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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/29/22 through 12/01/22. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems.	E 015		1/16/23

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

Electronically Signed | 01/09/2023

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E 015	Continued From page 1 (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to have at all times a three-day supply of emergency water (one gallon of water per person per day) for all residents and staff from 11/29/22 through 12/01/22. The findings included: An Emergency Preparedness interview was conducted with the Administrator and the Vice President of Operations on 12/1/22 at approximately 12:15 p.m. During the observation and calculation of the	E 015	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. The current emergency water supply was increased to meet the three-day supply of emergency drinking water (1 gallon per person) for residents and staff.	

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E 015	Continued From page 2 emergency water supply on 12/1/22 at approximately 2:25 p.m., there were 14 cases of 8 ounce bottles of drinking water. Each case totaled 24 bottles. With the emergency water supply was 5 cases of distilled water containing 6 gallons. The distilled water wasn't for consumption. This totaled 42 gallons of drinking water plus 30 gallons of non drinking water for a grand total of 72 gallons of water on hand on 12/1/22. The census on 11/29/22 was 138. The above-mentioned water supply was insufficient for one day for the number of residents residing in the facility and there wasn't any available for use by the staff. The facility's water supply wasn't sufficient for potential emergencies that could disrupt the normal course of service delivery including emergencies that would require expanded or extended care over a prolonged period of time. On 12/1/22 at approximately 8:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultants. The Administrator stated within 12 hours of notifying their food supplier additional water would be delivered to the facility.	E 015	2. The three-day supply of emergency drinking water (1 gallon per person) is currently available for residents and staff. 3. Director of Support Services/Designee will reeducate the management staff involved on the emergency water supply and emergency plan for potable water which includes how to calculate the amount needed for residents and staff. 4. The Administrator/Designee will monitor the emergency drinking water supply weekly for 8 weeks to ensure the facility has an adequate supply in place (1 gallon per person) for residents and staff. The Administrator/Designee will identify any patterns or trends and report to the Quality Assessment and Assurance Committee.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/29/22 through 12/01/22. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two (2) complaints were investigated during the survey: VA00056618-Substantiated, with a deficiency, VA00051482-Substantiated, without deficiency.	F 000		

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F 000	Continued From page 3 The census in this 154 certified bed facility was 134 at the time of the survey. The survey sample consisted of 34 current Resident reviews and 5 closed record reviews.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, self reported documentation, family and staff interviews, the facility staff failed to ensure one resident (Resident #41) was free from physical abuse to include having a bruise on her right lower extremity and failed to protect one resident, Resident #99 who was reviewed for neglect, in the survey sample of 39 residents. The findings included: 1. Resident #41 was admitted to the facility on 11/13/2017 from an acute care facility with a	F 600	1) Resident #41 has been evaluated by NP on 11/15/2022 with x-rays obtained. No acute findings for fracture or soft tissue injury identified. Resident remains at facility with no further negative outcome. Resident #15 was discharged from facility to a memory care unit on 11/22/22. Resident # 99 remains in facility and has been interviewed by Corporate team to ensure he is receiving care and services on a regular basis. Staff involved with Resident #41 have	1/16/23

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F 600	Continued From page 4 diagnosis of Alzheimer's disease with late onset and Major Depressive Disorder. The annual, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/02/22 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long- and short-term memory problems as well as severely impaired for daily decision making. Resident #41 requires total dependence of one person with dressing, grooming, eating, toileting, and personal hygiene, requires and bathing. The care plan dated 11/29/17 indicated: Focus-Resident is totally dependent on staff for all ADLs (Activity of Daily Living). Goal-Resident will have personal hygiene needs met and be transferred safely without injury. Interventions: assist her to turn/reposition in bed frequently mechanical lift for transfers personal hygiene done by staff usually has 2- 1/2 bedrails up. The self reported documentation dated 11/14/22 indicated Resident #15 wandered into Resident #41's room and during attempts to re-direct Resident #15, she became combative and forcefully grabbed Resident $41's right leg causing a bruise. On 11/21/22 a final plan to address the wandering behaviors of Resident #15 included programming development for her cognitive impairments and to work toward finding placement to be near her son. Additional training in addressing combative behaviors, redirecting residents with these behaviors in a manner to avoid escalting agitation. Discusssions during the Quality Assurance Committee Monthly meeting would address trends and patterns with corrective action plans implemented or revised if applicable.	F 600	been reeducated on the importance of safeguarding residents from resident to resident altercations. A FRI was initiated on 11/30/22 regarding resident #99 with final report submitted on 12/7/2022 after a complete and thorough investigation. Staff member involved with Resident #99 has been reeducated on actions that may constitute neglect and importance of listening to the needs of the resident. 2) The DON/designee will conduct a review of facility clinical notes for the past 30 days to identify any incidents of intrusive and wandering behaviors that could lead to resident to resident altercations. A review of incident reports for the past 30 days will be completed to ensure all incidence have been investigated for potential abuse or neglect and appropriate actions have been taken to ensure residents are free from abuse and neglect. All residents, families and staff will be informed of the importance of reporting any concerns of abuse or neglect to ensure all concerns have been investigated and addressed. 3) All direct care staff will be reeducated on Abuse Prevention and Neglect as well as Managing Intrusive and Aggressive Behaviors. The in-service will include a review of the policy for Abuse Prevention and the importance of reporting residents' concerns. Also included will be training on identifying aggressive and intrusive behaviors in Residents that could lead to	

