxation; 3) Positioning; 4) Ice/cold pack; 5) Diversional Activity; 6) Guided Imagery; 7) Rest; 8) Social Interaction; 9) Other. Date Initiated: 06/30/2021.

Review of the facility's nurse's notes for (R15) dated 10/01/2022 through 10/31/2022 failed to evidence non-pharmacological interventions being attempted on the dates and times listed above.

On 11/02/22 at approximately 2:15 p.m., an interview was conducted with (R15). When asked if the staff attempt to alleviate their pain before administering their as needed pain medication, (R15) stated no and that they give them the pain medication.

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On 11/03/22 at approximately 8:19 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked to describe the procedure when administering as needed pain medication LPN # 4 stated that the nurse assesses the resident's pain by obtaining the severity of the resident's pain on a scale of zero to ten, with ten being the worse pain, the location of the pain and the type of pain such as throbbing or stabbing. LPN # 4 stated that the nurse would then start with non-pharmacological interventions such as repositioning, ice pack, or heat, and if that does not alleviate the resident's pain, they would administer the prescribe medication. When asked how often non-pharmacological interventions LPN # 4 stated that it should be attempted each time before the as needed pain medication is administered. When asked where it would be documented that the location of pain, type of pain and non-pharmacological interventions were attempted LPN # 4 stated that it would be documented in the nurse's notes or the eMAR. When asked why it is important to attempt non-pharmacological interventions prior to the administration of as needed pain medication LPN # 4 stated that it could decrease use of pain medication. After review of (R15's) eMAR and progress notes dated 10/01/2022 through 10/31/2022 for non-pharmacological interventions prior to the administration of roxicodone and acetaminophen to (R15), LPN # 4 was asked about the missing documentation. LPN # 4 stated that they could not say non-pharmacological interventions were attempted because it was not documented.

The facility's policy "Pain Management" documented in part, "Procedure: 14. The staff will

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implement the care plan, monitor the guest/resident, and administer therapeutic interventions for pain, if ordered."

On 11/03/2022 at approximately 4:02 p.m., ASM # 1, administrator, ASM # 2, director of nursing and ASM # 4, regional clinical coordinator, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Are an immediate-release oral formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain where the use of an opioid analgesic is appropriate. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d48c22ff-bbb4-4a93-a35b-6eebff7b8e53 .

(2) Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html.

2. For (R21) the facility staff failed to attempt non-pharmacological interventions prior to the administration of a prn a(as needed) pain medications, oxycodone-acetaminophen (1).

(R21) was admitted to the facility with a diagnosis

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that included but was not limited to: low back pain.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 09/19/2022, (R21) scored 14 out of 15 on the BIMS (brief interview for mental status), indicating (R21) was cognitively intact for making daily decisions.

Section J0400 "Pain Frequency" coded (R21) as "Frequently." Under "J0600. Pain Intensity" it documented, "A. Numeric Rating Scale (00-10)." (R21) was coded a "5 (five)."

The physician's order for (R21) documented in part, "Oxycodone-Acetaminophen Tablet 5-325 MG (milligram). Give 1 (one) tablet by mouth every 12 hours as needed for pain. Order Date: 09/15/2022. Start Date: 09/15/2022."

The eMAR (electronic medication administration record) for (R21) dated October 2022 documented the physician's order as stated above. The eMAR revealed that (R21) received 5-325 mgs of oxycodone-acetaminophen on the following dates and times, with no evidence of non-pharmacological interventions being attempted on: 10/01/2022 at 9:02 p.m., 10/05/2022 at 7:58 p.m., 10/07/2022 at 3:48 p.m., 10/08/2022 at 2:17 p.m., 10/09/2022 at 4:06 p.m., and on 10/10/2022 at 8:05 p.m.

The comprehensive care plan for (R21) dated 09/14/2022 documented in part "Need: (R21) is at risk for pain and/or has acute/chronic pain r/t (related to) age related changes, recent fall with compression fracture ...Date Initiated: 09/14/2022." Under "Interventions" it documented in part, "Offer Non-Pharmacological

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Interventions: 1) Massage; 2) Meditation/relaxation; 3) Positioning; 4) Ice/cold pack; 5) Diversional Activity; 6) Guided Imagery; 7) Rest; 8) Social Interaction; 9) Other. Date Initiated: 06/30/2021.

Review of the facility's nurse's notes for (R21) dated 10/01/2022 through 10/31/2022 failed to evidence non-pharmacological interventions being attempted on the dates and times listed above.

On 11/02/2022 at approximately 2:25 p.m., an interview was conducted with (R21). When asked if they receive as needed pain medication (R21) stated yes. When asked of the nurse attempts to alleviate their pain by other means before administering their pain medication (R21) stated that the nurses don't always attempt to alleviate their pain by other means.

On 11/03/22 at approximately 8:19 a.m., an interview was conducted with LPN (licensed practical nurse) #4 regarding the implementation and documentation of non-pharmacological interventions prior to the administration of as needed pain medication to (R21). After review of (R21's) eMAR and progress notes dated 10/01/2022 through 10/31/2022 for non-pharmacological interventions prior to the administration of oxycodone-acetaminophen to (R21), LPN #4 was asked about the missing documentation. LPN #4 stated that they could not say non-pharmacological interventions were attempted because it was not documented.

On 11/03/2022 at approximately 4:02 p.m., ASM #1, administrator, ASM #2, director of nursing and ASM #4, regional clinical coordinator, were made

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aware of the above findings.

No further information was provided prior to exit.

References:
(1) Indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f2137f1a-b49a-40bd-97ac-cd6b36e295f4.

3. For (R96) the facility staff failed to attempt non-pharmacological interventions prior to the administration of a prn (as needed) pain medications, tramadol (1).

(R96) was admitted to the facility with a diagnosis that included but was not limited to: low back pain.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/05/2022, the (R96) scored 14 out of 15 on the BIMS (brief interview for mental status), indicating (R96) was cognitively intact for making daily decisions.
Section J0400 "Pain Frequency" coded (R96) as "Frequently." Under "J0600. Pain Intensity" it documented, "A. Numeric Rating Scale (00-10)." (R96) was coded an "8 (eight)."

The physician's order for (R96) documented in part, "Tramadol Tablet 50 MG (milligram). Give 50 mg by mouth every 6 hours as needed for back pain. Order Date: 09/29/2022. Start Date: 09/29/2022."

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The eMAR (electronic medication administration record) for (R96) dated October 2022 documented the physician's order as stated above. The eMAR revealed that (R96) received 50 mgs of tramadol on the following dates and times, with no evidence of non-pharmacological interventions being attempted on: 10/01/2022 at 4:01 a.m., 10/07/2022 at 8:11 p.m., 10/09/2022 at 2:10 a.m., 10/10/2022 at 4:00 a.m., 10/12/2022 at 12:19 a.m., 10/10/2022 at 8:05 p.m. and at 11:10 p.m., 10/13/2022 at 8:55 a.m., 10/15/2022 at 10:47 p.m., 10/19/2022 at 9:34 a.m., 10/21/2022 at 12:22 a.m., 10/26/2022 at 4:13 p.m., 10/27/2022 at 5:45 a.m. and at 11:47 a.m., 10/28/2022 at 5:11 a.m., 10/30/2022 at 8:24 p.m. and on 10/31/2022 at 6:17 a.m.

