STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MOUNT VERNON HEALTHCARE CENTER	8111 TISWELL DRIVE ALEXANDRIA, VA 22306

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{E 000}	Initial Comments An unannounced Emergency Preparedness revisit to the standard survey conducted 09/12/22 through 09/16/22 and 09/19/22 through 9/22/22, was conducted 01/04/23 through 01/11/23. The facility was in compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 09/12/22 through 09/16/22 and 09/19/22 through 9/22/22, was conducted 01/04/23 through 01/11/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Five (5) complaints were investigated during the survey. VA00057373-unsubstantiated. VA00056976-substantiated with deficient practice. VA00056771-substantiated with deficient practice. VA00056290-substantiated with deficient practice. VA00056280-substantiated with deficient practice. The census in this 130 certified bed facility was 110 at the time of the survey. The survey sample consisted of 33 Resident reviews.	{F 000}	This Center is submitting this plan of correction to comply with applicable laws, not as an admission or statement of agreement with the alleged deficiencies herein. To remain compliant with all federal and state regulations, the Center has taken the actions set forth in the following plan of correction. This plan of corrections constitutes the Center's allegation of compliance such that all alleged deficiencies have been or will be corrected by dates indicated.	
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:	F 553		

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

2/3/23

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

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F 553	Continued From page 1 (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, facility documentation and in the course of an investigation the facility staff failed to ensure the Resident's right to participate in the development and implementation of his person centered care process for one Resident (Resident #168) in a sample size of 33 Residents. The findings included:	F 553	1. Executive Director (ED) met with res. #168 to review interdisciplinary team members (IDT) involved in his care, incl. unit manager, social service staff, activity staff, dietary manager, and attending physician. Name and contact of each discipline were left with resident. ED reviewed facility care plan process with resident, to include providing res. and his representative (RP) sufficient notice of care plan and IDT meetings. 2. Residents residing in facility have the potential to be affected. Care plan mtg. standards will be provided to residents and their RP by facility through written notice and resident council. 3. Executive Director will in-service IDT of facility care plan meeting process to assure care plan meeting invitation are completed and sent to res. and RP with sufficient notice. IDT in-service will include making sure individuals are identifying their roles in the planning process; prior to the start of the meetings. 4. Social Service Director or designee will provide Administrator care plan mtg. schedules weekly, to include documentation of notices given to resident and their RP. Care plan schedule and notification will be audited by the Executive Director weekly x 4, then monthly x 3. Audit findings will be discussed in the Quality Assurance Performance Improvement (QAPI) meetings monthly x 4.	2/10/23

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F 553	Continued From page 2 For Resident #168 the facility staff failed to allow the Resident to identify individuals or roles to be included, and failed to inform him of meeting to discuss care plan. On 1/6/23 a review of the clinical record revealed that the Resident was seen by the Psychiatrist (Employee J) on 12/1/22 and the Psychiatrist entered the following orders in Resident #168's clinical record. "Physicians Progress Note 12/1/22" " -Continue same meds. -PT [patient] needs to attend treatment plan with facility Administration to address behavioral concerns. -Pt will be referred to psychotherapy " On 12/2/22 the following nursing note was entered: " 12/2/2022 10:13 Nurses Note : Resident refused to be seen by MD [Psychiatrist name redacted] psychogeriatric services. PSG [sic] [PGS=Psychogeriatric Services] recommendation, Pt. needs to attend treatment plan meeting with facility administration to address behavioral concerns, Pt. will be referred for psychotherapy. resident self RP/mother [name redacted] notify [sic] all risk and benefit explained with verbalization of understanding consented all question answered at this time. " On 12/6/22 the social worker entered the following note: " 12/6/2022 4:13 PM Social Services Note : This writer made aware on Thursday 12/8 at 2pm	F 553		

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F 553	Continued From page 3 psychogeriatric doctor requesting a IDT meeting to be held with resident. " There is no documentation stating that the Resident or family member was made aware of this meeting. The next note in the Resident record is 12/8/22 was recorded in the progress note as follows: " 12/8/2022 16:00 Social Services Note: This writer, psych doctor, resident, unit manager and social services assistant met with resident. Psych-doctor advise resident he don't require a 1:1 due to him not being suicidal, fall risk etc. Resident became upset stating "I'll call the state". Psych-doctor suggest speaking to i.e. unit manager, social services director or the supervisor if the staff he is reaching out to are not responding timely and to not assume the staff is ignoring him. Resident proceeded to call the state and spoke to a person via phone in front of the IDT and verbalize he is being bombarded by his psych doctor, unit manager and 4 or 5 other people. Patient also verbalize he want it to be known he is being harrassed [sic] and he is willing to meet with the state and do not want the psych-doctor to be his doctor. Meeting concluded with the psych-doctor recommending the IDT to meet with resident weekly." On 1/5/23 at 11:00 AM, an interview was conducted with Resident #168 who stated that on 12/1/22 he had a meeting with the psychiatrist and they really didn't talk about much. After the meeting with the psychiatrist he told the nursing staff he did not want to see him (the psychiatrist) again. He stated he wanted "talk therapy" and did not need the psychiatrist for that. The nurse	F 553		

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F 553	Continued From page 4	F 553		

entered that information into the clinical record on 12/2/22. The Resident stated that on 12/8/22 the social worker told him he would be meeting with the psychiatrist that day at 2 pm. He stated that he was under the impression it would be a therapist not the psychiatrist he had told them he did not want to see. Resident #168 stated that when 6 people walked into his room he was feeling like "They were ganging up on me." Resident #168 stated that he felt like it was harassment and he called the State Agency (OLC) to complain. He stated that he called the OLC while everyone was in his room. He said "They look at me as a problem because I will call state and the Ombudsman. Its my life its my care; and my health should be a priority. It is my right to complain if there is a problem."

On 1/6/23 a telephone interview was conducted with the Psychiatrist and he was asked about the meeting on 12/1/22 he stated that he introduced himself got background information and medication information and his history and physical, and spoke with the Resident. He told him they would be having psychotherapy services starting soon and the Resident seemed interested in those services. He stated that he did not make any changes to his medications because he seemed stable on the meds and dosages he was currently on.

When asked how the second meeting came about he said, "I was told by the nursing home staff that they are having a lot of challenges dealing with him, it is difficult to address all of his needs, for that reason, they have put a care giver across from his room, like 1:1 so his needs can be met. Usually 1:1 is placed when the patient is actively suicidal or may hurt someone or have

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physical disability that if they were to stand they would fall. [Resident name redacted] gets upset if he rings the bell and there is a delay he gets upset calls the Dept of Health and Ombudsman, so therefore my impression that the nursing home was trying their best to make sure his needs are met right away with no delay. The nursing home was feeling overwhelmed and didn't know how to meet his needs, what should be the treatment plan, etc. therefore I suggested a meeting, because I can't prescribe a medication and he will magically become pleasant. I told them it is not going to be an easy fix, I am not a magician, I can't come and immediately find a fix and everyone will be happy. He is someone you can have a meaningful conversation with, he understands what is happening around him. You have to sit down with them and have a dialogue."

"The nursing home admin was very apprehensive, it was like they have a sword hanging on their heads, they are afraid because of the complaints, and they are very scared. I said we have to do something, we can have a treatment plan and that is why the treatment plan conference was scheduled. When I arrived the DON was there, the social worker was there, unit manager and we all went into his room, it was a scheduled meeting. After seeing us he became apprehensive and asked why we were ganging up on him. We said just a conference where we can all meet. He said he wanted to complain and asked if we were going to stop him from complaining and we said no, he picked up the phone and called and talked to someone, said he was in [the facility]; they seemed to know him by name, there was not too much introduction. He said they are all in my room I want to make this complaint. "

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F 553	Continued From page 6 The Psychiatrist was asked if Resident #168 had bipolar disorder and he confirmed the diagnosis. He was asked if it was possible the Resident felt threatened by so many people in the room at once? The Psychiatrist said, "My impression was he that he was not afraid or threatened, he might have been surprised, he might not have been expecting this conference take place." A review of the clinical record revealed the following entry by the social worker: " 11/29/2022 12:07 PM -SocialServicesNote: This writer spoke with resident to remind him of his care plan meeting schedule for 11/30 at 2:30pm. Resident thanked this writer for stopping by." On the afternoon of 1/6/23 a telephone interview was conducted with the social worker, who was asked if it was usual practice to document patient notification of IDT meetings as she did on 11/29/22 and she stated that it was. She stated that she found out about the meeting on 12/6/22 and she verbally notified the Resident. When asked if she notified his mother she stated that she did not. On 1/10/22 during the end of day meeting the Administrator was made aware of concerns and no further information was provided.	F 553		
{F 569} SS=D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits-	{F 569}		

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{F 569}	Continued From page 7 (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and financial record review, the facility staff failed to convey within 30 days following discharge Resident funds that were deposited within the facility for one Resident (Resident #105) in a survey sample of 33 Residents. The findings included: For Resident #105, who discharged from the facility on 2/1/22, the facility staff didn't convey the funds to the Resident within 30 days of discharge. On 1/4/23, the regional mobile business office manager (BOM) (Employee E) provided Surveyor C with a listing of Resident trust account balances on 11/13/22, and on 1/4/22. Review of this document revealed that on 11/13/22, Resident	{F 569}	1. Facility verified resident #105 has received refund from trust fund balance owed on 1/31/23 at current facility. 2. BOM or designee will audit residents' discharged in the previous 1 year to ensure conveyance of funds were sent to the resident or probate jurisdiction administering the residents' estate within 30 days. Issues identified will be immediately corrected. 3. Division Director of Revenue Cycle will educate Business Office Manager on the process to timely reconcile and convey funds within 30 days of resident discharge. 4. Executive Director will audit residents' discharged to ensure timely reconciliation and conveyance of funds is made in 30 days of discharge. Audit will be conducted weekly x 4, then monthly x 3, then quarterly x 3. Audit findings will be reviewed by QAPI monthly.	2/10/23

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{F 569}	Continued From page 8	{F 569}		

#105 had a trust fund account balance of $2,560.55.