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F 600	Continued From page 5 A review of clinical records: A nursing note dated 11/12/22 at 4:15 AM., indicated that "Resident #15 was wondering into Resident #41's room and found lying in bed and became combative when the CNA (Certified Nurse's Aide) attempted to remove her. She grabbed Resident #41 legs and refused to let go. There are no injuries to report at this time. CNA and writer able to remove her out and place her back into her room." 11/12/22 at 11:58 AM., indicated: Discoloration noted to the lower extremities. Long Term Care aware. Representative aware. A nursing note dated 11/13/22 at 11:49 AM. Indicated that the nurse notified the NP (Nurse Practitioner) for something for agitation and behavior. Trazodone as needed was only for 14 days. The clinical notes dated 11/14/22 at 10:22 AM. Read: X-ray done as ordered, results show no fractures, no evidence of dislocation. no acute abnormality is seen. Results fax to provider. A nursing note dated 11/14/22 at 12:03 AM., indicated "Resident #15 was up wandering off the unit into another resident's room she was redirected back to her room drink and snack accepted bed alarm place under nursing interventions to monitor movement. She is in bed resting at this time bed in lowest position will continue to monitor call light and fluids are in reach." This occurred after the event on 11/12/22." Behavior monitoring notes in the clinical records	F 600	resident to resident altercations as well as techniques for redirection, non-pharmacological interventions and monitoring for increased behaviors. 4) The DON/ designee will perform five resident interviews weekly for eight weeks to ensure residents are free from abuse and neglect. The DON/designee will review all incident reports and clinical notes weekly for eight weeks to ensure any allegation of abuse or neglect has been identified and investigated. The DON /designee will review for patterns or trends and report to the Quality Assessment and Assurance Committee.	

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reads: Refer to Behavior Monitoring Sheet for 11/15/22, 11/16/22 and 11/17/22. Behavior Monitoring Sheets were not available.

A nursing note dated 11/18/22 at 5:21 AM., indicated that "Resident #15 was rested throughout this shift, no behaviors noted at this time will continue monitoring checks."

A nursing note dated 11/22/22 at 11:44 AM., indicated Resident #15 was transferred to another facility.

On 11/30/22 at approximately 12:11 PM., an interview was conducted with the resident's daughter concerning the incident. Resident #41 was observed resting quietly in her bed with her daughter and son at her bedside. The resident's daughter pulled back the blanket revealing a bluish discoloration about 1 inch in length below her right lower extremity knee. She said that her mother's Right lower leg was still bruised on 11/14/22, two days after the incident occurred. She also said that due to her mom having thin skin she bruises easily.

On 12/01/22 at approximately 1:00 PM an interview was conducted with the DON (Director of Nursing) concerning the above incident. The DON said that the incident occurred on 11/12/22 at 4:07 AM. but was not brought to her attention until 11/14/22 by the resident's (Resident #41) daughter. She completed a FRI. "Initially when I saw the resident, I called the administrator." They went to the resident's bedside and the daughter showed them the pictures of the bruise on the resident's right leg. "I initiated a FRI." She said that the nurse said that she forgot to put her note in. The DON also said that they should have

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reported this incident in 2 hours. No changes with her (Resident #15) medications but she appeared more confused. Her norm was not going into other people rooms. "She was not re-directable, so she grabbed onto Resident #41's right leg." They started the investigation on 11/14/22 and the DON did see a bruise on the resident's leg. She also said that a note was put in Resident #15's chart of her going into Resident #41's room. She said that the outcome of the FRI was that the resident was sent to another facility that had a memory care unit. Her daughter said that she was okay with the transfer.

The perpetrator, Resident #15 was admitted to the facility on 9/19/13. Her admitting diagnosis includes Schizophrenia, Dementia and Bipolar Disorder. The quarterly revision Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/08/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #15 cognitive abilities for daily decision making were severely impaired. Resident #15 requires extensive assistance of one person with dressing, bed mobility, limited assistance of one person with locomotion on and off the unit, transfers, walking on the unit, walking in the corridor on the unit and personal hygiene, requires supervision set-up help only with eating, requires total dependence of one person with bathing.

The Policy: Health Services will develop and implement policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, mistreatment, neglect, exploitation, and

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misappropriation of resident's property. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrence of resident abuse. Definitions: Abuse-Is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Abuse also concludes the deprivation by an individual. Including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being. Instances of abuse of all residents, irrespective of any mental or physical abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mistreatment means inappropriate treatment or exploitation of a resident. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Identification- Staff are encouraged to identify, correct and intervene in situations in which abuse, neglect is likely to occur. Protection: In the event of an allegation or observation of abuse, the facility will immediately assess the resident, notify the physician and resident representative, and protect the resident from other residents from further harm or incident.

No written statements from the staff were provided.

On 12/01/22 at approximately 3:15 pm a telephone interview was conducted with Resident #15's family member concerning her transfer to

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another facility. She said that she was okay with the family member being transferred to a memory care unit at another facility.

On 12/01/22 at approximately 8:00 p.m., a pre-exit interview was conducted with the administrator, the DON, and the Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

At the conclusion of survey, prior to survey exit, no further documentation was presented.

2. The facility failed to protect one resident Resident (R) (99) reviewed for neglect. Review of the facility's policy titled, "Resident Abuse Policy and Procedure," dated 11/07/22 revealed, "It is the policy of this facility to ensure the resident will be free from ... neglect, ..."