Review of the facility's nurse's notes for (R96) dated 10/01/2022 through 10/31/2022 failed to evidence non-pharmacological interventions being attempted on the dates and times listed above.

On 11/02/2022 at approximately 2:20 p.m., an interview was conducted with (R96). When asked if they receive as needed pain medication (R96) stated yes. When asked of the nurse attempts to alleviate their pain by other means before administering their pain medication (R96) stated that nurse just gives them their medication.

On 11/03/22 at approximately 8:19 a.m., an interview was conducted with LPN (licensed practical nurse) #4 regarding the implementation and documentation of non-pharmacological interventions prior to the administration of as needed pain medication to (R96). After review of (R96's) eMAR and progress notes dated 10/01/2022 through 10/31/2022 for

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F 697	Continued From page 148 non-pharmacological interventions prior to the administration of oxycodone-acetaminophen to (R), LPN #4 was asked about the missing documentation. LPN # 4 stated that they could not say non-pharmacological interventions were attempted because it was not documented. On 11/03/2022 at approximately 4:02 p.m., ASM #1, administrator, ASM #2, director of nursing and ASM #4, regional clinical coordinator, were made aware of the above findings. No further information was provided prior to exit. References: (1) Used to relieve moderate to moderately severe pain. Tramadol extended-release tablets and capsules are only used by people who are expected to need medication to relieve pain around-the-clock. Tramadol is in a class of medications called opiate (narcotic) analgesics. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html.	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to maintain a complete dialysis program for	F 698	Criteria 1 The identified dialysis records for resident #36 were obtained and placed in the	12/18/22

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F 698	Continued From page 149 one of 52 residents in the survey sample, Resident #36. The findings include: For Resident #36 (R36), the facility staff failed to evidence communication and coordination with the resident's dialysis provider. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/23/22, R36 was coded as being cognitively intact for making daily decisions, having scored 13 out of 15 on the BIMS (brief interview for mental status). R36 was coded as receiving dialysis services during the look back period. A review of R36's clinical record revealed the following physician order dated 5/23/22: "Dialysis Thursday, Thursday, Saturday." Further review of the clinical record revealed the resident had consistently received the dialysis services as ordered in September and October 2022. A review of R36's dialysis communication book revealed only one hemodialysis communication sheet. It was dated 9/13/22. This document contained information from the facility to the dialysis center, and information from the dialysis provider to the facility. The book contained no additional evidence of communication between the facility and the dialysis center. A review of R36's care plan dated 10/30/19 and revised on 10/4/22 revealed, in part: "Encourage resident to go for scheduled dialysis appointments. Resident receives dialysis on Tuesday, Thursday, and Saturday."	F 698	medical record. Criteria 2 All guests receiving dialysis have the potential to be affected by this practice. An audit was completed of dialysis resident medical records, and dialysis communications were obtained as needed. Criteria 3 The DON/designee will provide in-service education to licensed nursing staff on follow-up to dialysis centers when documentation is not provided. Criteria 4 Dialysis communications will be audited 3 times per week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month. Missing documentation will be obtained when needed, and additional in-service education and/or corrective action will be provided. On-going compliance will be monitored through routine audits of dialysis records. The results of the audits will be reviewed at the quality assurance meeting. Additional education and monitoring will be initiated for any identified concerns.	

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On 11/2/22 at 1:37 p.m., LPN (licensed practical nurse) #3 was interviewed. She stated the facility uses a communication book to exchange information about residents with the dialysis center. She stated the facility sends information to the dialysis center on each dialysis day. This information includes resident's weight, vital signs, any changes in medications, and other pertinent information. She stated the facility nurse sends the dialysis communication book with the resident to the dialysis center. The dialysis center staff records information the facility needs to know, including any fluid volumes, laboratory test results, medications administered, weight, and any other important information. The dialysis center sends the book back to the facility staff. She stated if a resident returns from dialysis without the dialysis communication book, she calls the dialysis center to get what the information she needs to continue to take care of the resident. She stated she would also call if the dialysis center portion of the form is blank.

On 11/2/22 at 3:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional clinical coordinator, were informed of these concerns.

A review of the facility policy, "Hemodialysis," revealed, in part: "The facility completes the appropriate section of the hemodialysis communication form prior to guest/resident receiving each dialysis session, and again when the guest/resident returns from hemodialysis."

No further information was provided prior to exit.

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F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to evidence assessment, education and consent for the use of side rails for three of 52 residents in the survey sample, Resident #62, Resident #23, and Resident #58. The findings include: 1. For Resident #62 (R62), the facility staff failed to complete an assessment, provide education	F 700	Criteria 1 Resident # 62 and #58 had a device assessment and siderail consent forms completed. Resident # 23 was discharged from facility. Criteria 2 All residents who have side rails or assist bars have the potential to be affected by the same alleged deficient practice. An audit was conducted of all guests to assure consents and assessments were	12/18/22

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F 700	Continued From page 152 and obtain a consent for the use of side rails. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/16/2022, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one person for moving in the bed. R62 was observed on 10/31/2022 at approximately 1:00 p.m. in bed with bilateral assist rails on the bed. A second observation was made of R62 on 11/1/2022 at 11:33 a.m. in bed with bilateral assist rails. Review of the physician orders on 11/2/2022, failed to evidence a physician order for the use of assist rails. The comprehensive care plan dated 4/12/2022 documented in part, "Need: [R62] is at risk for complication due to Bilateral assist bars to assist with mobility. Does not restrict mobility." The "Interventions" documented in part, "Utilize device as ordered. Device: Bilateral assist rails. Discuss and record with resident and family, the risks and benefits of bilateral assist rails use." Review of the clinical record, failed to evidence documentation of an assessment for the use of rails, education for the use of the assist rails (bars). On 11/3/2022 11:00 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked	F 700	completed. Criteria 3 Licensed nurses will be re-educated on the Side rail policy. Criteria 4 DON/designee will complete five (5) random audits of side rails three x a week for 4 weeks, then weekly x 4 and monthly x 1. These results will be forwarded to the QAPI committee for review. The committee will determine the need for further audits or actions.	

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the process for the use of bed rails, ASM #2 stated when a resident has rails, they are supposed to have an evaluation for appropriateness. She stated they get an order, get a consent and educate the guest or RP (responsible party). It is a written consent process that gets scanned in the medical record. We should do this on admission if they have rails or prior to putting rails on the bed.

Facility policy titled, "Restraint Management" dated effective 10/14/22 read in part:

"...Guidelines...5. Any guest/resident using a physical restraint or side rails must have a current, signed restraint consent in the medical record. The facility will explain how the use of the restraint would treat the guest's/residents medical symptoms and assist the guest/resident in attaining or maintaining his/her highest practicable level of physical and psychosocial well-being. In addition, the facility will explain the potential risks and benefits of that specific restraint in use by the guest/resident, and the least restrictive alternatives that have been attempted. If the responsible party/legal representative is not able to provide signed authorization for use of the restraint, telephone authorization will be documented until written consent is obtained..."

ASM #1, the administrator, ASM #2, and ASM #4, the regional clinical coordinator, were made aware of the above concern on 11/3/2022 at 4:30 p.m.