Review of the clinical record revealed Resident #105 discharged from the facility on 2/1/22.

On 1/5/23, the BOM was asked to provide a transaction history of the Resident's trust fund account. Review of this document revealed that the trust account was not closed until 11/29/22. A copy of the check written revealed that the check was not written until 12/5/22. The check was then mailed to this same facility, where the Resident was no longer a Resident.

On 1/5/23 at 11:51 AM, an interview was conducted with the BOM. When asked she indicated that accounts are to be closed and funds sent to the Resident or their estate within 30 days of discharge. When asked why Resident #105's account funds were not disbursed until 10 months after discharge, she said she was not aware of why the delay. The Regional Business office manager was able to confirm that the check was initially mailed to this facility and then had to be forwarded to the facility where he was a current resident. The envelope was post marked 12/14/22. When the facility mailed it to the other nursing facility where the Resident was, it got returned to this facility. As a result, as of 1/5/23, the Resident was still not in receipt of the funds.

On 1/5/23 at approximately 2:30 PM, the business office manager reported to Surveyor C that she had called the other nursing facility and confirmed that the Resident lives there and would be mailing the check out again.

On 1/10/23 at 9:45 AM, an interview was

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{F 569}	Continued From page 9 conducted with the Regional Business office manager. She stated, "When residents leave we should be closing their account within 30 days of their discharge". Review of the facility policy titled "Resident Trust Fund" was reviewed. This policy did not address the timing of closing a Resident's account following their discharge from the facility. On the morning of 1/10/23, the facility Administrator was made aware of the findings. No further information was provided.	{F 569}		
{F 571} SS=D	Limitations on Charges to Personal Funds CFR(s): 483.10(f)(11)(i)-(iii) §483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.) (i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services:	{F 571}	1. Resident #170 trust account was reviewed. Business office staff identified refund of $82 due. Resident #105 and RP notified of refund to be reimbursed by facility on 1/31/23. Resident #1111 trust account reviewed. Business office staff identified a refund of $134 due. Resident RP notified of refund to be reimbursed by facility on 1/31/23. 2. Business office manager will complete audit of current residents' account to ensure accurate care cost amount has been withdrawn. Issues identified will be immediately corrected. 3. Division Director of Revenue Cycle will in-service Business Office Manager on the process of care cost withdrawals, including validation of Virginia Medicaid Web Portal to ensure accurate charge of care cost amount is withdrawn.	

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{F 571}	Continued From page 10 (A) Nursing services as required at §483.35. (B) Food and Nutrition services as required at §483.60. (C) An activities program as required at §483.24(c). (D) Room/bed maintenance services. (E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry. (F) Medically-related social services as required at §483.40(d). (G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan. (ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through (L) of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: (A) Telephone, including a cellular phone. (B) Television/radio, personal computer or other electronic device for personal use.	{F 571}	4. Executive Director will audit care cost will all residents' care cost withdrawals monthly x 3, then 10 residents accounts quarterly x 3. Audit will include validation of Virginia Medicaid Portal amount for residents has been withdrawn. Audit findings will be reviewed monthly by QAPI, then quarterly.	2/10/23

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{F 571}	Continued From page 11 (C) Personal comfort items, including smoking materials, notions and novelties, and confections. (D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. (E) Personal clothing. (F) Personal reading matter. (F) Gifts purchased on behalf of a resident. (H) Flowers and plants. (I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.24(c). (J) Non-covered special care services such as privately hired nurses or aides. (K) Private room, except when therapeutically required (for example, isolation for infection control). (L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60. (1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per §483.60. (2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population. (iii) Requests for items and services. (A) The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident. (B) The facility must not require a resident to	{F 571}		

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{F 571}	Continued From page 12 request any item or service as a condition of admission or continued stay. (C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be. This REQUIREMENT is not met as evidenced by: Based on staff interview, Resident record review, financial record review and facility documentation review, the facility staff charged the Resident and deducted from their patient trust account funds more than what were due to the facility for two Residents (Resident #170 and #1111), in a survey sample of 33 Residents. The findings included: 1. For Resident #170 the facility staff withdrew $82 more than what was due towards the cost of care for January 2023. On 1/4/23, Surveyor C met with the regional business office manager and obtained a trust account transaction history and the patient liability verifications for Resident #170 dating November 2022-January 2023. Review of these documents revealed the following: On 1/3/23, the facility withdrew funds in the amount of $920 and indicated this was a "Care Cost withdrawal". The Virginia Medicaid Web Portal had indicated Resident #170 owed $838 towards the cost of care for the month of January. This was $82 more than the owed amount that the facility withdrew.	{F 571}		

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{F 571}	Continued From page 13	{F 571}		

2. For Resident #1111, the facility staff withdrew more than what was due to the facility for the cost of care and services for December and January.

Review of the patient trust account transaction history revealed the following:
On 12/2/22, the facility staff withdrew $1,436 from Resident #1111's trust account. On 12/5/22, an additional withdrawal in the amount of $54 was made. Review of the Virginia Medicaid Web Portal for December 2022, Resident #1111 only owed $1,463 for the month of December and a total of $1,490, was taken from Resident #1111's trust account, which was an overpayment of $27.

On 12/7/22, Resident #1111 received a refund check from the facility in the amount of $4,041, for prior instances where the facility withdrew funds more than what was due for the cost of care.

On 1/3/23, the facility staff withdrew funds in the amount of $1,597 from Resident #1111's trust account and noted with transaction as a "Care Cost Auto Withdrawal". The Medicaid web portal showed Resident #1111 only owed $1,463 for the month of January, therefore the facility withdrew an excess of $134.

On 1/4/22, in the afternoon an interview was conducted with the Regional Business office manager. She was asked about the above transactions and said, "Per the Medicaid portal he should have paid $1,463 for December and when I made the withdrawal, I transposed the numbers and only took $1,436. So, we went back and took the balance which is where the $54 withdrawal on

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{F 571}	Continued From page 14 12/5/22, came in". On the afternoon of 1/4/22, the Regional Business Office manager was asked about the money that was withdrawn from Resident #170 and #1111's trust accounts in the month of January that were more than what was due to the facility. The business office manager said, "I will have to do a refund back for January and everyone will have to be reviewed because of the cost-of-living increase in January, I'm sure they are all wrong". On 1/10/23 at 9:45 AM, an interview was conducted with the Regional business office manager. When asked to explain the process regarding trust funds and payments to the facility the following explanation was given. "When a resident sets up a RFMS (Resident Fund Management System) agreement we set up for it to transfer their PL (patient liability). We look at their deposit and make sure what we transfer matches the Medicaid portal". Review of the facility policy titled; "Resident Trust Fund" was conducted. This policy read, "Purpose: To hold, safeguard, manage, control and reconcile the personal needs funds deposited with the facility by the residents, as authorized, in a manner and in compliance with all laws and regulations to provide the residents with accurate and timely information regarding their personal funds...B. Withdrawals...8. Withdrawals are not made from a resident trust funds account for items or services that are reimbursed by Medicare and/or Medicaid. On the morning of 1/11/23, the facility Administrator was made aware of the above	{F 571}		

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{F 571}	Continued From page 15 findings. No further information was provided.	{F 571}		
{F 582} SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least	{F 582}	1. Executive Director provided Resident #109 information regarding Skilled Notice Facility Advance Benefits, that should have been provided to resident at the time when Notice of Medicare Non Coverage letter was issued on 1/31/23. Explained benefits and appeal process that will be provided to resident in the future prior skilled services ending. Resident #109 had no concerns. Resident RP of resident #110 notified of SNF/ABN that should have been provided at time NOMNC issued 12/21/23. Explained benefits and appeal process to that will be provided to resident in the future as indicated prior to skilled services ending. 2. Residents residing in facility have the potential to be affected. Current residents receiving skilled care services will be audited to ensure Skilled Notice Facility Advance Benefits and Notice of Medicare Non Coverage letters are given at least 48 hours prior to the end of skilled services and appeal process is explained to residents and/or their RP. 3. Regional Social Services consultant will in-service Interdisciplinary Team on the process for completion and timely delivery of NOMNC and SNF/ABN; to assure residents and/or RP are notified of benefit coverage and appeal process.	

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{F 582}	Continued From page 16 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to provide a SNF ABN (Skilled Nursing Facility Advance Beneficiary Notice) to 2 Residents (Resident #109, 110) in a survey sample of 2 Residents reviewed for such notices. The findings included: On 1/4/23, the facility Administrator was asked to provide a listing of Residents who were discharged from Medicare Part A services. From this listing a sample was selected which consisted of Resident #109 and 110. The notices issued to these Residents were reviewed and revealed the following: 1. For Resident #109, the facility staff failed to provide a SNF ABN notice prior to skilled care	{F 582}	4. Social services or designee will audit residents' transitioning from skilled care services weekly and validate that SNF/ABN and NOMNC are issued timely. Audit will be completed weekly x 4 weeks then monthly x 3, then quarterly x 3. Audit findings will be reviewed by QAPI monthly, then quarterly.	2/10/23

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{F 582}	Continued From page 17	{F 582}		

services ending. Resident #109 was not afforded the opportunity to continue skilled care services and have Medicare make a determination about coverage of such services.

Review of the clinical record revealed that Resident #109 was readmitted to the facility on 12/22/22, for skilled care, Medicare part A services. When skilled services were scheduled to end on 12/25/22, the Resident remained in the facility. The facility staff issued a NOMNC (Notice of Medicare Non-Coverage) form on 12/23/22. The facility staff failed to provide Resident #109 with the second required notice, a SNF ABN, which allows the resident an option to continue to receive services, be notified of the expected cost, and have Medicare make the coverage determination once a bill is submitted to Medicare.

2. For Resident #110, the facility staff failed to provide a SNF ABN notice prior to skilled care services ending, therefore eliminating the Resident's opportunity to have Medicare make the coverage determination.

Review of the clinical record for Resident #110 revealed that the Resident was readmitted to the facility on 11/24/22, under skilled care/Medicare part A benefits. Skilled care ended on 12/23/22, and the Resident remained in the facility for long-term care.

The facility staff issued Resident #110 a NOMNC on 12/21/22 but had no evidence that the SNF ABN was issued.