During an interview with R99 on 11/30/22 at 9:12 AM, R99 stated that he had been dropped from the mechanical lift last summer. He stated he had told Certified Nurse Aide (CNA) 2 to stop because "it did not feel right" while he was in the mechanical lift. R99 stated, "I said this isn't going to work. I wasn't secure to begin with. I told her to stop, and I jerked, and she just kept on." R99 stated CNA 2 did not stop and continued with the transfer. R99 stated, since the fall, "something changed inside me." He stated he had more discomfort and pain since the fall. He stated it felt disrespectful that management had not talked with him about the fall until a week after the fall had occurred.

During an interview with R99, on 12/01/22 at 9:51 AM, R99 stated he trusted some of the staff that

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assisted him with transfers. He stated that he did not feel anxious anymore and was glad CNA 2 had transferred to another unit.

Review of R99's "Face Sheet" located in the electronic medical record (EMR) under the "Resident Profile" tab, revealed an admission date of 02/25/22 with medical diagnoses of Quadriplegia and Anxiety Disorder.

Review of R99's quarterly "Minimum Data Set (MDS)" located in the EMR under the "RAI" tab with an Assessment Reference Date (ARD) of 10 /21/22, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R99 was cognitively intact. The MDS revealed R99 required total assistance from staff for all activities of daily living (ADL).

Review of the "Progress Note" dated 06/10/22 found in the EMR under the "Resident Profile," tab, signed by the Nurse Practitioner revealed, "I found [R99] to be laying on the floor under the Hoyer lift with his head on the bottom leg of the lift. He had the Hoyer sling partially underneath him. He was awake, alert and very shaken by the incident. Staff assisted him back to bed. He states that he hit the back of his head on the metal leg of the lift. He tells me that "I tried to tell them that it was not hooked up right." He tells me that when he fell, he was in the sling at approximately the level of his bed. It is unclear exactly what happened."

Review of the event report dated 06/10/22, revealed R99 fell on 06/10/22 at 12:30 PM and revealed R99 had "Swelling left low back of head and mid low back of head." The incident report revealed R99 "Slipped from pad."

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Review of the "Statement Form" dated 06/10/22, signed by CNA2 revealed, "At 12:30 PM I was helping [CNA 3] putting [R99] back to bed he slide [sic] out of the pad unto the lift he hitted [sic] the legs I called for nurses to looked [sic] at him."

Review of the "Statement Form" dated 06/10/22, signed by CNA3, revealed "I went in room around 12:30 [PM] to give [R99] a bath. [CNA2] came in and said [R99] wanted to go to bed. She help [sic] me put him to bed. We were connecting the Hoyer lift (Mechanical Lift) pad to the Hoyer lift and started lifting him when he first got lifted in the air, I heard the Hoyer lift snap like it was about to fall but the recliner chair was still behind him. [CNA2] was still lifting the Hoyer lift and she told me to lower the bed. In the middle of me lifting the bed [R99] said he feel [sic] like he falling [sic] next thing you know he fell and hit his head on the Hoyer lift."

Review of the "Statement Form" dated 06/16/22, signed by the Corporate Infection Preventionist nurse, revealed "Resident interview after staff reporting [R99] wanted to speak to someone about concerns surrounding fall on 06/10/22 ... [CNA2] did not listen to him when he told her it felt like the leg portion of the sling was not properly secured ...He told [CNA2] please stop it feels like I'm slipping ...[CNA2] was operating the lift controls."

Review of "Employee Counseling/Tracking Form" found in CNA employee file, dated 06/17/22 (seven days after the fall and one day after the resident was interviewed), CNA 2 was suspended. The document revealed the employee was receiving counseling "Failure to

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adhere to policy and procedure related to use of mechanical lift." Suggestions for improvement of performance included "Ensure you are listening to resident verbal cues of discomfort of distress during transfer." The summary revealed "Her [CNA 2] failure to follow procedure may result in injury to resident ...Due to nature of the concern, [CNA 2] will be suspended for two days."

Review of the "Training Record", dated 07/06/22, revealed four staff had been trained on "Correct application of sling with contracted resident. Paying attention to resident cues (verbal/nonverbal). Safe transfer technique-two staff members, position of resident, position of chair."

During an interview with the DON, the Vice President of Nursing (VPN), and the Assistant Director of Nursing (ADON) 5 , on 11/30/22 at 4:27 PM, the DON stated that CNA 2 should have "listened to the resident. The resident knows if there is a problem." The VPN stated that an abuse investigation had not been completed.

During an interview with the Corporate Infection Preventionist nurse, on 11/30/22 at 4:50 PM, she confirmed she had interviewed R99 on 06/16/22 (six days after the fall). She stated the reason she had interviewed him was because staff "kept hearing from him." She stated this was the first time the resident had been interviewed.

During an interview with the Nurse Practitioner, on 12/01/22 at 4:39 PM, she stated, after R99 fell, she had seen the resident. She stated R99 told her, "I tried to tell them that it was not hooked up right." The Nurse Practitioner stated that after R99 told her this, she had reported the

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F 600	Continued From page 13 information to staff. The facility self reported documentation on 11/30/22, revealed the event date of 06/10/22 as alleged neglect that indicated the resident was being transferred via a full mechanical lift and he told the CNA to stop the transfer because he felt he was sliiping from the sling. According to [R99] they did not stop, and he slipped from the sling. The action taken revealed "The former DON talked with [R99], conducted an investigation and had staff in-serviced on proper transfer with the lifts."	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.	F 607		1/16/23