3. For Resident #23 (R23), the facility staff failed to evidence assessment for the need for side rails, education regarding the risks and benefits

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of side rail use, and consent for the use of side rails.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/11/22, R23 was coded as being moderately cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS (brief interview for mental status. R 23 was coded as requiring the extensive assistance of facility staff for bed mobility.

On the following dates and times, R23 was observed lying in bed with quarter side rails up: 10/31/22 at 8:42 a.m., and 11/1/22 at 8:45 a.m.

A review of R23's clinical record failed to reveal evidence of an assessment of the resident's need for the use of side rails, of education for the resident/RP (responsible party) regarding the potential risks and benefits of side rail use, and a signed consent for the use of side rails for R23.

A review of R23's care plan dated 10/5/22 revealed no information related to the resident's use of side rails.

On 11/2/22 at 10:58 a.m., ASM (administrative staff member) #1, the administrator, stated there was no side rail assessment, education, or consent for R23.

On 11/2/22 at 1:37 p.m., LPN (licensed practical nurse) #3 was interviewed. She stated side rails should not be implemented unless a resident has been assessed, educated, and a consent has been signed. She stated the admission nurse is responsible for completing these tasks. She stated if the resident is using the side rails, they

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should go on the care plan.

On 11/2/22 at 3:55 p.m., ASM #1, ASM #2, the director of nursing, and ASM #4, the regional clinical coordinator, were informed of these concerns.

No further information was provided prior to exit.
3. For Resident #58 (R58), the facility failed to evidence a consent for the use of bed rails.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/8/2022, the resident scored 11 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were moderately impaired to make daily decisions. The resident was coded as requiring supervision of one person for bed mobility and supervision with setup help only from staff for transfers.

On 10/31/2022 at approximately 2:30 p.m., an observation was made of R58 in bed with bilateral bar shaped bed rails in place.

An additional observation of R58 was made on 11/1/2022 at 8:28 a.m. of R58 in bed with bilateral bar shaped bed rails in place. An interview was conducted with R58. R58 stated that they used the bed rails on the sides of the bed to grab onto when turning in the bed. R58 stated that they did not remember whether or not they had signed a consent because they were on the bed when they got it.

The comprehensive care plan for R58 documented in part, "[R58] is at risk of complications related to use of bilateral enabler

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bars, does not restrict movement, guest has impaired mobility. Date Initiated: 04/13/2021. Revision on: 04/13/2021."

The physician orders for R58 documented in part, "Order Date: 4/13/2021 14:18 (2:18 p.m.). Bilateral enabler bars to assist with bed mobility..."

A Physical Device Evaluation dated 5/10/2022 for R58 documented an assessment for the use of assist bars as an enabler for repositioning/support, to enable/increase bed mobility and to enhance mobility.

Further review of R58's clinical record failed to evidence consent for the use of side rails.

On 11/02/2022 at approximately 8:00 a.m., a request was made via written list to ASM (administrative staff member) #1, the administrator, for evidence of consent for use of bed rails for R58.

On 11/03/2022 at 8:42 a.m., ASM #1 stated that they did not have a consent for R58's bed rails and they had completed one on 11/2/2022.

On 11/3/2022 at 11:00 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that residents who had bed rails were supposed to have an evaluation for appropriateness. ASM #2 stated that if bed rails were appropriate they obtained an order for them, educated the guest and/or the responsible party and obtained a consent for them. ASM #2 stated that the consent was a written process and after it was signed by the guest or the responsible party

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F 700	Continued From page 157 it was scanned into the medical record. ASM #2 stated that this process should be completed on admission or prior to putting rails on the bed. On 11/3/2022 at 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the above concern. No further information was provided prior to exit.	F 700		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide performance evaluations for four of five CNA's (certified nursing assistants). The findings include: During the Sufficient and Competent Staffing facility task review on 11/2/22 at 2:00 PM there was no evidence of performance evaluations and mandatory training for four of five CNA's (certified nursing assistants) reviewed. On 11/2/22 at 9:00 AM, ASM (administrative staff member) #1, the administrator was provided a list	F 730	Criteria 1 The missing evaluations have now been completed. Criteria 2 An audit has been completed to ensure annual performance evaluations have been completed for all CNAs. Corrections were made as needed. Criteria 3 The Administrator/designee will provide in-service education to Administrative Nurses on the requirement for timely CNA evaluations.	12/18/22

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F 730	Continued From page 158 of five CNA's with a request for evidence of performance reviews. On 11/2/22 at 10:00 AM, ASM #2, the director of nursing stated, "April is when I started. I do not know if some of these performance reviews have been done." 1. CNA #4 with a date of hire of 12/15/08, evidenced no annual performance evaluation. 2. CNA #6 with a date of hire of 10/20/20, evidenced no annual performance evaluation. 3. CNA #7 with a date of hire of 12/17/20, evidenced no annual performance evaluation. 4. CNA #8 with a date of hire of 9/3/21, evidenced no annual performance evaluation. On 11/02/22 at 5:06 PM, ASM #2, the director of nursing stated, "We do not have any more performance reviews." ASM #2 was informed that 4 out of 5 performance reviews were missing. On 11/3/22 at 3:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the findings. A review of the facility's policy "Staff Development" policy dated 4/2022, revealed, "A competency evaluation will be completed annually for certified nurse aides." No further information was provided prior to exit.	F 730	Criteria 4 An audit of required CNA evaluations will be completed weekly x 4 weeks, then monthly for 1 month to assure timely completion. On-going compliance will be monitored through routine license audits. The results of the audits will be reviewed at the quality assurance meeting. Additional education and monitoring will be initiated for any identified concerns.	
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information.	F 732		12/18/22

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F 732	Continued From page 159 §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility	F 732	Criteria 1 Nursing Staffing is now being posted daily	

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F 732	Continued From page 160 staff failed to post daily nurse staffing for two of four days reviewed. The findings include: During the Sufficient and Competent Staffing facility task review started on 10/31/22 and ending on 11/3/22, a review of the daily nurse staffing evidenced the following: On 10/31/22 at approximately 11:00 AM the surveyors entered the facility. On the bulletin board in the main lobby was the staff posting with a date of 10/27/22. On 11/1/22 at 7:15 AM, the bulletin board in the main lobby had the staff posting with a date of 10/27/22. On 11/2/22 at 8:15 AM the bulletin board in the main lobby had the staff posting with a date of 11/2/22. On 11/3/22 at 8:15 AM the bulletin board in the main lobby there is staff posting with a date of 11/3/22. On 11/2/22 at 8:15 AM, an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked who was responsible for posting the daily staffing, ASM #2 stated, the staffing and scheduling coordinator is responsible for posting the daily staffing. ASM #2 stated, "I have not followed behind to make sure it is being done." On 11/2/22 at 10:15 AM an interview was conducted with CNA (certified nursing assistant) #2, the scheduling coordinator. When asked who	F 732	as required. Criteria 2 Administrative Nurses, or designee will provide in-service education to the staffing coordinator on the staff posting to include weekends. The Weekend Manager will ensure that the staff posting is current on each weekend day. Criteria 3 The daily staff postings will be audited on weekdays x 4 weeks, weekly x 4 weeks, and daily x 1 month. Criteria 4 On-going compliance will be monitored through routine monitoring. The results of the monitoring will be reviewed at the quality assurance meeting. Additional education and monitoring will be initiated for any identified concerns.	