1/9/23 at 9:38 AM, an interview was conducted

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{F 582}	Continued From page 18 with Employee M, a facility social worker. Employee M was asked to explain the NOMNC and ABN forms and explain when they are issued. Employee M stated, "The ABN is a waiver of liability. The provider gives it to let them know Medicare coverage rules. It lets them know where expenses will incur. Our policy is that we issue it 2 days prior that way if they appeal, they can do that". The social work department issues the notices, but the business office tells us which form to provide". The facility policy titled, "Non-coverage and Advanced Beneficiary Notices Policy" was reviewed. It read, "...4) SNFABN (Part A Traditional Medicare only). a) Regulations mandate that Medicare Part A beneficiaries be notified in advance when the Skilled Nursing Facility (SNF) makes a determination that the SNF stay may not be covered by Medicare. b) This usually happens on two occasions, either upon admission, or at the end of a Medicare covered stay. c) The SNFABN is based on not meeting the skilled level of care criteria. d) The SNFABN is not REQUIRED (but recommended) if noncoverage is related to a technical denial (no 3-day hospital stay, no benefits available). e) The facility will issue the SNFABN prior to Medicare A services ending to inform them that there will potentially be a cost incurred to the resident as a result of the Med A coverage ending. i) Typically, the facility will make every effort to issue this notice at the same time as the NOMNC..." CMS gives the following guidance to skilled nursing facilities regarding ABN notices in the "Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections". An excerpt from Page 72 read, "...70.2 - Situations in Which a	{F 582}		

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{F 582}	Continued From page 19 SNF ABN Should Be Given...In the situation in which a SNF proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care, the SNF must provide a SNF ABN to the beneficiary before it terminates such extended care items or services...". Accessed online at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf On 1/11/23 at approximately 9 AM, the facility administrator was made aware of the above findings. No further information was provided.	{F 582}		
{F 583} SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened	{F 583}	1. Residents #101 and #102 no longer reside at facility. The physiatrist ceased providing services for residents of facility on 1/13/23. Physiatrist no longer provides services for resident #188 or resident #116, effective 1/13/23. 2. Residents residing at facility have the potential to be affected. Audit of facility providers for all residents and consent for treatment of providers was completed by Electronic Medical Records Nurse.	

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{F 583}	Continued From page 20 mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to protect Resident's confidential records, to include Protected Health Information (PHI) and Protected Private Information (PPI), for 4 Residents (#101, 102, 188, and 116) in a survey sample of 33 Residents. The findings included; This access was given to an individual who was an alleged physiatrist (in sports medicine) who was not in contract with the facility to provide services. The individual was not in contract nor known by the Rehab Department for services, and not ordered to consult with the Residents by the physician. The individual was not known by the Residents nor their responsible parties, and had not received consent to this access the	{F 583}	3. Executive Director will in-service staff on privacy and confidentiality of resident information to assure access to clinical records is only to staff and providers involved in the resident's care to prevent authorized use. In-service education also be provided to the IDT on ensuring consent to treatment and physician orders are obtaining for consultation as indicated. 4. Electronic Medical Record Nurse will audit new admissions to ensure consent for treatment is obtained and authorized providers are assigned to each resident. DON or designee will audit physician orders to ensure consent for treatment by consulting providers is obtained and followed as indicated. Audits will be completed weekly x 4, then monthly x 3. Audit findings will be reviewed monthly by QAPI.	2/10/23

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medical record from them.

1. For Resident #101, the facility allowed disclosure of PPI, and PHI, by way of access to the electronic clinical record.

Resident #101's most recent Minimum Data Set assessment (a federal assessment protocol) was a discharge assessment dated 11-14-22. The document denoted the Resident as fully cognitively intact.

A review Resident #101's physician's orders in the clinical record, revealed Physical Therapy (PT), and Occupational Therapy (OT) orders but there were no orders for "Physiatry consult."

Resident #101 was interviewed via telephone on 1-9-23 and stated that she had never met, nor been seen by the alleged Physiatrist. Resident #101 further stated the medical doctor's name, the nurse practitioners name, the OT staff names, and the PT staff names, indicating she had seen all of them and could describe them. The Resident was oriented, and a good historian to include dates given during the interview. Research in the clinical record revealed that the Resident's account of her stay was exactly accurate.

On 1-9-23 initially multiple interviews, with multiple surveyors present for each interview, were conducted with Employee C (Therapy manager), and Employee F (OT) in regard to the physiatrist specifically.

The interviews with the therapy department continued throughout the course of the survey from 1-4-23 through 1-11-23. Both employees C,

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and F, stated that no one in the Rehab department knew the alleged physiatrist and further "never met and am unaware if (name) is a woman or a man."

Employees C and F stated that the therapy department (Rehab) did not have any contract nor any business agreement with the physiatrist, nor was the physiatrist consulted by them to see the Residents on their case load. They stated that the rehabilitation department (Rehab) did not bill the residents for the physiatrist alleged visits. They stated the physiatrist would not have been needed as the medical doctor saw the residents for their medical needs and for orders to be issued for therapy, then they treated the residents.

Employee C, and F, stated that the operating standard for therapy was for OT, PT, and Speech Therapy (ST), to evaluate the Residents first, then make recommendations to the doctor for treatment needs. After the doctor received the evaluations, the doctor would issue therapy orders, and finally, they as therapists would follow the doctors orders to treat the residents, document and report to the doctor the Residents progress, or lack thereof.

Licensed Practical Nurses (LPN) B unit 2, and (LPN) D unit 1 manager, were interviewed and stated they had not seen, and did not know the physiatrist.

Progress notes were reviewed and revealed that the physiatrist had documented in the clinical record as "type" of note "Rehab progress note". The physiatrist documented 40 notes stating he was providing "Physiatry follow up" and seeing

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the Resident approximately every two days, with weekends off, in a 124 day stay. The notes revealed that all of them were "late entry notes" and were placed in the medical record 4-5 weeks after alleging to have seen the Resident. The notes would not have been available to the physician nor the rehab department for 4-5 weeks which made them unnecessary to the facility for use in care of the Resident. The notes were all essentially identical as though they were copied and pasted into the record with only 1 or 2 words changed of no significance to findings. All of the notes indicated that the physiatrist documented the visits had occurred during daytime business hours.

The National Institutes of Health define a physiatrist as "Physical Medicine and Rehabilitation physicians."

The Resident was discontinued from Physical Therapy on 9-28-22, as having plateaued and not a further candidate for therapy services, however, the physiatrist continued to write "Rehab progress notes" as having seen the Resident, on 9-29-22, 10-1-22, 10-4-22, 10-6-22, 10-8-22, and 10-11-22. The last note on 10-11-22 was put into the clinical record by the physiatrist on 11-16-22, (5 weeks late) and 2 days after the Resident was discharged.

On 1-9-23 at 11:00 a.m., the Administrator and Director of Nursing (DON) were interviewed and stated the physiatrist was unknown to them, and they had no contract with him to provide services in the facility. They further stated they would check with corporate and get back to surveyors if one could be found.

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{F 583}	Continued From page 24 On 1-9-23 at 4:00 p.m., the Administrator stated there was no corporate contract with the physiatrist, and that the facility did not bill for him. She stated she had contacted the medical director and he said he would call and talk to the physiatrist and tell him that he was revoked from the building, and was not to enter. The Administrator had no contact information for the physiatrist, and she was not aware of how the physiatrist was able to access the clinical record. She stated that she was investigating. On 1-10-23 at 10:00 a.m., the Administrator told surveyors that she had spoken to the physiatrist and notified him she was conducting an investigation into the matter and that state surveyors were conducting an investigating as well. Surveyors asked for the contact information of the physiatrist and she stated that she didn't have a number for him as he had contacted her and told her he had been coming there for more than 6 years. She stated his business office was in Florida and he billed through his own office. She further stated his office was listed as a Post Office box. The Administrator was notified at that time that online search had proven he had listed his business office as this facility, and at this facility address, and that he did bill insurances to include Medicare. Policy and procedure was requested for a physiatry program, and the DON stated "we don't have a physiatry program." Facility billing records were reviewed and revealed that no resident billing for this physiatrist had been conducted from this facility. At an end of day meeting on 1-10-23 the	{F 583}		

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{F 583}	Continued From page 25	{F 583}		

Administrator, and DON were made aware of the failure of staff to protect residents records. The alleged physiatrist accessed Resident protected private information (PPI), and protected health information (PHI) without Resident nor responsible party consent.

On 1-11-23 at the end of day meeting at 5:00 p.m., the facility Administrator and DON were again notified by the survey team of the deficient practice, and they stated they had no further information to provide the survey team.

2. For Resident #102, the facility failed to protect the resident's right to privacy and confidentiality of personal, health and medical records.

For Resident #102, the facility failed to protect the resident's right to privacy and confidentiality of personal, health and medical records. The facility allowed access of PPI (Protected Personal Information) and PHI (Protected Health Information) through the electronic clinical record

Resident # 102 most recent Minimum Data Set (MDS) was an Admission assessment with an Assessment Reference Date (ARD) of 7/13/2022. The MDS coded Resident # 102 with a BIMS (Brief Interview for Mental Status) Score of 14 out of 15 indicating no cognitive impairment.

Review of the closed electronic clinical record was conducted on 01/04/2023-01/06/2023 and 01/09/2023-01/11/2023.

Thorough review revealed no Physician's Order for a Rehab Consultation by the Physiatrist.