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F 607	Continued From page 14 §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, facility self report documentation, family and staff interviews, the facility staff failed to implement their policies and procedures to report and investigate an abuse allegation involving two residents, Resident #41 and Resident #15 (the perpetrator), a closed record resident in the survey sample of 39 residents. The findings included: 1. For Resident #41 the facility staff failed to report and investigate a physical abuse allegation that resulted in the resident having a bruise on her right lower extremity to the Resident Representative, Administrator/ designee, APS (Adult Protective Services) or to the State certification and certification agency. The incident occurred on 11/12/22 but was not reported until 11/14/22. Resident #41 was admitted to the facility on 11/13/17 from an acute care facility with diagnosis Alzheimer's disease with late onset and Major Depressive Disorder. The annual, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/02/22 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long- and short-term memory problems as well as severely impaired for daily decision making. Resident #41 required	F 607	1) Resident #41 has been evaluated by NP on 11/15/2022 with x-rays obtained. No acute findings for fracture or soft tissue injury identified. Resident remains at facility with no further negative outcome. Resident #15 was discharged from facility to a memory care unit on 11/22/22. Staff involved with Resident #41 have been reeducated on the importance of immediately reporting any resident to resident interactions to administration for investigation and reporting. 2) The DON/designee will review the past 30 days of current residents clinical notes to identify incidents of intrusive and wandering behaviors that may lead to resident to resident altercations. If identified, incident will be investigated and reported to OLC according to reporting guidelines. 3) All direct care staff will be reeducated on abuse prevention and reporting. The in-service will include a review of the Resident Abuse Policy and the importance of immediately reporting any resident to	

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F 607	Continued From page 15 total dependence of one person with dressing, grooming, eating, toileting, and personal hygiene, requires and bathing. The care plan dated 11/29/17 indicated: Focus-Resident is totally dependent on staff for all ADLs (Activity of Daily Living). Goal-Resident will have personal hygiene needs met and be transferred safely without injury. Interventions: assist her to turn/reposition in bed frequently mechanical lift for transfers personal hygiene done by staff usually has 2- 1/2 bedrails up. The self reported documentation was not initiated until two days after the event occurred on 11/14/22. The event occurred on 11/12/22. The residents involved included Resident #41 and Resident #15 (A Closed Record Resident). Injuries included a bruise below the right knee. The facility documented that the event was an allegation of abuse/mistreat. Resident #15 wandered into Resident #41's room and during attempts to re-direct Resident #15, she became combative and forcefully grabbed Resident $41's right leg causing a bruise. On 11/21/22, the five day final self reported documented included to address the wandering behaviors of Resident #15 included programming development for her cognitive impairments and to work toward finding placement to be near her son. Additional training in addressing combative behaviors, redirecting residents with these behaviors in a manner to avoid escalating agitation. Discussions during the Quality Assurance Committee Monthly meeting would address trends and patterns with corrective action plans implemented or revised if applicable. The fax confirmation dated 11/14/22 revealed the initial self reported documentation of the	F 607	resident altercation that may constitute abuse. The staff will be educated on the process for reporting an allegation or suspicion of abuse to their immediate supervisor as well as the importance of timely reporting to ensure the resident is safeguarded and a complete and thorough investigation is conducted. 4) The DON/designee will review the clinical notes of current residents weekly for eight weeks to ensure any resident to resident altercations have been thoroughly investigated and reported to the appropriate agencies according to reporting guidelines. The Director of Nursing will review for patterns or trends and report to the Quality Assessment and Assurance Committee.	

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aforementioned event, sent to the State survey and certification agency. The fax confirmation dated 11/21/22 revealed the final self reported documentation, sent to the State survey and certification agency.

According to the abuse policy under Procedure: All alleged violations involving mistreatment, neglect, exploitation or abuse including injuries of an unknown source and misappropriation of residents property must be reported immediately to the administrator/designee of the facility. The facility Administrator or designee will then report by fax to the State survey and certification agency no later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in bodily injury. Resident to Resident altercations will be investigated as a potential abuse situation. An incident of "willful" intent that inflicts injury or harm to a resident by another resident is considered abuse and will be reported to the State survey and certification agency and Adult Protective Services. A resident-to-resident suspected abuse will also be reported to law enforcement if appropriate. The facility must complete a thorough written investigation and must prevent further potential abuse while the investigation is in progress.

A review of clinical records:

11/12/22 at 11:58 AM., indicated: Resident #41 had discoloration noted to the lower extremities. Long Term Care aware. Representative aware.

A nursing note dated 11/12/22 at 4:15 AM.,

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indicated that "Resident #15 was wondering into Resident #41's room and found lying in bed and became combative when the CNA (Certified Nurse's Aide) attempted to remove her. She grabbed Resident #41 legs and refused to let go. There are no injuries to report at this time. CNA and writer able to remove her out and place her back into her room."

A nursing note dated 11/13/22 at 11:49 AM. Indicated that the nurse notified the NP (Nurse Practitioner) for something for agitation and behavior. Trazodone as needed was only for 14 days.

The clinical notes dated 11/14/22 at 10:22 AM. Read: X-ray done as ordered, results show no fractures, no evidence of dislocation. no acute abnormality is seen. Results fax to provider.

A nursing note dated 11/14/22 at 12:03 AM., indicated "Resident #15 was up wondering off the unit into another resident's room she was redirected back to her room drink and snack accepted bed alarm place under nursing interventions to monitor movement. She is in bed resting at this time bed in lowest position will continue to monitor call light and fluids are in reach." This occurred after the event on 11/12/22."

A nursing note date 11/18/22 at 5:21 AM., indicated that "Resident #15 was rested throughout this shift, no behaviors noted at this time will continue monitoring checks."

Behavior monitoring notes in the clinical records reads: Refer to Behavior Monitoring Sheet for 11/15/22, 11/16/22 and 11/17/22. Behavior

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Monitoring Sheet not available.