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F 732	Continued From page 161 was responsible for posting the daily staffing, CNA #2 stated, "During the week, I am responsible, on the weekends it is the nursing supervisor." When asked the process to post staffing, CNA #2 stated, "It is posted by 7:00 AM when I am here. I get here at 6:30 AM during the week." On 11/3/22 at 3:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the findings. According to the facility's "Required Regulatory Postings" policy, dated 4/19/22, included, "The following information will be posted on a daily basis by the facility: Data requirements: facility name, current date, total number and actual hours worked of the following categories of licensed and unlicensed nursing staff directly responsible for guest/resident care per shift (registered nurses, licensed practical nurses, certified nursing aides and medication aides) and resident census." No further information was provided prior to exit.	F 732		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		12/18/22

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F 757	Continued From page 162 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure a resident was free of unnecessary medications for one of 52 residents in the survey sample, Resident #15 (R15). The findings include: For (R15), the facility staff administered a prn (as needed) pain medication Roxicodone (1) outside of the physician ordered pain level parameters. (R15) was admitted to the facility with a diagnosis that included but was not limited to: right leg fracture. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 10/15/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R15) was cognitively intact for making daily decisions. Section J0400 "Pain Frequency" coded (R15) as	F 757	Criteria 1 The medication order for resident #15 was corrected, and the resident is now receiving medication according to the correct pain scale. Criteria 2 Residents receiving PRN pain medications have the potential to be affected by the alleged deficient practice. An audit has been completed of all PRN pain medications to ensure that the pain scale is correct. Criteria 3 The DON/designee will provide in-service education to licensed nurses on transcription of pain medication scales Criteria 4 The DON/designee will conduct a random 3 times per week x 4 weeks, weekly x 4 weeks, then monthly x 1 month of guests receiving pain medications according to a	

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"Occasionally." Under "J0600. Pain Intensity" it documented, "A. Numeric Rating Scale (00-10)." (R15) was coded a "4 (four)."

The physician's order for (R15) documented in part, "Roxicodone Tablet 5 (five) MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 09/30/2022. Start Date: 09/30/2022."

The "(Name of Pharmacy) Admission Medication Regimen Review Report" for (R15) dated "September 30, 2022 through October 7, 2022" documented in part, "Roxicodone Tablet 5 mg 1 tab (tablet) po (by mouth) every 6 hours as needed for pain discharge summary states for pain 6-10 (should be 7-10) since ibuprofen (2) is for pain 4-6)." Further review of the medication regimen review revealed the signature by the nurse practitioner dated "10-10-22 (October 10, 2022)."

The eMAR (electronic medication administration record) for (R15) dated October 2022 documented the physician order as stated above. Further review of the eMAR revealed that (R15) received five milligrams of roxicodone for a pain level of five on 10/18/2022.

The comprehensive care plan for (R15) dated 09/18/2022 documented in part "Need: (R15) is at risk for pain and has pain related to neuropathy, C2 fracture (fracture of the second cervical vertebra) with fusion, post concussion headache with Odontaoid fracture (a toothlike upward projection at the back of the second vertebra of the neck), OA, (osteoarthritis) fracture of femur (leg). Date Initiated: 09/18/2022." Under "Interventions" it documented in part, "Administer

pain scale.

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medications as ordered. Date Initiated: 06/30/2021."

On 11/03/22 at approximately 8:19 a.m., an interview was conducted with LPN (licensed practical nurse) #4. After reviewing (R15's) medication regimen review, the October 2022 eMAR LPN # 4 stated that (R15) should have not received the roxicodone on 10/18/2022.

On 11/03/22 at approximately 11:37 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. After reviewing (R15's) medication regimen review, and the October 2022 eMAR ASM # 2 stated that the medication was administered outside of the pain parameters. When asked if it was an unnecessary medication ASM # 2 stated yes.

The facility's policy "Pain Management" documented in part, "Procedure: 8. Following the pain evaluation notify the physician if indicated and implement new orders as received."

On 11/03/2022 at approximately 4:02 p.m., ASM #1, administrator, ASM #2, director of nursing and ASM #4, regional clinical coordinator, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Are an immediate-release oral formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain where the use of an opioid analgesic is appropriate. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d48c22ff-bbb4-4a93-a35b-6eebff7b8e53

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F 757	Continued From page 165 . (2) Prescription ibuprofen is used to relieve pain, tenderness, swelling, and stiffness caused by osteoarthritis (arthritis caused by a breakdown of the lining of the joints) and rheumatoid arthritis (arthritis caused by swelling of the lining of the joints). It is also used to relieve mild to moderate pain, including menstrual pain (pain that happens before or during a menstrual period). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682159.html.	F 757		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to notify the physician of critical lab results in a timely manner for one of 52 residents in the survey sample, Resident #162.	F 773	Criteria 1 Resident #162 has been discharged from the facility. Criteria 2 All residents have the potential to be affected by the alleged deficient practice.	12/18/22

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F 773	Continued From page 166 The findings include: For Resident #162 (R162), the facility staff failed to act upon critical lab results reported to the facility on 7/8/2022; the facility staff did not report the critical lab results to the physician until 7/9/2022 after R162's family member inquired about them. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/29/2022, the resident scored 4 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. Section I documented R162 having an active diagnosis of anemia. Section O documented R162 receiving transfusions while not a resident of the facility and within the last 14 days. The progress notes documented in part, - "6/24/2022 12:56 (12:56 a.m.) Physician Note. ...[R162] was admitted to [Name of hospital] on 6/18/2022 following ground-level fall. [R162] was found to have a left femoral neck fracture and underwent a left hip hemiarthroplasty. [R162] required 1 unit of packed red cells transfusion..." - "7/7/2022 18:49 (6:49 p.m.) Nurses Notes. Note Text: Patient and family requesting labs due to patient's history of anemia. Practitioner notified and new order received. Husband, [Name of husband] made aware." - "7/9/2022 08:35 (8:35 a.m.) Nurses Notes. Note Text: daughter [Name of daughter] called looking for results on labs, ...HEMOGLOBIN 5.8 g/dL (grams per deciliter) (R162's test result); 12.0-16.0 (normal range); LL (Critical Low) Final... CALL TO PRIMARY : [Name of physician] reported results awaiting orders."	F 773	Criteria 3 The DON/designee will provide in-service education to licensed nurses on timely physician notification of critical lab results. Criteria 4 The DON/designee will conduct lab result audits on weekdays x 4 weeks, monthly x 4 weeks, and monthly x 1 month. On-going compliance will be monitored through routine monitoring. The results of the monitoring will be reviewed at the quality assurance meeting.	

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- "7/9/2022 09:06 (9:06 a.m.) Nurses Notes. Late Entry: Note Text: Guest is going to the ER (emergency room) due to critical labs, Hemoglobin was elevated. Daughter requested for [R162] to be sent to [Name of hospital]. Patient was pale in color did not complain of any pain. Will continue to monitor."

The physician orders for R162 documented in part,
- "CBC (complete blood count) with diff (differential) and BMP (basic metabolic panel) in the next 3 days one time only for anemia for 3 days. Order Date: 07/07/2022."