The dates of the alleged Physiatrist encounters

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{F 583}	Continued From page 26 and the dates the note were created were documented as follows: 7/12/2022 15:01:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 8/15/2022 13:02:24 7/14/2022 15:05:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 8/17/2022 13:05:26 7/16/2022 15:29:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 8/19/2022 13:30:12 7/21/2022 15:39:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 8/24/2022 13:39:53 7/23/2022 15:01:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 8/26/2022 14:02:11 7/26/2022 15:15:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 8/29/2022 13:15:27 7/28/2022 15:14:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 8/31/2022 13:14:15 7/30/2022 15:23:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 9/2/2022 09:23:53 8/2/2022 15:21:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 9/5/2022 15:21:16 8/4/2022 16:31:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 9/7/2022 16:31:38 8/6/2022 14:20:00 Department: Physician Position: Physician Created By: (name redacted)Created Date : 9/9/2022 14:20:25 8/9/2022 15:01:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 9/12/2022 12:01:46	{F 583}		

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{F 583}	Continued From page 27 8/11/2022 15:49:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 9/14/2022 12:49:14 8/13/2022 15:19:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 9/16/2022 13:19:18 8/18/2022 15:26:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 9/21/2022 12:26:22 8/20/2022 15:22:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 9/23/2022 12:23:03 8/23/2022 15:16:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 9/26/2022 15:17:00 8/25/2022 15:55:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 9/28/2022 15:55:34 8/27/2022 17:11:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 9/30/2022 17:11:32 8/30/2022 15:59:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 10/3/2022 07:00:15 9/1/2022 13:39:00 Department: Physician Position: Physician Created By: (name redacted) Created Date : 10/5/2022 13:40:05 9/3/2022 14:19:00 Department: Physician Position: Physician Created By: (name redacted)Created Date : 10/7/2022 14:19:27 Review of the Progress notes revealed the notes appeared to be essentially the same verbiage during every encounter. The Assessment and Plan section addressed 8 areas. All of the notes had the narratives written in the 8 areas. On 1/5/2023 at 4:01 p.m., an interview was conducted with Resident #102's family member	{F 583}		

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who stated she visited Resident # 102 daily and stayed for all waking hours for weeks. The family member stated she did not see a Rehab doctor visit Resident # 102.

Interviews by another surveyor with another alert resident (with a BIMS score of 15/15 indicating no cognitive impairment) in the survey sample revealed that particular Resident stated she had never met the Physiatrist, never consented to receive services from the Physiatrist and was certain to not have ever heard that name (when asked about the name of the Physiatrist).

The interviews with the therapy department continued throughout the course of the survey from 1-4-23 through 1-11-23. Both employees C, and F, stated that no one in the Rehab department knew the alleged physiatrist. They also stated they never met the Physiatrist and were "unaware if [Physiatrist] is a woman or a man."

Employees C and F stated that the therapy department (Rehab) did not have any contract nor any business agreement with the Physiatrist, nor was the Physiatrist consulted by them to see the Residents on their case load. They stated that the rehabilitation department (Rehab) did not bill the residents for the Physiatrist alleged visits. They stated the Physiatrist would not have been needed as the medical doctor saw the residents for their medical needs and for orders to be issued for therapy, then they treated the residents.

Employee C and Employee F stated that the operating standard for therapy was for the Medical Doctor to give the order for OT, PT, and

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{F 583}	Continued From page 29 Speech Therapy (ST), to evaluate the Residents first, then make recommendations to the doctor for treatment needs. After the doctor received the evaluations, the doctor would issue therapy orders, and finally, they as therapists would follow the doctor's orders to treat the residents, document and report to the doctor the Residents progress, or lack thereof. Licensed Practical Nurses (LPN) B unit 2, and (LPN) D unit 1 manager, were interviewed and stated they had not seen, and did not know the Physiatrist. Progress notes were reviewed and revealed that the Physiatrist had documented in the clinical record as "type" of note "Rehab progress note". The physiatrist documented 22 notes stating he was providing "Physiatry follow up" and seeing the Resident approximately every two days, with weekends off. The notes revealed that all of them were "late entry notes" and were placed in the medical record 4-5 weeks after alleging to have seen the Resident. The notes would not have been available to the physician nor the rehab department for 4-5 weeks which made them unnecessary to the facility for use in care of the Resident. The notes were all essentially identical as though they were copied and pasted into the record with only 1 or 2 words changed of no significance to findings. All of the notes indicated that the physiatrist documented the visits had occurred during daytime business hours. According to the Physical Therapy records, Resident # 102 was discharged from therapy on 9/2/20222.	{F 583}		

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{F 583}	Continued From page 30 The last note from the Physiatrist on 9/3/22 was put into the clinical record by the physiatrist on 10/16/22, (over 5 weeks late) and 6 weeks after the Resident was discharged on 9-4-22. There were a total of 14 late entry notes entered into the clinical record by the Physiatrist after Resident # 102 was discharged. On 1/9/23 at 11:00 a.m., the survey team conducted interviews with the Administrator and Director of Nursing (DON) who both stated the physiatrist was unknown to them, and they had no contract with him to provide services in the facility. They stated they would check with their corporate office and get back to surveyors if one could be found. Further, they could not say if he was an MD (medical doctor), DO (Doctor of Osteopathic Medicine) or a PHD (Doctor of Philosophy.) The Administrator stated she would check and let the survey team know the next day On 1/9/23 at 4:00 p.m., the Administrator stated there was no corporate contract with the physiatrist, and that the facility did not bill for him. The Administrator had no contact information for the physiatrist, and she was not aware of how the physiatrist was able to access the clinical record. The Administrator stated she did not know the credentials of the individual and that she talked with the Medical Director who stated "he knew him" and that he was a Physiatrist. She stated the medical director and he said he would call and talk to the physiatrist and tell him that he was revoked from the building, and was not to enter. The Administrator stated she "deactivated him" from seeing residents and was going to launch an investigation. The Administrator stated she asked the therapy staff if they knew the Physiatrist and they did not. The Administrator	{F 583}		

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stated she did not know how this happened and how the Physiatrist was able to see so many residents. When asked exactly how many residents were being seen by the Physiatrist, the Administrator stated she did not know for sure but would check.

The Administrator was informed that the Electronic Medical Record System had two specific tabs designated for documentation by this particular Physiatrist. One tab was for "(Dr. name redacted) initial Rehab consultation and the other was for "(Dr. name redacted) Rehab progress notes." The Administrator stated she did not know how it happened that this Physiatrist had access to electronic health records.

On 1/10/23 at 10:00 a.m., the Administrator told surveyors that she had spoken to the physiatrist and notified him she was conducting an investigation into the matter and that state surveyors were conducting an investigating as well. Surveyors asked for the contact information of the physiatrist and she stated that she didn't have a number for him as he had contacted her and told her he had been coming there for more than 6 years. She stated his business office was in Florida and he billed through his own office. She further stated his office was listed as a Post Office box. The Administrator was notified at that time that online research had proven the Physiatrist had listed his business office as this facility, and at this facility address, and that he did bill insurances to include Medicare. Surveyors also notified her that his license to practice was only 5 years old.

Policy and procedure was requested for a physiatry program, and the DON stated "we don't

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{F 583}	Continued From page 32 have a physiatry program." Facility billing records were reviewed and revealed that no resident billing for this physiatrist had been conducted from this facility. During the end of day meeting on 1/10/23, the Administrator, and DON were made aware of the failure of staff to protect residents from access to their person and protected records. This was in regard to the potential for unsupervised visits in the private rooms of vulnerable Residents by a person who was unknown by staff, Residents, and Residents' responsible parties. Resident #102 was not afforded the right to privacy nor the right to deny the Physiatrist access to confidential personal and medical records. The protected health and private information was disclosed to the Physiatrist without Resident # 102's knowledge or consent. For Resident # 102, the facility failed to ensure protected health and protected private information. According to the facility staff including administrative staff, the facility had no business relationship with the physiatrist who was allowed to view the personal and protected information for every resident in the facility. On 1/11/23 at the end of day meeting at 5:00 p.m., the facility Administrator and DON were again notified by the survey team of the findings and they stated they had no further information to provide the survey team. 3. For Resident #188 the facility staff failed to ensure privacy of Protected Health and Protected Private Information.	{F 583}		

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{F 583}	Continued From page 33 For Resident #188 the facility staff failed to ensure privacy of Protected Health and Protected Private Information by physiatrist, who did not have contract, or agreement with the facility or rehab department and who was not referred by the medical director or Nurse practitioner working under him. Resident #188 was not available for interview as he was out of the facility. On 1/11/23 during clinical record review it was discovered that Employee G (a physiatrist) had entered progress notes in the Residents chart including the time period when the Resident was not receiving therapy. Many of the physiatrist notes were identical as if copied and pasted to include typos. The notes do not reflect any services provided by the physiatrist they only give history and physical as input by the medical director and list of diagnoses the notes do not reflect any changes in patient status, any recommendations for patient care or therapy modalities. All progress notes placed in the system were at minimum 1 month after the alleged visit and maximum 2 1/2 months after the alleged visit. All of the notes from 9/24/22 - 10/7/2 (4 in total) were while this Resident was not receiving therapy. On 1/11/23 at approximately 3:00 PM an interview was conducted with employee C (Physical Therapy Manager) who stated that she did not know who this doctor was and she had asked around in the department and no one was aware of him working with therapy patients. On 1/11/23 at approximately 4:30 PM an interview	{F 583}		

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was conducted with the Administrator who stated that she was not aware of the physiatrist but stated that she had suspended services in the building and had spoken to the medical director about him. She stated that some of the nurses recall him but said "They have not seen him lately." When asked if the facility has a contract with this physiatrist or if the medical director has consulted him to see residents she stated that he had not.

On 1/11/23 at approximately 2:00 PM an interview was conducted with the business office manager who stated that she does not bill for the physiatrist she bills for in house therapy providers.

On 1/11/23 during the end of day meeting the Administrator was made aware of the concerns and she stated that she was going to launch a formal investigation. The Administrator then submitted a copy of the document she sent to the state agency reporting the investigation of the physiatrist. No further information was provided.

4. For Resident #116, the facility allowed disclosure of PPI, and PHI by way of access to the electronic clinical record.