A nursing note dated 11/22/22 at 11:44 AM., indicated Resident #15 was transferred to another facility.

On 11/30/22 at approximately 12:11 PM., an interview was conducted with Resident #41's daughter at the resident's bedside concerning the incident. Resident #41 was observed resting quietly in her bed with her daughter and son at her bedside. The resident's daughter pulled back the blanket and sheet on the resident revealing a bluish discoloration about 1 inch in length on her right lower extremity below the resident's knee. She said that her mother's Right lower leg was still bruised on 11/14/22, two days after the incident occurred. She also said that due to her mom having thin skin she bruises easily.

2. For Resident #15, the perpetrator, the facility staff failed to report an abuse allegation involving the perpetrator within a two-hour time frame. Resident #15 was admitted to the facility on 9/19/13. Her admitting diagnosis includes Schizophrenia, Dementia and Bipolar Disorder. The quarterly revision Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/08/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #15 cognitive abilities for daily decision making were severely impaired. Resident #15 requires extensive assistance of one person with dressing, bed mobility, limited assistance of one person with locomotion on and off the unit, transfers, walking on the unit, walking in the corridor on the unit and personal hygiene, requires supervision set-up help only with eating,

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requires total dependence of one person with bathing.

A nursing note dated 11/22/22 at 11:44 AM., indicated Resident #15 was transferred to another facility.

On 12/01/22 at approximately 1:00 PM an interview was conducted with the DON (Director Of Nursing) concerning the above incident. The DON said that the incident occurred on 11/12/22 at 4:07 AM. but was not brought to her attention until 11/14/22 by the resident's (Resident #41) daughter. She completed a self reported document. She said, "Initially when I saw the resident, I called the administrator." Then they went to the resident's bedside and the daughter showed them the pictures of the bruise on the resident's leg. She said that the nurse said that she forgot to put her note in. The DON said that they should have reported this incident in 2 hours. No changes with (Resident #15, the perpetrator) medications but she appeared more confused. Her norm was not going into other people rooms. "She was not re-directable, so she grabbed onto Resident #41's right leg." She said they started the investigation on 11/14/22 and the DON said that she did see a bruise on the resident's leg. She also said that a note was put in Resident #15's chart of her going into Resident #41's room. She said that the outcome of the self reported investigation was that the resident was sent to another facility that had a memory care unit and that Resident #15's daughter said that she was okay with the transfer.

On 12/01/22 at approximately 1:00 PM an interview was conducted with the DON (Director of Nursing) concerning the above incident. The

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DON said that the incident occurred on 11/12/22 at 4:07 AM. but was not brought to her attention until 11/14/22 by the resident's (Resident #41) daughter. She completed a self reported document. She said, "Initially when I saw the resident, I called the administrator." She said that the nurse said that she forgot to put her note in. The DON said that they should have reported this incident in 2 hours.

The Policy: Health Services will develop and implement policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, mistreatment, neglect, exploitation, and misappropriation of resident's property. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrence of resident abuse. Definitions: Abuse-Is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Abuse also concludes the deprivation by an individual. Including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being. Instances of abuse of all residents, irrespective of any mental or physical abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mistreatment means inappropriate treatment or exploitation of a resident. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental

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F 607	Continued From page 21 anguish, or emotional distress. Identification-Staff are encouraged to identify, correct and intervene in situations in which abuse, neglect is likely to occur. Protection: In the event of an allegation or observation of abuse, the facility will immediately assess the resident, notify the physician and resident representative, and protect the resident from other residents from further harm or incident. On 12/01/22 received in-service training record dated 11/15/22 at 8:30 AM. Subject: Changes to Reporting Resident Abuse After October 24, 2022, and How to Approach A Dementia Patient, Dated: 11/17/2022. No written statements from the staff were provided at this time. On 12/01/22 at approximately 8:00 p.m., a pre-exit interview was conducted with the administrator, the DON, and the Corporate Consultant. The Administrator said that the staff had received inservice training in July and on November the 15th (2022) and the staff did not do what they were trained to do. At the conclusion of survey, no other documentation was presented.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		1/16/23

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F 609	Continued From page 22 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, facility self report document, family and staff interviews, the facility staff failed to ensure appropriate abuse training was implemented to include reporting an abuse allegation involving two residents, Resident #41 and Resident #15 (the perpetrator), a closed record resident, and they failed to timely report an allegation of neglect for one resident, Resident #99 in a survey sample of 39 residents. The findings included: 1. For Resident #41 the facility staff failed to report a physical abuse that resulted in resident having a bruise on her right lower extremity in a	F 609	1) Resident #41 has been evaluated by NP on 11/15/2022 with x-rays obtained. No acute findings for fracture or soft tissue injury identified. Resident remains at facility with no further negative outcome. Resident #15 was discharged from facility to a memory care unit on 11/22/22. Resident # 99 remains in facility without negative outcome and has been interviewed to ensure he is receiving all necessary care and services. Staff involved with Resident #41 have been reeducated on the importance of immediately reporting resident to resident	