The laboratory report included in R162's electronic medical record documented a basic metabolic panel and a complete blood count with differential collected on 7/8/2022 at 01:46 (1:46 a.m.), received on 7/8/2022 at 07:25 (7:25 a.m.) and reported on 7/8/2022 at 17:08 (5:08 p.m.). The report documented the critical low Hemoglobin of 5.8 g/dl highlighted in red text and a red stop sign at the top of the report under lab information/Flag. The report legend documented the red stop sign meaning the "report contains critical results (results with red text)."

On 11/2/2022 at 8:08 a.m., an interview was conducted with ASM #7, medical doctor. ASM #7 stated that critical lab results were called to the facility by the lab to the nurse. ASM #7 stated that the nurses called the physician or nurse practitioner on call regarding the labs. ASM #7 stated that they did not recall staff contacting them about critical labs but the documentation stated that they did on 7/9/2022.

On 11/2/2022 at approximately 10:40 a.m., ASM

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(administrative staff member) #2, the director of nursing stated that the LPN (licensed practical nurse) who obtained the lab results after the daughter called for them on 7/9/2022 no longer worked at the facility and could not be interviewed. ASM #2 stated that the LPN who sent R162 to the emergency room on 7/9/2022 was not working and provided a phone number to contact them. Attempts were made to reach the LPN with no answer and the voice mail full.

On 11/2/2022 at 2:57 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated that they had spoken with R162's family member when they requested to have lab work done due to their history of anemia. RN #3 stated that they had contacted the physician and relayed the request from the family and received an order for routine lab work. RN #3 stated that the lab work was not ordered as stat (right away) but ordered to be done within the next 3 days. RN #3 stated that R162's lab work was ordered on 7/7/2022 and drawn the next day. RN #3 stated that they contracted an outside lab for blood work which sent a phlebotomist in early in the morning to draw the blood. RN #3 stated that the lab called the facility and spoke to the nurse with any critical lab results. RN #3 stated that when the nurse received critical lab results over the telephone from the lab they should verify the lab value with the lab, obtain their name, notify the physician or nurse practitioner, notify the responsible party and document everything in the medical record.

On 11/3/2022 at 8:11 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that an outside lab came to the facility to draw the blood early on the night shift.

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LPN #7 stated that there was a lab book kept at each nurses station documenting what lab work needed obtaining that the lab staff member used. LPN #7 stated that the nurse assisted the lab member with verifying the resident name and date of birth as needed. LPN #7 stated that the routine lab work was drawn the next draw after the order was placed. LPN #7 stated that if there were any critical lab results that the lab called the facility and notified the nurse who called the doctor or the nurse practitioner to report it.

On 11/3/2022 at 11:00 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that they had received a phone call on 7/9/2022 which was a Saturday saying that R162's daughter was irate because there were labs drawn and the results had not been called to the physician. ASM #2 stated that they had been informed of the critical hemoglobin and advised the nurse to send the resident to the hospital for evaluation and contacted the nurse practitioner. ASM #2 stated that they had investigated and discovered that the labwork had been drawn the day before and resulted the same day around 5:00 p.m. ASM #2 stated that they had found out that a nurse had notified the former ADON (assistant director of nursing) of the critical lab result on 7/8/2022 and the physician or nurse practitioner were not notified. ASM #2 stated that they had educated the nurses on the units regarding prompt physician notification of critical lab results and completed a 30 day audit of labs to ensure that all results had been reviewed by the physician and/or the nurse practitioner.

On 11/3/2022 at 12:23 p.m., an interview was conducted with LPN #8. LPN #8 stated that critical lab results were called to the facility to the

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F 773	Continued From page 170 nurse. LPN #8 stated that any critical labs were to be called to the physician immediately. On 11/3/2022 at 12:27 p.m., an interview was conducted with RN #2. RN #2 stated that the lab called any critical results to the facility to the nurse. RN #2 stated that the critical labs should be called to the physician immediately. On 11/3/2022 at 3:26 p.m., ASM #2 stated that they were unable to find evidence of the education that they had completed regarding the notification of critical lab results. On 11/3/2022 at 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the above concern. No further information was presented prior to exit. Complaint deficiency.	F 773		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		12/18/22

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F 812	Continued From page 171 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to serve food in a sanitary manner in one of one resident dining rooms. The findings include: The facility staff failed to keep their thumbs from touching the food surfaces of the resident's plates while serving the resident's lunch in the second-floor dining room. On 10/31/2022 at approximately 12:30 p.m., an observation of the second-floor dining room was conducted. CNA (certified nursing assistant) #1 was observed with gloved hands sorting resident meal tickets on top of the ice chest, then placing the meal ticket on top of the steam table and placing their open gloved hands on top of the steam table. CNA #1 was then observed placing their thumb on the surface edge resident lunch plates when serving them to eight residents. On 10/31/2022 at approximately 1:45 p.m., an interview was conducted with CNA #1. When asked why they wore gloves when serving the resident's lunch that day CNA #1 stated that they were told to wear them. After informed of the above observation CNA #1 stated that they should have not placed their hand on the ice chest and steam table surfaces and that they	F 812	Criteria 1 No negative outcome was associated with the deficient practice. Criteria 2 All residents have the potential to be affected by this practice. Criteria 3 The DON/designee will provide in-service education to the nursing staff on the procedure for serving meals in a sanitary manner. Criteria 4 Dining room observations will be completed 3 times per week x 4 weeks, weekly x 4 weeks, and monthly x 1 month. Additional education and/or counseling will be provided as needed. On-going compliance will be monitored through routine monitoring. The results of the monitoring will be reviewed at the quality assurance meeting.	

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F 812	Continued From page 172 should have placed their hands on the bottom of the resident's plate to prevent their thumb from touching the surface edge of the plates. On 11/02/2022 at approximately 5:00 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #4, regional clinical coordinator were made aware of the above findings. No further information was provided prior to exit.	F 812		
F 839 SS=D	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and employee record review, it was determined that the facility staff failed to evidence maintenance of required certification for one of five CNAs (certified nursing assistants), CNA #7. The findings include: The facility staff failed to provide evidence of required certification for one of five CNAs that were employed for greater than one year, CNA #7.	F 839	Criteria 1 The identified Nurse Aide has a current license on file. Criteria 2 All licensed staff have the potential to be affected by this practice. An audit has been completed to ensure that all licenses are current, and the current license is on file. Corrections were made as needed. Criteria 3 Administrative Nurses, or designee will	12/18/22

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F 839	Continued From page 173 During the Sufficient and Competent Staffing facility task review on 11/2/22 at 2:00 PM, CNA #7's employee record contained a certification verification from the Virginia Department of Health Professions on 5/27/22. CNA #7 was hired on 12/17/20. There was no evidenced of CNA certification verification prior to 5/27/22. On 11/2/22 at 4:15 PM, an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked who is responsible for pulling certifications, ASM #2 stated, "The staffing and scheduling coordinator and unit managers are responsible for pulling the certifications. I have not followed behind to make sure it is being done." On 11/3/22 at 3:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the findings. According to the ASM #1, the administrator, there is no facility policy regarding CNA certification verification. No further information was provided prior to exit.	F 839	provide in-service education to Payroll staff on the requirement of maintaining copies of current licenses on file. Criteria 4 The Payroll Department will provide monthly tracking of licenses expiration dates to appropriate department managers for license follow-up. The tracking long will be 3 times per week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month, with corrective action taken when necessary. On-going compliance will be monitored through routine license audits. The results of the audits will be reviewed at the quality assurance meeting. Additional education and monitoring will be initiated for any identified concerns.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		12/18/22