During the survey, Resident #116's clinical record was reviewed. There were three progress notes (05/26/2020, 06/02/2020, and 06/09/2020) written by Employee G, an alleged physiatrist (in sports medicine) who was not in contract with the facility to provide services. All three progress notes were written as late entries over two months after the dates of service. All three progress notes were identical and included the following excerpt:

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{F 583}	Continued From page 35 "Patient is in therapies working towards functional goals as noted in the functional status updates in the chart. Plan is to continue intensive skilled nursing rehabilitation including PT/OT [Physical Therapy/Occupational Therapy] and if needed SLP [Speech Language Pathology] to work toward functional goals which include improvement in mobility, ADLs [Activities of Daily Living], transfers, cognition, safety awareness, balance, selfcare, and hygiene. Continue 5-6 days a week of therapy to achieve the above-mentioned goals." A review of the physician orders revealed that there were no therapy orders nor a physiatry consult in 2020. On 01/11/2023 at 4:20 P.M., the Therapy Manager was interviewed. The Therapy Manager verified that Resident #116 did not receive any therapy services in 2020. On 01/11/2023 at approximately 4:45 P.M., the Administrator was notified of findings. The Administrator stated she would be launching a formal investigation into the matter.	{F 583}		
{F 584} SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	{F 584}	1. Resident #103 room was cleaned by housekeeping staff on 1/10/23 at 8:00am. All areas identified were addressed. Resident #1111 room was cleaned by housekeeping staff on 1/10/23 at 10:30am. Maintenance repaired areas on the bathroom wall. All areas were addressed. Employee L is no longer employed at facility.	

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MOUNT VERNON HEALTHCARE CENTER	8111 TISWELL DRIVE ALEXANDRIA, VA 22306

(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 584}	Continued From page 36 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility staff failed to provide a clean and homelike environment for two Residents (Resident #103, 1111) in a survey sample of 33 Residents. The findings included:	{F 584}	2. Residents residing at facility have the potential to be affected. An audit of all resident rooms was conducted by Regional Environmental Services Director and Maintenance Director. Housekeeping issues identified were immediately corrected. Maintenance Repairs were completed and/or scheduled for repair as applicable. 3. The Regional Director of Environmental Services will in-service housekeeping staff on daily cleaning tasks, to ensure rooms and bathroom are maintained in sanitary conditions. The Executive Director will in-service staff on the completion of work orders, to ensure areas requiring maintenance repair is reported daily, using facility TELS system. The Executive Director will ensure a charge nurse or designee has access to the TELS work order system 7 days a week. Work orders will be reviewed daily by the Maintenance Director or designee. Issues needing repair will be completed within 72 hours and/or reported to the Executive Director as indicated. Resident Ambassadors will be in-serviced on recording and reporting room issues on their daily room rounds via TELS work system or to Environmental Services Director.	2/10/23

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{F 584}	Continued From page 37 1. For Resident #103 the facility staff failed to provide a clean and homelike environment as evidenced by a significant amount of splatters and drips of a tan colored substance on the wall behind the head of the bed. On 1/5/23 at 2:23 PM, Surveyor C made observations of Resident #103's room. The wall behind the head of the bed had a tan colored substance splattered all over the wall with drips running from the over bed light to the baseboard. The splattered substance was on a photo that was hanging on the wall over the Resident's head of the bed. There was a tube feeding pole that had the same-colored substance with drips on the entire length of the pole. Resident #103 was non-verbal and unable to be interviewed about the findings or with regards to the cleaning frequency of her room. On 1/6/23 at approximately 11:40 AM, an additional observation was made of Resident #103's room with the same findings noted. On the afternoon of 1/9/23, Surveyor G made observations of the same in Resident #103's room. On 1/9/23 at 9:47 AM, an interview was conducted with Employee L, the housekeeping supervisor. The housekeeping supervisor described the facility housekeeping process to be that Resident rooms are checked three times daily. Employee L said, "in the morning they prepare their carts, go to every Resident room and get trash and sweep the floor. After breakfast, we start a full cleaning of every room".	{F 584}	4. Executive Director will review TELS work orders weekly x 4, then monthly x 3, then quarterly x 3. Ambassador rounds will be reviewed daily by Executive Director or designee. Environmental issues identified will be corrected immediately. Audit findings will be reviewed monthly by QAPI, then quarterly by QAPI.	2/10/23

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{F 584}	Continued From page 38	{F 584}		

He described this process to be, "cleaning the floor, sweeping and mopping, wiping down all surfaces, and cleaning the bathroom".

Employee L then went on to say, "After lunch we go back to every Resident room and sweep, mop and clean the room again". When asked about cleaning of the entire room and walls, the housekeeping supervisor said, "We call that a terminal clean, we do 5 rooms a day, so that all rooms are done monthly".

On 1/10/23 at 9:30 AM, a video call was held with the facility Administrator. The Administrator was made aware of the observations. The Administrator stated that Resident #103's room had been brought to her attention that morning and had been cleaned. The Administrator went to the room and showed Surveyor C that it had been cleaned. The Administrator confirmed the Surveyor's prior observations and stated she was very upset when she saw the condition of the room prior to the cleaning.

Review of the "Terminal Cleaning Schedule" provided by the facility staff revealed that Resident #103's room was scheduled for a terminal cleaning on 11/4/22, 12/8/22, 1/5/23.

The facility policy titled "Occupied Patient/Resident Room Cleaning" was reviewed. This policy read, "...5. Disinfecting: Beginning at the door, using a germicide-soaked microfiber cloth, disinfect all touch points and areas that have a high probability of carrying infections including: doorknobs, edges of furniture, bed rails, the phone, nurse call button, needle box, and sink by the patient/resident, not in the bathroom. Work in a single direction around the

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{F 584}	Continued From page 39 room to ensure that no key areas are missed. Fold your cloth using a clean surface as needed...". On 1/11/23 at 9:00 AM, the facility administrator was made aware of the above findings. No further information was provided. 2. For Resident #1111, the facility staff failed to provide a homelike environment as evidenced by missing sections of wallpaper and peeling wallpaper in the Resident's bathroom. On 1/5/23 at 2:20 PM, observations were made of Resident #1111's bathroom. The observation revealed there was a large section of wallpaper missing below the paper towel dispenser. The missing area measured approximately 6 inches long and approximately 16 inches wide. Additionally, there was a significant amount of wallpaper throughout the bathroom which was peeling and was not adhered to the wall. On 1/6/23 at approximately 11:40 AM, observations revealed the same findings in Resident #1111's bathroom. Resident #1111 was interviewed and had no knowledge as to how long the bathroom had been in this condition. On 1/9/23 at 3:40 PM, Surveyor G observed the same findings in Resident #1111's bathroom, which included the missing wallpaper and peeling wallpaper. Review of the maintenance work orders from November 13, 2022, until the time of survey	{F 584}		

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{F 584}	Continued From page 40 revealed no listing of Resident #1111's room being communicated to maintenance. On 1/10/23 at 9:40 AM, during a video call with the facility Administrator, the Administrator was made aware of the observations. The Administrator went to Resident #1111's room and confirmed the findings. No further information was provided prior to the conclusion of the survey. Complaint related deficiency.	{F 584}		
{F 610} SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review, the facility staff	{F 610}	1. Investigative documents available were for Resident #147 by the Executive Director on 1/7/23 and provided to surveyor C. Resident #147 notified of investigation outcome and action taken by Executive Director again on 1/31/23. No concerns were noted. 2. Residents residing at facility have the potential to be affected. 3. Regional Director of Operations will in-service Executive Director on Abuse Reporting, to assure investigations are thoroughly investigated, and evidence of the investigation is completed timely. Executive Director will log Risk events and ensure investigation documents are present for each investigation.	

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{F 610}	Continued From page 41 failed to provide evidence of an investigation being conducted when an allegation of misappropriation was reported for 1 Resident (Resident #147) in a survey sample of 33 Residents. The finding included: On 1/5/23 at 2:03 PM, Resident #147 was visited in his room. Resident #147 was in bed resting and when asked about a check that had been left at the facility for payment that went missing the Resident's response was non-sensical. The Resident interview was not continued as there was noted confusion. On 1/6/23 at 11:14 AM, an interview was conducted with the spouse of Resident #147. The spouse stated that she had dropped off a check to the facility to pay for her husband's care at the facility and the check got lost. She reported she went to her bank and stopped payment on the check. She reports she notified the facility administration of this. On 1/6/23, the facility Administrator provided the survey team with an investigation file that contained some documents with regards to the above allegation. The file contained a copy of the stop payment request that the spouse of Resident #147 initiated at her bank. There was also a document dated 11/11/22, where the facility Administrator reported this allegation to the state survey agency and law enforcement. There was no supporting evidence that a thorough investigation had been conducted. On the afternoon of 1/6/23, the facility Administrator was given the investigation file back	{F 610}	Interdisciplinary Team will be in-service on Risk Reporting P & P to ensure investigations are being thoroughly completed and documents maintained. 4. Risk reports will be audited weekly by the Regional Director of Clinical Operations. Issues identified will be immediately corrected. Audits will continue as an ongoing quality assurance measure. Audit findings will be reviewed monthly by QAPI.	