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F 609	Continued From page 23 timely manner (Within 2 hours) that occurred on 11/12/22 until 11/14/22 . Resident #41 was admitted to the facility on 11/13/2017 from an acute care facility with diagnosis Alzheimer's disease with late onset and Major Depressive Disorder. The annual, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/02/22 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long-and short-term memory problems as well as severely impaired for daily decision making. Resident #41 requires total dependence of one person with dressing, grooming, eating, toileting, and personal hygiene, requires and bathing. The care plan dated 11/29/17 indicated: Focus-Resident is totally dependent on staff for all ADLs (Activity of Daily Living). Goal-Resident will have personal hygiene needs met and be transferred safely without injury. Interventions: assist her to turn/reposition in bed frequently mechanical lift for transfers personal hygiene done by staff usually has 2- 1/2 bedrails up. The self reported documentation dated 11/14/22 indicated Resident #15 wandered into Resident #41 and during attempts to re-direct Resident #15, she became combative and forcefully grabbed Resident #41's right leg causing a bruise. On 11/21/22 the final report of the event indicated a plan to address the wandering behaviors of Resident #15 included programming development for her cognitive impairments and to work toward finding placement to be near her son. Additional training in addressing combative behaviors, redirecting residents with these behaviors in a manner to avoid escalating	F 609	altercations that could constitute abuse. Facility management staff have been trained on neglect and importance of reporting and investigation all allegations neglect. 2) The DON/designee will review the past 30 days of current residents clinical notes to identify incidents of intrusive and wandering behaviors that may lead to resident to resident altercations. If identified, incident will be investigated and reported to OLC according to reporting guidelines. A review of incident reports for the past 30 days will be completed to ensure all incidence have been investigated for abuse or neglect and appropriate actions have been taken to ensure residents are free from abuse and neglect. 3) All direct care staff will be reeducated on abuse Prevention and reporting. The in-service will include a review of the Resident Abuse Policy, definition of neglect and the importance of immediately reporting any resident to resident altercation that may constitute abuse. The staff will be educated on the process for reporting an allegation or suspicion of abuse or neglect to their immediate supervisor as well as the importance of timely reporting to ensure the resident is safeguarded and a complete and thorough investigation is conducted. 4) The Director of Nursing/designee will	

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F 609	Continued From page 24 agitation. Discussions during the Quality Assurance Committee Monthly meeting would address trends and patterns with corrective action plans implemented or revised if applicable. The fax confirmation dated 11/14/22 revealed the initial self reported documentation of the aforementioned event, sent to the State survey and certification agency which was 2 days after the event. The event occurred on 11/12/22. The fax confirmation dated 11/21/22 revealed the final self reported investigation documentation of the event, sent to the State survey and certification agency. According to the abuse policy under Procedure: All alleged violations involving mistreatment, neglect, exploitation or abuse including injuries of an unknown source and misappropriation of residents property must be reported immediately to the administrator/designee of the facility. The facility Administrator or designee will then report by fax to the State survey and certification agency no later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in bodily injury. Resident to Resident altercations will be investigated as a potential abuse situation. An incident of "willful" intent that inflicts injury or harm to a resident by another resident is considered abuse and will be reported to the State survey and certification agency and Adult Protective Services. A resident to resident suspected abuse will also be reported to law enforcement if appropriate. A review of clinical records:	F 609	review the education and training records of twenty employees weekly for eight weeks to ensure completion of Abuse training. Any variances identified will be addressed and findings will be reported to the Quality Assessment and Assurance Committee.	

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11/12/22 at 11:58 AM., indicated: Resident #41 had discoloration noted to the lower extremities. Long Term Care aware. Representative aware.

A nursing note dated 11/12/22 at 4:15 AM., indicated that "Resident #15 was wondering into Resident #41's room and found lying in bed and became combative when the CNA (Certified Nurse's Aide) attempted to remove her. She grabbed Resident #41 legs and refused to let go. There are no injuries to report at this time. CNA and writer able to remove her out and place her back into her room."

A nursing note dated 11/13/22 at 11:49 AM. Indicated that the nurse notified the NP (Nurse Practitioner) for something for agitation and behavior. Trazodone as needed was only for 14 days.

The clinical notes dated 11/14/22 at 10:22 AM. Read: X-ray done as ordered, results show no fractures, no evidence of dislocation. no acute abnormality is seen. Results fax to provider.

A nursing note dated 11/14/22 at 12:03 AM., indicated "Resident #15 was up wondering off the unit into another resident's room she was redirected back to her room drink and snack accepted bed alarm place under nursing interventions to monitor movement. She is in bed resting at this time bed in lowest position will continue to monitor call light and fluids are in reach." This occurred after the event on 11/12/22."

A nursing note date 11/18/22 at 5:21 AM., indicated that "Resident #15 was rested throughout this shift, no behaviors noted at this

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time will continue monitoring checks."

Behavior monitoring notes in the clinical records reads: Refer to Behavior Monitoring Sheet for 11/15/22, 11/16/22 and 11/17/22. Behavior Monitoring Sheet not available.

A nursing note dated 11/22/22 at 11:44 AM., indicated Resident #15 was transferred to another facility.

On 11/30/22 at approximately 12:11 PM., an interview was conducted with Resident #41's daughter at the resident's bedside concerning the incident. Resident #41 was observed resting quietly in her bed with her daughter and son at her bedside. The resident's daughter pulled back the blanket and sheet on the resident revealing a bluish discoloration about 1 inch in length on her right lower extremity below the resident's knee. She said that her mother's Right lower leg was still bruised on 11/14/22, two days after the incident occurred. She also said that due to her mom having thin skin she bruises easily.

On 12/01/22 at approximately 1:00 PM an interview was conducted with the DON (Director Of Nursing) concerning the above incident. The DON said that the incident occurred on 11/12/22 at approximately 4:07 AM. but was not brought to her attention until 11/14/22 by the resident's (Resident #41) daughter. She completed a self reported document. She said, "Initially when I saw the resident, I called the administrator." Then they went to the resident's bedside and the daughter showed them the pictures of the bruise on the resident's leg. She said that the nurse said that she forgot to put her note in. The DON said that they should have reported this incident in 2 hours.