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F 842	Continued From page 174 to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §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	F 842		

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F 842	Continued From page 175 (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, facility document review and clinical record review, it was determined the facility staff failed to maintain a complete and accurate clinical record for two of 52 residents in the survey sample, Residents #6 and Resident #58. The findings include: 1. For Resident #6 (R6) the facility failed to document on the TAR (treatment administration record) the fluids provided to R6; and the CNAs (certified nursing assistants) failed to document the fluids consumed during the meals. On the most recent MDS (minimum data set) assessment, a quarterly assessment with an assessment reference date of 10/4/2022, coded the resident as scoring a 15 out of 15, indicating the resident is not cognitively impaired for making	F 842	Criteria 1 Fluid intake is now being recorded properly, with no negative impact to resident #6. Resident #58 has been seen by the physician and has no additional concerns. Criteria 2 All residents receiving fluid restrictions have the potential to be affected by these practices. A physician visit audit has been completed, with needed visits completed. Criteria 3 The DON/administrative nurse will conduct in-service education to nursing staff on documentation of fluid-restricted diets, and the Medical Records Coordinator will receive education on	

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F 842	Continued From page 176 daily decisions. R6 has a diagnosis of congestive heart failure (CHF). The physician order dated, 9/27/2022, documented, "Fluid restriction - 1800 ml (milliliters) - for nursing - 300 ml 7-3 (7:00 a.m. to 3:00 p.m. shift), 300 ml for 3-11 (3:00 p.m. to 11:00 p.m.) and 120 ml for night (11:00 p.m. to 7:00 a.m.) every shift." Review of the TAR for September 2022 documented the above physician order. On the following days, the blocks to document the consumed fluids were blank: 9/28/2022 for 3-11 (3:00 p.m.. to 11:00 p.m.) shift. Review of the TAR for October 2022 documented the above physician order. On the following days, the blocks to document the consumed fluids were blank: 10/2/2022 for the 3-11 shift 10/3/2022 for the 7-3 (7:00 a.m. to 3:00 p.m.) shift 10/11/2022 for the 3-11 shift 10/21/2022 for the 7-3 shift 10/30/2022 for the 3-11 shift. Review of the CNA documentation for October 2022, documented the fluids taken during a meal except on the following dates, the blocks were empty for meal consumption and fluid intake: 10/2/2022 - dinner 10/3/2022 - breakfast, lunch and dinner 10/4/2022 - dinner 10/5/2022 - breakfast and lunch 10/6/2022 - breakfast and lunch 10/7/2022 - dinner 10/9/2022 - breakfast and lunch 10/10/2022 - breakfast and lunch 10/11/2022 - breakfast and lunch	F 842	required physician visits. Criteria 4 Administrative Nurses will audit the MAR for residents on a fluid-restricted diet daily and CNA intake records for documentation of fluid intake, and corrections will be made as identified. The audits will be completed on weekdays x 4 weeks, then weekly for 4 weeks, then monthly for one month. Additional training and/or corrective actions will be completed as needed. On-going compliance will be monitored through routine monitoring. The results of the monitoring will be reviewed at the quality assurance meeting. Additional education and monitoring will be initiated for any identified concerns.	

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10/12/2022 - breakfast, lunch and dinner
10/13/2022 - breakfast and lunch
10/14/2022 - breakfast, lunch and dinner
10/15/2022 - breakfast and lunch
10/16/2022 - breakfast, lunch and dinner
10/19/2022 - dinner
10/20/2022 - breakfast and lunch
10/22/2022 - breakfast, lunch and dinner
10/23/2022 - breakfast, lunch and dinner
10/24/2022 - breakfast and lunch
10/26/2022 - lunch and dinner
10/27/2022 - breakfast and lunch
10/28/2022 - breakfast, lunch and dinner
10/29/2022 - breakfast, lunch and dinner
10/30/2022 - breakfast, lunch and dinner
10/31/2022 - breakfast, lunch and dinner

Review of the CNA documentation for November 2022, documented the fluids taken during a meal except on the following dates, the blocks were empty for meal consumption and fluid intake:
11/1/2022 - breakfast, lunch, and dinner
11/2/2022 - breakfast, lunch, and dinner.

The above documentation was shared with ASM (administrative staff member) #2, the director of nursing, on 11/3/2022 at 10:52 a.m. When asked what the blanks on the TAR and the CNA documentation indicate, ASM #2 stated, nobody documented. Should there be documentation, ASM #2 stated, yes.

The facility policy, "Medical Records Management" documented in part, "Policy: The facility must maintain medical records on each guest/resident, in accordance with accepted professional standards and practice and state and federal law. Medical records must be complete, accurately documented, readily

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accessible, systematically organized and maintained in a safe and secure environment."

ASM #1, the administrator, ASM #2, and ASM #4 the regional clinical coordinator, were made aware of the above concern on 11/3/2022 at 4:30 p.m.

No further information was provided prior to exit.
2. For Resident #58 (R58), the facility failed to maintain a complete and accurate medical record.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/8/2022, the resident scored 11 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were moderately impaired to make daily decisions.

On 11/1/2022 at 8:28 a.m., an interview was conducted with R58. R58 stated that they did not see the physician often and wanted to speak with them regarding their prostate. R58 stated that they did not remember the last time they saw their doctor.

Review of R58's clinical record documented a physician 60-day recertification note dated 7/20/2022.

Further review of R58's clinical record failed to evidence any physician or nurse practitioner progress notes between 7/21/2022-11/3/2022.

On 11/3/2022 at 8:50 a.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated

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that physician's saw residents at the facility alternating with the nurse practitioners per the regulations every 60 days. ASM #1 stated that they would look into R58 not having a physician or nurse practitioner progress note between 7/21/2022-11/3/2022.

On 11/3/2022 at approximately 10:45 a.m., ASM #1 provided a printed document of progress notes for R58 from the nurse practitioner for visits on 8/30/2022, 9/7/2022, 9/26/2022, 10/5/2022, 10/10/2022, 10/19/2022, and 10/24/2022. Review of the progress notes in R58's electronic medical record all documented "Late Entry" with a "Created Date: 11/3/2022."

On 11/3/2022 at 11:00 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that R58's nurse practitioner writes their progress notes in their system and then transfers them over to R58's medical record at the facility. ASM #2 stated that the progress notes provided were added to the record that morning and prior to that the record was not complete.