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{F 610}	Continued From page 42 and asked to provide Surveyor C with a copy of the documents. The Administrator was made aware that evidence of the investigation was missing. On 1/9/23, the facility Administrator provided 2 written statements from facility staff that were dated 1/5/23. Review of the facility abuse policy revealed the following statement, "...V. Investigation of Incidents. 1. In the event a situation is identified as abuse, neglect or misappropriation, an investigation by the executive leadership will immediately follow." This policy went on to read, "2. A suspected abuse. a. Neglect or Misappropriation Investigation report will be initiated by the Director of Nursing or designee. b. Initial findings will be reported to the Executive Director, the physician (except in case of misappropriation of funds/property) and the resident representative.... d. Statements will be obtained from staff related to the incident, including victim, person reporting incident, accused perpetrator and witnesses. This statement should be in writing, signed, and dated at the time it is written...e. Statements should include the following: i. First-hand knowledge of the incident. ii. A description of what was witnessed, seen, or heard. f. Findings/conclusion of the investigation are then reported to the physician and Resident representative and documented on the investigation form. g. By the fifth day, the alleged abuse investigation form is completed and reviewed for completeness and accuracy by the Executive Director or designee and submitted to the state. h. Investigation files are kept in a confidential file located in the Executive Director's office. i. This file will be	{F 610}		

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{F 610}	Continued From page 43 accessible for follow-up and state or local police review of the investigation". On 1/11/23, the facility Administrator was made aware of the lack of evidence of an investigation being conducted. No further information was provided.	{F 610}		
{F 625} SS=D	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 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	{F 625}	1. Resident #109 was re-admitted to facility from hospital on 12/22/22 to same room. No payment for bed hold was due from resident. A copy of the bed hold policy was maintained in the admissions office. 2. All residents residing at facility have the potential to be affected. 3. Executive Director will in-service staff on facility Bed Hold policy and procedure to assure policies to authorization form is provided to resident or RP. Copies of bed hold policy will be maintained on the clinical record. 4. Audit of discharged residents will be completed by the Admissions Director or designee to ensure residents/RP are provided Bed Hold Authorizations. Audits will be completed 3x/wk for 4 weeks, then weekly x 4, then monthly x 3. Issues identified will be immediately corrected. Audit findings will be reviewed monthly by QAPI.	2/10/23

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{F 625}	Continued From page 44 described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to issue a written bed hold notice for 1 resident (Resident # 109) of 33 residents in the survey sample. Findings included: For Resident # 109, there was no Bed Hold Authorization form at discharge on 12/21/2022. Resident # 109 was discharged from the facility on 12/21/2022. Review of the electronic clinical record was conducted 1/10/2023-1/11/2023. Review of the miscellaneous forms revealed no documentation of a "Bed Hold Authorization Form" Thorough review of the clinical record revealed no Bed Hold Authorization Form. Resident # 109 was readmitted to the facility on 12/22/2022. On 1/10/2023 at 12:30 p.m., an interview was conducted with the Social Services Director (Employee K) who stated written Bed Hold Authorization Forms should be completed at the time of discharge. Employee K stated her Assistant (Employee M) had a access to Bed Holds from December. Employee M was asked to show the surveyors the signed Bed Hold Authorization Form.	{F 625}		

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{F 625}	Continued From page 45 During the end of day debriefing on 1/10/2023, the Administrator stated "we have it. I will give it to you." The Administrator did not present a copy of a Bed Hold Authorization Form for Resident # 109. During the end of day debriefing on 1/11/2023, the facility Administrator, Director of Nursing, and Regional Nurse Consultant were informed of the findings. The Administrator and Regional Nurse stated the Bed Hold forms should be completed at the time of discharge. No further information was provided.	{F 625}		
{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 657}	1. Resident 102 no longer resides at facility. Resident 168 care plan has been revised to include psych recommendations. 2. Current resident care plans will be reviewed and revised as needed to ensure changes in plan of care, including new interventions are added to the plan of care. 3. In-service education will be provided by Regional Resident Care Coordinator to the Interdisciplinary Team on Care Planning Process to include adding or revision interventions to each care plan at the time changes are made.	

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{F 657}	Continued From page 46 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, facility documentation and in the course of a complaint investigation, the facility staff failed to review and revise care plans for 2 Residents (#168 & 102) in a survey sample of 33 Residents. The findings included: 1. For Resident #168 the facility staff failed to revise and update the care plan to reflect psychiatrist recommendations during IDT (Inter-Disciplinary Team) meeting. A Social Services note read: "12/8/22 5:52 PM - Resident was agreeable with the psychiatrist recommendation smiling and thanking him for the suggestion of weekly IDT meeting." On 1/5/22 during clinical record review it was found that the behavior section of the care plan for Resident # 168 did not mention weekly IDT meetings. On 1/9/23 during the end of day meeting the Administrator was asked if the outcomes of care plan meetings are used in updating the care plans and she stated that they were. When asked about the meeting on 12/8/22 she stated that was not a care plan meeting it was an Interdisciplinary Meeting that the psychiatrist	{F 657}	4. DON or designee will conduct an audit of 7 residents to validate that the care plan focus, goal and interventions are updated timely. This audit will be conducted weekly x 4 followed by monthly x 3 to ensure compliance. Results of this audit will be submitted to QAPI for review and recommendations.	2/10/23

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{F 657}	Continued From page 47	{F 657}		

requested. The Administrator was asked if the care plan should be updated if a physician makes a recommendation as to the care of modality of treatment. She stated that it should. When asked if the care plan was updated after that meeting the clinical consultant stated that it was not a care plan meeting and no recommendations were made. When asked if they had read the notes of the social worker she indicated that she had not.

On 1/10/23 at approximately 2:50 PM an interview was conducted with the DON who stated that IDT meetings are usually conducted in the patient rooms. She stated that the patients and the family or RP are notified and told of who will attend. She was asked about the meeting on 12/8/22 and stated that it was an IDT meeting the psychiatrist (Employee) had called the meeting. She stated that it was about how the facility could meet the Resident needs so that he would not continue to phone police or state.

When asked if the care plan should be updated with new treatments or physician recommendations she stated that it should. When asked if the care plan was updated after the IDT meeting on 12/8/22 she stated that it wasn't because there was no new recommendations. The DON was shown the Social Services note read:

"12/8/22 5:52 PM - Resident was agreeable with the psychiatrist recommendation smiling and thanking him for the suggestion of weekly IDT meeting."

She was then asked if the care plan should have been updated to include the weekly IDT meetings and she stated that it should have been.

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{F 657}	Continued From page 48 A review of the facility care plan policy read: Page 1 Procedure 1. C "c. Resident / representative will have the right to participate in the development and implementation of his/her own POC [plan of care] including but not limited to: i. Right to request meeting ii. Right to identify individuals or roles to be included in the planning process." On 1/11/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #102, the facility staff failed to revise the comprehensive care plan to include interventions for episodes of hypotension. Review of Resident # 102's closed electronic clinical record was conducted on 01/04/2023-01/06/2023 and 01/09/2023-01/11/2023. Review of the progress notes revealed a note written on 8/19/22 regarding episodes of hypotension with physician's orders given to hold Amlodipine, check blood pressures every shift . Resident #102's care plan was reviewed and revealed none of the physician recommendations from 8-19-22 were placed on the care plan to guide treatment. At the end of day meeting on 1/10/23, the Administrator, and DON were notified of the concerns regarding the lack of implementing revisions to the careplan to address the management of hypotension. They were asked if	{F 657}		

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{F 657}	Continued From page 49 it was the facility's policy to review and revise care plans and both agreed it was their policy to do so. During the end of day debriefing on 1/11/2023, the corporate nurse stated the changes in the care plan to reflect hypotension did not exist. No further information was provided by the facility.	{F 657}		
{F 661} SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements	{F 661}	1. Resident #101 no longer resides at facility. 2. Residents residing at facility have the potential to be affected. An audit all of residents discharged from facility within previous 30 days will be completed to ensure a discharge summary has been completed by the physician. 3. Electronic Health Record nurse will review discharge summary standards with attending physicians to ensure completion of discharge summaries for residents. 4. Electronic Health Record nurse will audit clinical records of residents discharging weekly x 4, then monthly x 3. Audit findings will be reviewed by QAPI monthly.	2/10/23

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{F 661}	Continued From page 50 that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility physician staff failed to complete a discharge summary to include recapitulation of stay for 1 resident (Resident #101) in the survey sample of 33 residents. The findings included: For Resident #101, the facility staff failed to complete a recapitulation (discharge summary) of care, upon discharge from the facility. Resident #101 was discharged home on 11-14-22. The Resident's closed record was reviewed on 1-4-23. No discharge summary, nor recapitulation of stay was included in the closed record. There was a discharge assessment by an Licensed Practical Nurse in the facility, however, no recapitulation of stay from the doctor. The Administrator and Director of Nursing (DON) were notified of the missing discharge summary at the end of day meeting on 1-9-23. On 1-11-23 at 1:30 p.m. the Administrator stated that they could not locate a discharge summary in the clinical record for Resident #101. No further information was provided by the facility.	{F 661}		
{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	{F 677}		

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{F 677}	Continued From page 51 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation the facility staff failed to provide services to maintain personal hygiene for 1 Resident (#101) in a survey sample of 33 Residents. The Findings included: For Resident #101, the Resident did not receive hygiene care on multiple days. Resident #101 had an admission minimum data set assessment which coded the Resident with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. The Resident was coded as incontinent of bladder and bowel, and coded as requiring extensive to total dependence on staff for all activities of daily living, with the exception of eating and was able to feed herself. Resident #101 was discharged home. On 1-9-23 Resident #101 was interviewed and stated she had not received incontinence care frequently while in the facility. Resident #101's care plan was reviewed and revealed that the Resident was incontinent of bladder and bowel. The Resident's closed record "point of Care" certified nursing assistant documentation record for ADL care was reviewed on 1-4-23. No ADL	{F 677}	1. Resident #101 no longer resides at facility 2. Residents residing at facility have the potential to be affected. 100% audit conducted by DON and unit managers to identify other residents not receiving ADL care. All residents found to be affected by the practice will be corrected. 3. DON or designee will in-service nursing staff on facility policy on providing daily ADL care, including incontinence care and hygiene. 4. DON or designee will conduct 10 random ADL care audit for residents requiring incontinence and hygiene care 3 x a week for 4 weeks, then monthly x 3. Issues identify will be corrected. Findings will be reviewed by QAPI monthly.	2/10/23

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{F 677}	Continued From page 52 (activities of daily living) hygiene care was documented as being provided for the Resident on the following days and shifts. 7a.m. to 3p.m. shift - 8-1-22, 9-16-22, 9-29-22, 10-10-22, and 11-11-22. 3p.m. to 11p.m. shift - 7-28-22, 7-29-22, 8-1-22, 8-18-22, 9-2-22, 9-5-22, 9-10-22, 9-11-22, 9-30-22, 10-5-22, 10-6-22, 10-9-22, 10-12-22, 10-28-22, 11-3-22, 11-6-22, and 11-11-22. 11p.m. to 7a.m. shift - 14 times in July 2022, 21 times in August 2022, 23 times in September 2022, 21 times in October 2022, 9 times in November 2022, On multiple occasions 2 shifts (16 hours) were skipped before the Resident was given hygiene care. On 1-6-23 The Director of Nursing was asked if the point of care documents should be signed correctly indicating care was given, and she stated "if it's not documented, it's not done." The DON stated that the facility policy is to provide incontinence care hygiene when getting out of bed, or waking in the morning, before and after meals, before bed time, and whenever residents are soiled. The Administrator and Director of Nursing (DON) were notified of the missing documentation and the complaint allegation, at the end of day meeting on 1-10-23. No further information was provided by the facility. Complaint deficiency.	{F 677}		