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No changes with (Resident #15, the perpetrator) medications but she appeared more confused. Her norm was not going into other people rooms. "She was not re-directable, so she grabbed onto Resident #41's right leg." She said they started the investigation on 11/14/22 and the DON said that she did see a bruise on the resident's leg. She also said that a note was put in Resident #15's chart of her going into Resident #41's room. She said that the outcome of the FRI was that the resident was sent to another facility that had a memory care unit and that Resident #15's daughter said that she was okay with the transfer.

2. For Resident #15, the perpetrator, the facility staff failed to report an abuse allegation involving the perpetrator within a two hour time frame. Resident #15 was admitted to the facility on 9/19/13. Her admitting diagnosis includes Schizophrenia, Dementia and Bipolar Disorder. The quarterly revision Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/08/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #15 cognitive abilities for daily decision making were severely impaired. Resident #15 requires extensive assistance of one person with dressing, bed mobility, limited assistance of one person with locomotion on and off the unit, transfers, walking on the unit, walking in the corridor on the unit and personal hygiene, requires supervision set-up help only with eating, requires total dependence of one person with bathing.

On 12/01/22 at approximately 1:00 PM an interview was conducted with the DON (Director Of Nursing) concerning the above incident. The

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DON said that the incident occurred on 11/12/22 at 4:07 AM. but was not brought to her attention until 11/14/22 by the resident's (Resident #41) daughter. She completed a self report document. She said, "Initially when I saw the resident, I called the administrator." She said that the nurse said that she forgot to put her note in. The DON said that they should have reported this incident in 2 hours.

12/01/22 3:15 pm called family member concerning. Said she's ok with family member being in memory care at another facility.

The Policy: Health Services will develop and implement policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, mistreatment, neglect, exploitation, and misappropriation of resident's property. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrence of resident abuse. Definitions: Abuse-Is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Abuse also concludes the deprivation by an individual. Including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being. Instances of abuse of all residents, irrespective of any mental or physical abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mistreatment means inappropriate treatment or

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exploitation of a resident. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Identification-Staff are encouraged to identify, correct and intervene in situations in which abuse, neglect is likely to occur. Protection: In the event of an allegation or observation of abuse, the facility will immediately assess the resident, notify the physician and resident representative, and protect the resident from other residents from further harm or incident.

On 12/01/22 receive inservice training record dated 11/15/22 at 8:30 AM. Subject: Changes to Reporting Resident Abuse After October 24, 2022 and How To Approach A Dementia Patient, Dated: 11/17/2022.

No written statements from the staff were provided.

On 12/01/22 at approximately 8:00 p.m., a pre-exit interview was conducted with the administrator, the DON, and the Corporate Consultant. The administrator said that the staff had received inservice training in July and on November the 15th (2022) and the staff didn't do what they were trained to do.

At the conclusion of survey, no other documentation was presented.

3. The facility failed to timely report an allegation of neglect for one Resident (R) #99. Review of the facility's policy titled, "Resident Abuse Policy and Procedure," dated 11/07/22 revealed, "The facility Administrator/designee will report to the

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State survey and certification no later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse."

During an interview with R99, on 11/30/22 at 9:12 AM, R99 stated that he had been dropped from the mechanical lift last summer.

Review of R99's "Face Sheet" located in the electronic medical record (EMR) under the "Resident Profile" tab, revealed an admission date of 02/25/22 with medical diagnoses of Quadriplegia and Anxiety Disorder.

Review of R99's quarterly "Minimum Data Set (MDS)" located in the EMR under the "RAI" tab with an assessment reference date (ARD) of 10 /21/22, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R99 was cognitively intact. The MDS revealed R99 required total assistance from staff for all activities of daily living (ADL).

During an interview with the DON, the Vice President of Nursing (VPN), and the Assistant Director of Nursing (ADON) 5, on 11/30/22 at 4:27 PM, the VPN stated that nothing had been reported to the State survey and certification agency.

Review of the self report document dated 11/30/22, revealed the event date was 06/10/22. The event type was noted to be an allegation of neglect. Description of event revealed the the resident claimed while being transferred with a lift he told the CNAs to stop because he felt he was slipping from the sling. The self report document indicated that according to [R99] they did not stop, and he slipped from the sling.

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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 record review, self report document, family and staff interviews, the facility staff failed to thoroughly investigate and take appropriate action as a result of investigation findings surrounding an abuse allegation involving two (2) residents. Resident #41 and Resident #15 (the perpetrator), a closed record resident and failed to thoroughly investigate an allegation of neglect for one (1) resident Resident #99, in a survey sample of 39 residents. The findings included: 1. For Resident #41 the facility staff failed to report and investigate a physical abuse allegation that resulted in the resident having a bruise on her right lower extremity to the Resident	F 610	1) Resident #41 has been evaluated by NP on 11/15/2022 with x-rays obtained. No acute findings for fracture or soft tissue injury identified. Resident remains at facility with no further negative outcome. Resident #15 was discharged from facility to a memory care unit on 11/22/22. An investigation was completed and submitted to the appropriate agencies. Resident # 99 has been interviewed and given additional resources to ensure any concerns with his transfers in the mechanical lift will be reported and thoroughly investigated. The Facility Reported Incident was submitted to the	1/16/23