The facility policy "Medical Records Management" last revised 1/31/2022, documented in part, "...A complete medical record contains an accurate and functional representation of the guest's/resident's actual experience in the facility. The electronic medical record is defined as containing the following items: ...Any document that has been scanned and attached to the resident's electronic medical record (i.e. physician consults, laboratory and diagnostic reports, history and physicals). The medical record must contain enough information to show that the facility knows the status of the

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F 842	Continued From page 180 guest/resident, has adequate plans of care, and provides sufficient evidence of the effects of care provided..." On 11/3/2022 at 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the above concern. No further information was provided prior to exit.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		12/18/22

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but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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F 880	Continued From page 182 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain an effective infection control program in 5 of 14 rooms; and one of ten staff members failed to wear PPE (personal protective equipment) per facility protocol. The findings included: 1. The facility staff failed to wash hands after doffing (removing) PPE (personal protective equipment) in transmission-based precaution isolation rooms during meal tray delivery to 5 of 14 rooms in the survey sample. On 10/31/2022 at 12:23 p.m., an observation was made of staff delivering meal trays to residents in rooms on the first floor of the facility. - At 12:34 p.m., CNA (certified nursing assistant) #9 was observed outside of Room 112 wearing a mask and donning a faceshield, gown, and gloves. CNA #9 was observed to take a meal tray off of the cart in the hallway and take it into Room 112 to the resident. CNA #9 doffed the gown and gloves at the door and disposed of them in the trash can in the resident room. CNA #9 then closed the door to the room and proceeded to the meal cart. CNA #9 failed to wash or sanitize their hands. - At 12:37 p.m., CNA #9 was observed outside of Room 111 wearing a mask and a faceshield, and donning a gown, and gloves. CNA #9 was observed to take a meal tray off of the cart in the hallway and take it into Room 111 to the resident. CNA #9 doffed the gown and gloves at the door and disposed of them in the trash can in the	F 880	Criteria 1 There was no negative outcome from these deficient practices. Criteria 2 Upon notification, facility rounds were completed to ensure that the proper mask was being used and that proper sanitation was observed between residents on isolation precautions. Criteria 3 The DON/designee will provide in-service education to all nursing staff on the correct mask to utilize and the hand washing procedure to be used after doffing PPE. Criteria 4 Facility rounds will be conducted 3 times per week x 4 weeks, weekly x 4 weeks, then monthly for 1 month to ensure proper mask usage and hand washing. On-going compliance will be monitored through routine monitoring. The results of the monitoring will be reviewed at the quality assurance meeting. Additional education and monitoring will be initiated for any identified concerns.	

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resident room. CNA #9 then closed the door to the room and proceeded to the meal cart. CNA #9 failed to wash or sanitize their hands.
- At 12:40 p.m., CNA #9 was observed outside of Room 110 wearing a mask and a faceshield, and donning a gown, and gloves. CNA #9 was observed to take a meal tray off of the cart in the hallway and take it into Room 110 to the resident. CNA #9 doffed the gown and gloves at the door and disposed of them in the trash can in the resident room. CNA #9 then proceeded to the meal cart. CNA #9 failed to wash or sanitize their hands.
- At 12:43 p.m., CNA #9 was observed outside of Room 113 wearing a mask and a faceshield, and donning a gown, and gloves. CNA #9 was observed to take a meal tray off of the cart in the hallway and take it into Room 113 to the resident. CNA #9 doffed the gown and gloves at the door and disposed of them in the trash can in the resident room. CNA #9 then closed the door to the room and proceeded to the meal cart. CNA #9 failed to wash or sanitize their hands.
- At 12:46 p.m., CNA #9 was observed outside of Room 115 wearing a mask and a faceshield, and donning a gown, and gloves. CNA #9 was observed to take a meal tray off of the cart in the hallway and take it into Room 115 to the resident. CNA #9 doffed the gown and gloves at the door and disposed of them in the trash can in the resident room. CNA #9 then closed the door to the room and proceeded to the meal cart. CNA #9 failed to wash or sanitize their hands.

Observation of the doors of rooms 112, 111, 113 and 115 all documented "Droplet and Contact Precautions (1)." A sign posted on the doors documented in part, "Droplet and Contact Precautions, Wash hands before entering and

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when leaving room, Clean hands with A) Hand Sanitizer or B) soap and water..."

On 10/31/2022 at 12:48 p.m., an interview was conducted with CNA #9. CNA #9 stated that residents on droplet and contact precautions required the mask, faceshield, gown and gloves prior to going in the room and they removed the gown and gloves prior to exiting the room. CNA #9 stated that there were trash cans in the rooms to dispose of the PPE after they removed it. CNA #9 stated that handwashing should be performed every time they leave any residents room. CNA #9 stated that they normally kept hand sanitizer in their pocket and did not have it with them.

On 11/2/2022 at 10:22 a.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that handwashing was done prior to entering and exiting a residents room and after removing gloves. LPN #5 stated that this was done to prevent the spread of infection.

The facility policy, "Hand Hygiene" last revised 9/9/2022 documented in part, "Hand washing/hand hygiene is generally considered the most important single procedure for preventing healthcare-associated infections...Hand hygiene should be performed: Before and after contact with the guest/resident; ...After removing personal protective equipment (e.g., gloves, gown, facemask);..."

On 11/02/2022 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were informed of these concerns.

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F 880	Continued From page 185 No further information was provided prior to exit. Reference: (1) "Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient ' s environment as described in I.B.3.a. The specific agents and circumstance for which Contact Precautions are indicated are found in Appendix A. The application of Contact Precautions for patients infected or colonized with MDROs is described in the 2006 HICPAC/CDC MDRO guideline.927 Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission. A single-patient room is preferred for patients who require Contact Precautions. When a single-patient room is not available, consultation with infection control personnel is recommended to assess the various risks associated with other patient placement options (e.g., cohorting, keeping the patient with an existing roommate). In multi-patient rooms, =3 feet spatial separation between beds is advised to reduce the opportunities for inadvertent sharing of items between the infected/colonized patient and other patients. Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient ' s environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through	F 880		

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environmental contamination (e.g., VRE, C. difficile, noroviruses and other intestinal tract pathogens; RSV)." This information is taken from the website https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html#IIIb.

2. Licensed Practical Nurse (LPN) #2 did not wear the appropriate face mask per facility protocol during medication administration on 10/31/22 at 4:10 AM.

Upon entry to the facility on 10/31/22 at approximately 11:00 AM, ASM (administrative staff member) #1, the administrator stated, "We are all wearing N95 face masks when we are in the patient units. We have four COVID positive residents and residents on observation."

Observations on day shift 10/31/22, night shift 11/1/22, day/evening/night shift 11/2/22 and day/night shift on 11/3/22 evidenced staff wearing N95 masks except for one LPN on the evening shift, on 10/31/22.

On 10/31/22 at 4:10 PM, LPN (licensed practical nurse) #2 was observed administering medications. The room LPN #2 was in was identified as an enhanced isolation room. LPN #2 was observed wearing a surgical mask. Upon exit from room, LPN #2 was asked what face masks they were required to wear in patient areas, LPN stated, it keeps changing. We have some Covid positive residents so I believe it is a N95 mask. When asked if she had been informed of what mask to wear, LPN #2 stated, "Yes, the N95. I have one in the car. I will go get it now."