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{F 689}	Continued From page 53	{F 689}		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure Residents are free from accidents and hazards for 1 Resident (#131) in a survey sample of 33 Residents. The findings included: 1. For Resident #131 the facility staff failed to ensure the mechanical lift was properly secured and that all of the pieces of the equipment were present and in working order. On 1/6/22 at 10:30 AM Surveyor C went to Resident #131's room and did not find her in the room. She observed a mechanical lift was positioned over the bed on closer inspection the lift was found to be missing one of the safety clips that prevents the sling from backing off of the hook during lifting. Surveyor C stepped in the hall and conducted an interview with CNA D who stated that she just gotten Resident #131 out of bed and into her wheelchair. Surveyor C inquired about the transfer and CNA D stated she used the mechanical lift located in Resident #131's room. She stated that another CNA	{F 689}	1. Resident #131 was transferred without incident. 2. All mechanical lifts were removed and inspected by Maintenance Director on 1/6/23 at 4:15pm. Lifts were not returned to units until cleared by Maintenance Director. 3. In-service education was initiated on 1/6/23 to nursing staff on Hoyer Lift safety. Education included removal of mechanical lift when any safety issue identified, including hook closures, battery issues, etc. Safe transfer training will be provided to nursing staff by therapy, in the event mechanical lifts cannot be used and other lifts are not available. 4. Maintenance director will inspect mechanical lifts weekly and as needed for 4 weeks, then monthly as an ongoing safety measure. Issues identified will require removal of the lift per policy until repaired. Lift inspection reports will be reviewed weekly by the Administrator. Audit findings will be reviewed by QAPI monthly.	2/10/23

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{F 689}	Continued From page 54 assisted her with the lift. Surveyor C & D then went to the room of Resident #116 and observed CNA E and F using the mechanical lift. When asked what the clip on the hook was for the CNA stated it was so that the sling doesn't back up and slip off the hook during transfer. When asked if it was ok to use the lift with the clip missing CNA E stated that the slings never back up its safe to use. Surveyors C & D then inspected a total of three (3) mechanical lifts. Of the three lifts inspected, one of them had one (1) clip missing and the other had two (2) clips missing the third lift was intact. A review of the mechanical lift manual provided to surveyors by the facility read: "Before lifting the patient, perform safety check: Examine all hooks and fasteners to ensure they will not unhook during use. Double-check position and stability of straps and other equipment before lifting patient. Ensure clips, latches and bars are securely fastened and structurally sound." On 1/6/23 at approximately 4:00 PM the Administrator was interviewed and the concern with the lifts was explained and she stated that the staff should not be using any equipment that is not fully operational and in good repair. She stated that she was going to pull the lifts from use until they are repaired. On 1/6/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	{F 689}		

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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 §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, facility record review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure 1 Resident was free from unnecessary medications (Resident #101) in a survey sample of 33 Residents. The findings included: Resident #101 received Atenolol anti-hypertensive medication, Dexamethasone anti-inflammatory steroid medication, and Metronidazole antibiotic medication against	F 757	1. Resident #101 no longer resides at facility. 2. Current residents will be audited to ensure ordered medications are given as directed by the physician to ensure unnecessary drugs are not given. Issues identified will be corrected. 3. DON will in-service all nurses on policy and procedure for unnecessary drugs. Education will include ensuring medications that require parameters are not given as indicated; and medications with stop or change orders are not given per physician orders. 4. DON will audit order listing report daily for 30 days, then monthly x 3. Audit results will be presented to QAPI Committee for review and recommendations monthly.	2/10/23

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F 757	Continued From page 56	F 757		

physician ordered parameters.

Resident #101 was admitted to the facility on 7-9-22. Diagnoses included but were not limited to; hypertension.

Resident #101's most recent Minimum Data Set assessment (a federal assessment protocol) was a discharge assessment dated 11-14-22.

Review of the physician's orders and Medication Administration Record (MAR), in the clinical record, revealed the following;

1. Ordered 7-10-22 - Atenolol for high blood pressure - 100 MG (milligrams) in the morning, hold for systolic blood pressure (SBP) less than 110.

The Atenolol unnecessary medication was given on the following days;
On 7-22-22 with an SBP of 105,
On 8-10-22 SBP of 104,
On 8-14-22 SBP of 100,
On 8-28-22 SBP of 102,
On 10-29-22 SBP of 101.

2. Ordered 7-11-22 - Dexamethasone for diverticulitis inflammation - 1 MG in the morning for 3 days. However, the Dexamethasone medication was given for 7 days.

3. Ordered 7-10-22 - Metronidazole antibiotic for diverticulosis - 500 MG once per day, and the next day on 7-11-22 the order changed to - Metronidazole antibiotic for diverticulitis - 500 MG every 8 hours (3 times per day) for 7 days. There were 2 extra does of Metronidazole given.

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F 757	Continued From page 57 On 1-10-23 an interview was conducted with LPN D who stated about the Atenolol medications being administered unnecessarily, she stated "we don't want to give Antihypertensives outside of parameters because we don't want them to bottom out." (become Hypotension), and "antibiotics and steroids should only be given for a short time and per orders. The facility policy for Medication Administration was reviewed, and documented that medications must be given according to the physician's orders. On 1-10-23 at 12:00 p.m., the Administrator and Director of Nursing (DON) were made aware of the findings. At the time of exit the DON stated there was no further information available to submit to surveyors.	F 757		
{F 760} SS=D	Complaint Deficiency Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility record review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure 1 Resident was free from significant medication errors (Resident #101) in a survey sample of 33 Residents. The findings included:	{F 760}	1. Resident #101 no longer resides at facility 2. Current residents will be audited to ensure ordered medications are given as directed by the physician to ensure unnecessary drugs are not given. Issues identified will be corrected. 3. DON will in-service all nurses on policy and procedure for unnecessary drugs. Education will include ensuring medications that require parameters are not given as indicated; and medications with stop or change orders are not given per physician orders.	

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{F 760}	Continued From page 58 Resident #101 received Atenolol anti-hypertensive medication, Dexamethasone anti-inflammatory steroid medication, and Metronidazole antibiotic medication outside of physician ordered parameters. Resident #101 was admitted to the facility on 7-9-22. Diagnoses included but were not limited to; diverticulosis, sciatica, spinal stenosis, stroke, hypertension, type 2 diabetes, and morbid obesity. Resident #101's most recent Minimum Data Set assessment (a federal assessment protocol) was a discharge assessment dated 11-14-22. The document denoted the Resident as fully cognitively intact, no mood or behavior disorders, and requiring extensive assistance with dressing toileting and hygiene. Review of the physician's orders and Medication Administration Record (MAR), in the clinical record, revealed the following 3 significant medication errors; 1. Ordered 7-10-22 - Atenolol for high blood pressure - 100 MG (milligrams) in the morning, hold for systolic blood pressure (SBP) less than 110. The Atenolol was given on the following days when it was not supposed to be given; On 7-22-22 with an SBP of 105, On 8-10-22 SBP of 104, On 8-14-22 SBP of 100, On 8-28-22 SBP of 102, On 10-29-22 SBP of 101. 2. Ordered 7-11-22 - Dexamethasone for	{F 760}	4. DON or designee will audit order listing report daily for 30 days, then monthly x 3. Audit results will be presented to QAPI Committee for review and recommendations monthly.	2/10/23

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{F 760}	Continued From page 59 diverticulitis inflammation - 1 MG in the morning for 3 days. However, the Dexamethasone was given for 7 days. 3. Ordered 7-10-22 - Metronidazole antibiotic for diverticulosis - 500 MG once per day, and the next day on 7-11-22 the order changed to - Metronidazole antibiotic for diverticulitis - 500 MG every 8 hours (3 times per day) for 7 days. The Metronidazole was given an 2 extra doses. On 1-10-23 an interview was conducted with LPN D who stated about the Atenolol medications being administered unnecessarily, she stated "we don't want to give Antihypertensives outside of parameters because we don't want them to bottom out." (become hypotensive), and "antibiotics and steroids should only be given for a short time and per orders. The facility policy for Medication Administration was reviewed, and documented that medications must be given according to the physician's orders. On 1-10-23 at 12:00 p.m., the Administrator and Director of Nursing (DON) were made aware of the findings. At the time of exit the DON stated there was no further information available to submit to surveyors.	{F 760}		
{F 825} SS=D	Complaint Deficiency Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services.	{F 825}	1. Resident #103 was evaluated by Occupational Therapy and plan of care updated as indicated.	

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{F 825}	Continued From page 60 If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to provide rehab services as ordered to one Resident (Resident #103) in a survey sample of 33 Residents. The findings included: On 1/5/23 at 2:23 PM, Resident #103 was observed in bed. Resident #103 was noted to be non-verbal and not able to be interviewed. Resident #103 was noted to have bilateral hand contractures with splints/palm protectors on both hands. Review of the clinical record revealed a current and active physician order dated 12/13/22, that read, "Skilled OT [occupational therapy] indicated 3x/wk. x 4wks for self-care training, therapeutic	{F 825}	2. Nursing team will complete 100% audit of current residents' records to identify residents with active orders for therapy. Residents with active orders that are not completed will be assessed by rehab services. MD/RP will be notified and care plan updated as indicated. Residents receiving hospice care will be screened by PT, OT, ST to determine if therapy services are needed to improve or maintain residents' functional ability. Residents identified with have plan of care revised and or measures in place as recommended by therapy or physician, in conjunction with hospice provider. 3. Regional Director of Rehab Services will in-service on provision of therapy services, if needed for hospice residents. DON will in-service licensed nursing on physician orders, including entering and discontinuing orders per plan of care. 4. DON or designee will audit all active therapy orders daily x 4 weeks, then monthly x 3. Audit findings will be presented to QAPI for review and recommendation.	2/10/23

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{F 825}	Continued From page 61 activities, therapeutic exercises, neuromuscular re-education, manual techniques, and orthotic management". Review of the care plan for Resident #103 revealed the following focus areas, "[Resident name redacted] ADL [activities of daily living] Self Care Performance deficit, requires assistance with ADL Cognitive deficit, Disease Process, Functional Deficit. BL [bilateral/both] Hand Splints to be worn as tolerated" and one that read, "[Resident #103's name redacted] has rehab oriented nursing program as related to physical limitations identified in therapy R/T [related to] acute respiratory failure, COPD, CVA. Review of the nursing notes revealed that Resident #103 was readmitted to this facility following a hospitalization on 12/12/22 at 10:05 PM. On 12/13/22, a wound nurse practitioner saw the Resident and noted the following in the progress note: "...Chief Complaint: Comprehensive skin and wound evaluation for readmission to facility for Multiple DTI [deep tissue injuries] to fingers of both hands... Musculoskeletal - Patient has decreased ROM. Patient has contractures. Dermatologic - Wound(s)present; Please see wound assessment below. Wounds - Hands are contracted. Fingernails are long. Not wearing hand braces. DTI [deep tissue injury] with scabbing to bilateral hands/fingers...PLAN OF CARE: Wound plan of care: Stressed importance of needing nails cut short and file sharp edges. Need to obtain patient's hand braces and needs to wear them per OT recommendation..." There were additional notes within the chart dated	{F 825}		

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{F 825}	Continued From page 62 12/13/22, that indicated wounds/skin impairments. The areas included but were not limited to: Right thumb, right third finger, left third finger, right inner thumb, right fourth finger, right fifth finger. The listing of Resident's currently on therapy case load was reviewed and Resident #103 was not noted to be listed as being on active therapy caseload. On 1/4/23 at 3:42 PM, an interview was conducted with Employee C, the therapy director. Employee C accessed Resident #103's electronic chart and confirmed the active physician order for occupational therapy services. Employee C stated, "She is on hospice now so it wasn't dc 'ed [discontinued] and it should have been". Employee C went on to say, "My OT put the order in, we had planned to pick her up and she came in with orders, so we did the evaluation". Employee O, the evaluating occupational therapist/OTR then came to talk with Surveyor C. The OTR confirmed that she had evaluated Resident #103 upon her readmission. The OTR went on to say that she felt therapy services were necessary to help with the contractures in her hands to maintain skin integrity and hygiene of her hands and for splints. She said that she had initially ordered for therapy services three times per week for four weeks. However, after her evaluation she, the OTR, learned that Resident #103 had went on hospice care and so she revised the evaluation to indicate it was an evaluation only with no treatment but had not discontinued the order. During the above interview with the therapy	{F 825}		

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{F 825}	Continued From page 63	{F 825}		

manager and OTR, the manager confirmed that while it is not a common occurrence there are times that a Resident can and does receive therapy services while under hospice care. The OTR said she had not experienced this in her tenure as a therapist. When asked if the need for therapy was discussed with hospice to see if they would agree to and permit therapy to continue both confirmed that this had not been discussed as an option and was not initiated.

Review of the "OT evaluation and Plan of Treatment" with a start of care date of 12/13/22, was conducted. This document noted: "Caregiver goals: improve condition of B [bilateral] hands. Potential for achieving goals: fair due to previous success with B orthotics... Reason for Referral: Patient is a 72 y/o [year old] F [female] resident of this LTC [long term care] referred to skilled OT eval following hospitalization for UTI and hypernatremia..."

Page 4 of the above referenced document read, "Clinical Impressions: Current Value changed from Patient currently positioned well in semi fowler's with B offloading boots. Because of significant ulnar deviation of R D2, patient with moist skin and re-design of the palm protector to include finger spacing/more appropriate fit warranted, L palm protector to be changed accordingly as well. Nursing has voiced concern for skin breakdown and contracture; however, flexor tone is very tight; this paired with lack of consistent hand hygiene has resulted in skin softening, redness, and unpleasant smell. Skilled OT indicated to re-address current splints in place. to: Patient with previous success with placement of B palm protectors, soft type (Rolyan Palm Shield for severe hand tightness) which

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{F 825}	Continued From page 64 took multiple visits and collaboration with nursing due to severity. Patient is s/p [status post] hospitalization with B orthotics removed and B hands with 2+ edema and back into flexor tone. Skilled OT indicated to re-address current splints in place and ensure proper fit to maintain gains made by previous therapy included: decreased moisture, healed wounds, decreased skin-to-skin contact, and increased PROM [passive range of motion] for adequate hand hygiene". On 1/4/23 at 4:01 PM, the therapy manager provided Surveyor C with a copy of the physician order that discontinued to OT evaluation. When the therapy manager was asked to explain the document she stated, "They dc 'ed the evaluation only order but didn't discontinue the other one". On 1/9/23 at 1:40 PM, a follow-up interview was conducted with Employee C, the therapy director and Employee O, the OTR. They stated that the benefits of therapy services for a resident like Resident #103 with hand contractures is to "decrease the risk of infection, sores on the fingers, pressure sores between the fingers, and to maintain skin integrity". Additionally, to "improve quality of life by decreasing pain and improve hand hygiene. Prior to hospitalization she [Resident #103 was on case load, when she came back, I wanted to schedule to continue to make sure the splints were appropriate, and I spent a lot of time placing the splints slowing to prevent pain. My focus was also to decrease the overgrowth of bacteria in her hands due to the moisture". The facility policy titled "Order Guidelines" was reviewed. This policy read, "...Clarification Orders: Clarification orders are to be written on	{F 825}		

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{F 825}	Continued From page 65 the same day the evaluation is completed. The evaluating therapist is responsible for writing the clarification order. Clarification orders should contain the following: Discipline type, frequency, duration- must match the certification period of the evaluation, which is typically 30 days, therapy services- treatments listed must match the CPT [billing codes] codes listed on the evaluation..." On the morning of 1/11/23, the facility Administrator was made aware of the above noted concern. No additional information was provided.	{F 825}		
{F 921} SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility documentation review, the facility staff failed to maintain a sanitary and comfortable environment for 1 Resident (Resident #1111) in a survey sample of 33 Residents. The findings included: On 1/5/23 at 2:20 PM, observations were made of Resident #1111's bathroom. The observation revealed there was a brown substance on the wall that appeared to be feces. There was also a copious amount of a brown substance on the floor of the bathroom, that appeared to be feces	{F 921}	1. Resident #1111 room was cleaned by housekeeping staff on 1/10/23 at 10:30am. Maintenance repaired areas on the bathroom wall. All areas were addressed. Employee L is no longer employed at facility. 2. Residents residing at facility have the potential to be affected. An audit of all resident rooms was conducted by Regional Environmental Services Director and Maintenance Director. Housekeeping issues identified were immediately corrected. Maintenance Repairs were completed and/or scheduled for repair as applicable.	

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{F 921}	Continued From page 66 as well. On 1/6/23 at approximately 11:40 AM, observations revealed the same findings in Resident #1111's bathroom. Resident #1111 was interviewed and had no knowledge as to how long the substance had been in the bathroom. On 1/9/23 at 9:47 AM, an interview was conducted with Employee L, the housekeeping supervisor. The housekeeping supervisor during interview described the facility housekeeping process to be that Resident rooms are checked three times daily. Employee L said, "in the morning they prepare their carts, go to every Resident room and get trash and sweep the floor. After breakfast, we start a full cleaning of every room". He described this process to be, "cleaning the floor, sweeping and mopping, wiping down all surfaces, and cleaning the bathroom". Employee L then went on to say, "After lunch we go back to every Resident room and sweep, mop and clean the room again". When asked about cleaning of the entire room and walls, the housekeeping supervisor said, "We call that a terminal clean, we do 5 rooms a day, so that all rooms are done monthly". On 1/9/23 at 3:40 PM, Surveyor G observed the same findings in Resident #1111's bathroom, which included the brown substance on the wall and on the floor. On 1/10/23 at 9:30 AM, a video call was held with the facility Administrator. The Administrator was made aware of the observations. The Administrator then went to Resident #1111's room	{F 921}	3. The Regional Director of Environmental Services will in-service housekeeping staff on daily cleaning tasks, to ensure rooms and bathroom are maintained in sanitary conditions. The Executive Director will in-service staff on the completion of work orders, to ensure areas requiring maintenance repair is reported daily, using facility TELS system. The Executive Director will ensure a charge nurse or designee has access to the TELS work order system 7 days a week. Work orders will be reviewed daily by the Maintenance Director or designee. Issues needing repair will be completed within 72 hours and/or reported to the Executive Director as indicated. Resident Ambassadors will be in-serviced on recording and reporting room issues on their daily room rounds via TELS work system or to Environmental Services Director. 4. Executive Director will review TELS work orders weekly x 4, then monthly x 3, then quarterly x 3. Ambassador rounds will be reviewed daily by Executive Director or designee. Environmental issues identified will be corrected immediately. Audit findings will be reviewed monthly by QAPI, then quarterly by QAPI.	2/10/23

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{F 921}	Continued From page 67 and observed the bathroom and confirmed the brown substance was present. The Administrator stated that she would have this cleaned immediately. On 1/10/23, during mid-late morning the facility Administrator notified the survey team that Resident #1111's bathroom had been cleaned. Review of the "Terminal Cleaning Schedule" provided by the facility staff revealed that Resident #1111's room was scheduled for a terminal cleaning on 1/4/23. The facility provided a policy titled, "Restroom Cleaning". This policy read, "...6. Check the wall for spots and clean if necessary...". The facility policy titled, "Occupied Patient/Resident Room Cleaning- Individual Cleaning", was reviewed. This policy stated, "...6. Restroom disinfecting: Return to the room with germicide-soaked microfiber cloths. Disinfect all fixtures in the restroom, paying special attention to soap dispensers, underneath the sink, and grab rails. Clean the toilet last.... 10. Use a microfiber mop from your charging bucket on the cart, soaked in stride neutral cleaner, to damp mop the patient room floor...Include the restroom when mopping the floor". No further information was provided prior to the conclusion of the survey. Complaint related deficiency.	{F 921}		