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F 880	Continued From page 187 An interview was conducted on 11/2/22 at 7:30 AM with ASM #2, the director of nursing. When asked what PPE is to be worn in a resident's room with enhanced precautions, ASM #2 stated, Enhanced precautions are used with anyone with wound or other infections, then we do enhanced precautions, if going to perform care the staff must wear complete PPE (personal protective equipment). If it is just an interview, then just wear the N95 mask." On 11/3/22 at 3:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the findings. No further information was provided prior to exit.	F 880		
F 887 SS=D	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	F 887		12/18/22

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F 887	Continued From page 188 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 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:	F 887		

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F 887	Continued From page 189 Based on clinical record review, staff interview, facility document review, and in the course of a complaint investigation, it was determined the facility staff failed to offer and/or administer the COVID-19 vaccination to one of 9 residents reviewed for immunizations in the survey sample, Resident #162. The findings include: For Resident #162 (R162), the facility staff failed to offer the COVID-19 (1) vaccination after admission to the facility or document a contraindication for not offering the vaccination. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/29/2022, the resident scored 4 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. The comprehensive care plan for R162 documented in part, "COVID-19, [R162] has the potential for developing COVID-19 infection r/t (related to) current pandemic, Has diagnosis of dementia/Alzheimer's with decreased safety awareness and is unable to understand the need for a mask. Date Initiated: 06/23/2022. Revision on: 07/20/2022." The nursing comprehensive evaluation for R162 dated 6/22/2022 on admission to the facility documented in part, "...Resident/Guest COVID-19 Vaccine Status: Partially vaccinated, received only 1 of 2 doses. Type of COVID-19 vaccine (i.e. Moderna, Pfizer-BioNTech, Janssen) and dates received: Pfizer 1.17.22..." The assessment was completed by the former	F 887	Criteria 1 Resident #162 was discharged from the facility. Criteria 2 All residents have the potential to be impacted by this practice. An audit of immunization records for all residents has been completed, and vaccines have been offered/given as indicated. Criteria 3 The DON/designee will provide in-service education to the nursing staff on the procedure for offering vaccines on a timely basis. Criteria 4 An audit will be completed 3 times per week x 4 weeks, weekly for 4 weeks, then monthly x 1 month. Any omissions will be corrected at that time. On-going compliance will be monitored through routine monitoring. The results of the monitoring will be reviewed at the quality assurance meeting. Additional education and monitoring will be initiated for any identified concerns.	

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assistant director of nursing (ADON).

The clinical record further documented a printed copy of the Virginia Immunization Information System dated 6/22/22 for R162 which documented the resident receiving dose 1 of 2 of the Pfizer COVID-19 Vaccine (2) on 1/17/2022. It further documented R162 with a recommended date of 2/3/2022 and a past due date of 3/14/2022 for the COVID-19 Vaccine.

The clinical record failed to evidence documentation of the COVID-19 vaccine being offered during R162's stay at the facility or a contraindication for not offering the vaccine to them.

On 11/2/2022 at approximately 8:00 a.m., a request was made via written list to ASM (administrative staff member) #1, the administrator for evidence of the COVID-19 vaccine being offered and/or administered to R162.

On 11/2/2022 at 10:40 a.m., ASM #1 stated that they did not have evidence to provide of the facility offering or administering the COVID-19 vaccine to R162 and/or their responsible party.

On 11/3/2022 at 11:00 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that the former ADON was responsible for resident COVID-19 vaccination when R162 resided at the facility and no longer worked there. ASM #2 stated that new admissions were assessed for vaccination status and offered the vaccine if it was due. ASM #2 stated that R162 should have been offered the COVID-19 vaccine when they were admitted to

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the facility.

According to Centers for Disease Control, documented in part, "...People ages 12 years and older, especially those at higher risk of myocarditis associated with mRNA COVID-19 vaccines, may receive the second primary dose of the COVID-19 vaccine by Pfizer BioNTech 3-8 weeks after the first primary dose. The second dose should not be received earlier than 3 weeks after the first dose. People ages 12 years and older who recently had SARS-CoV-2 infection may receive a second primary dose after a deferral period of 3 months from symptom onset or positive test (if infection was asymptomatic). (3)

The facility policy, "Guests/Resident COVID-19 Vaccination" dated "effective 9/12/2022" documented in part, " ...All new and re-admissions will be evaluated by the nurse and/or physician for previous immunization and will be offered the vaccine if appropriate and available." The policy further documented, " ...The vaccine administrator will identify guests/residents that would qualify to receive the additional dose or booster dose of COVID-19 Vaccine. This can be accomplished by: Review of medical record for copy of vaccine card, state immunization report or documentation of administration of COVID-19 Vaccine ..."

On 11/3/2022 at 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the above concern.

No further information was presented prior to exit.

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F 887	Continued From page 192 Complaint deficiency. Reference: (1) COVID-19 COVID-19 is caused by a coronavirus called SARS-CoV-2. Coronaviruses are a large family of viruses that are common in people and may different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people. This occurred with MERS-CoV and SARS-CoV, and now with the virus that causes COVID-19. The SARS-CoV-2 virus is a betacoronavirus, like MERS-CoV and SARS-CoV. All three of these viruses have their origins in bats. The sequences from U.S. patients are similar to the one that China initially posted, suggesting a likely single, recent emergence of this virus from an animal reservoir. However, the exact source of this virus is unknown. This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/faq.html#How-COVID-19-Spreads (2) Pfizer COVID-19 vaccine On August 23, 2021, FDA announced the first approval of a COVID-19 vaccine. The vaccine has been known as the Pfizer-BioNTech COVID-19 Vaccine, and the approved vaccine is marketed as Comirnaty, for the prevention of COVID-19 in individuals 12 years of age and older. Comirnaty is a monovalent COVID-19 vaccine that is approved for use as a two-dose primary series for the prevention of COVID-19 in individuals 12 years of age and older. It is also authorized for emergency use to provide a third primary series dose to individuals 12 years of age and older with certain kinds of	F 887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

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F 887	Continued From page 193 immunocompromise. This information was obtained from the website: https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccines (3) This information was obtained from the website: https://www.cdc.gov/vaccines/covid-19/eui/downloads/Pfizer-Caregiver.pdf.	F 887		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and employee record review, it was determined that the facility staff failed to provide annual	F 947	Criteria 1 The identified associate has now completed the required education.	12/18/22

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F 947	Continued From page 194 required training for one of five CNAs (certified nursing assistants). The findings include: The facility staff failed to provide the required mandatory training for abuse, neglect and dementia training for one of five CNAs that were employed for greater than one year, CNA #6. During the Sufficient and Competent Staffing facility task review conducted on 11/2/22 at 2:00 PM, there was no evidence of mandatory training for CNA #6. CNA #6 had a date of hire of 10/20/20, there was no evidence of dementia or abuse training. An interview was conducted on 11/2/22 at 4:00 PM with ASM #1, the administrator. When asked for the education record for CNA #6, ASM #1 stated, we do our training in the Relias system but evidently this CNA did not complete their education this year. On 11/3/22 at 3:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the findings. A review of the facility's policy "Staff Development" policy dated 4/2022, revealed, "The annual training schedule should include programs relating to but not limited to: fire prevention and safety, emergency disaster procedures and drills, infection prevention, chemical hazards, quality assessment performance improvement, compliance program, resident rights and responsibilities, care program, abuse prohibition, areas of weakness identified	F 947	Criteria 2 All Nurse Aides have the potential to be affected by this practice. An audit has been completed on the required dementia/abuse training for CNAs. All associates are now current in this required training. Criteria 3 The DON/RCC will provide in-service education to the ADON on the monitoring of staff training to ensure requirements are met. Criteria 4 An audit will be completed monthly x 3 months to ensure that required in-service education is completed. Any variances will be corrected with additional training and/or corrective action provided. On-going compliance will be monitored through routine monitoring. The results of the monitoring will be reviewed at the quality assurance meeting. Additional education and monitoring will be initiated for any identified concerns.	

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F 947	Continued From page 195 inn nurse aide performance reviews, special guest/resident needs, dementia care and quality of care problems." No further information was provided prior to exit.	F 947		