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F 610	Continued From page 32 Representative, Administrator/ designee, APS (Adult Protective Services) or to the State survey and certification agency. The incident occurred on 11/12/22 but was not reported until 11/14/22. Resident #41 was admitted to the facility on 11/13/2017 from an acute care facility with diagnosis Alzheimer's disease with late onset and Major Depressive Disorder. The annual, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/02/22 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long- and short-term memory problems as well as severely impaired for daily decision making. Resident #41 requires total dependence of one person with dressing, grooming, eating, toileting, and personal hygiene, requires and bathing. The care plan dated 11/29/17 indicated: Focus-Resident is totally dependent on staff for all ADLs (Activity of Daily Living). Goal-Resident will have personal hygiene needs met and be transferred safely without injury. Interventions: assist her to turn/reposition in bed frequently mech lift for transfers personal hygiene done by staff usually has 2-1/2 bedrails up. The initial self report document was not initiated until two days after the incident occurred with an event and report date of 11/14/22. The residents involved included Resident #41 and Resident #15 (a closed record resident). Resident #41 sustained a bruise as a result of the event. The self report document described an allegation of abuse/mistreatment dated 11/14/22 and indicated Resident #15 wandered into Resident #41's room and during attempts to re-direct Resident #15, she became combative and forcefully grabbed	F 610	appropriate agencies on 11/30/22 regarding resident #99. A complete and through investigation followed, and the final letter was sent to the appropriate agencies on 12/07/2022, after recieving an extension. 2) The DON/designee will conduct a review of facility clinical notes for the past 30 days to identify residents exhibiting intrusive and wandering behaviors. Any resident identified with this behavior will be evaluated by the provider to ensure appropriate interventions are in place and care plan will be updated. A review of incident reports for the past 30 days will be completed to ensure any bruise of unknown origin or incident involving a mechanical lift have been thoroughly investigated for potential abuse or neglect and reported if indicated to the appropriate agencies. 3) All driect care staff will be reeducated on Abuse and Neglect Prevention and reporting requirements. The in-service will include the importance of reporting resident to resident altercations immediately to ensure a timely, complete and thorough investigation is conducted to include appropriate actions to be taken to safeguard residents. Staff will also be trained on the importance of reporting residents allegations of neglect to ensure a complete and thorough investigation is conducted. 4) The DON/designee will review the clinical notes of current residents weekly	

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F 610	Continued From page 33 Resident #41's right leg causing a bruise. On 11/21/22 the final report of the event indicated a plan to address the wandering behaviors of Resident #15 included programming development for her cognitive impairments and to work toward finding placement to be near her son. Additional training in addressing combative behaviors, redirecting residents with these behaviors in a manner to avoid escalating agitation. Discussions during the Quality Assurance Committee Monthly meeting would address trends and patterns with corrective action plans implemented or revised if applicable. The fax confirmation dated 11/14/22 revealed the initial self reported documentation of the aforementioned event, sent to the State survey and certification agency which was 2 days after the event occured on 11/12/22. The fax confirmation dated 11/21/22 revealed the final self reported investigation documentation of the event sent to the State survey and certification agency. According to the abuse policy under Procedure: All alleged violations involving mistreatment, neglect, exploitation or abuse including injuries of an unknown source and misappropriation of residents property must be reported immediately to the administrator/designee of the facility. The facility Administrator or designee will then report by fax to VDH/OLC (Virginia Department of Health/Office of Licensure and Certification) no later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in bodily injury. Resident to Resident altercations will be investigated as a potential abuse situation.	F 610	for eight weeks to ensure any resident to resident altercations have been thoroughly investigated and reported to the appropriate agencies according to reporting guidelines and appropriate action has been taken to safeguard resident. She will also review all incident reports for bruises of unknown origin or incidents involving a mechanical lift to ensure a complete and thorough investigation has been conducted. The Director of Nursing will review for patterns or trends and report to the Quality Assessement and Assurance Committee.	

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An incident of "willful" intent that inflicts injury or harm to a resident by another resident is considered abuse and will be reported to the VDH/OLC and Adult Protective Services. A resident-to-resident suspected abuse will also be reported to law enforcement if appropriate. The facility must complete a thorough written investigation and must prevent further potential abuse while the investigation is in progress.

A review of clinical records:

11/12/22 at 11:58 AM., indicated: Resident #41 had discoloration noted to the lower extremities. Long Term Care aware. Representative aware.

The clinical notes dated 11/14/22 at 10:22 AM. Read: X-ray done as ordered, results show no fractures, no evidence of dislocation. no acute abnormality is seen. Results fax to provider.

On 11/30/22 at approximately 12:11 PM., an interview was conducted with Resident #41s daughter at the resident's bedside concerning the incident. Resident #41 was observed resting quietly in her bed with her daughter and son at her bedside. The resident's daughter pulled back the blanket and sheet on the resident revealing a bluish discoloration about 1 inch in length on her right lower extremity below the resident's knee. She said that her mother's Right lower leg was still bruised on 11/14/22, two days after the incident occurred. She also said that due to her mom having thin skin she bruises easily.

2. For Resident #15, the perpetrator, the facility staff failed to report an abuse allegation involving the perpetrator within a two-hour time frame.

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Resident #15 was admitted to the facility on 9/19/13. Her admitting diagnosis includes Schizophrenia, Dementia and Bipolar Disorder. The quarterly revision Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/08/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #15 cognitive abilities for daily decision making were severely impaired. Resident #15 requires extensive assistance of one person with dressing, bed mobility, limited assistance of one person with locomotion on and off the unit, transfers, walking on the unit, walking in the corridor on the unit and personal hygiene, requires supervision set-up help only with eating, requires total dependence of one person with bathing.

A nursing note dated 11/22/22 at 11:44 AM., indicated Resident #15 was transferred to another facility.

On 12/01/22 at approximately 1:00 PM an interview was conducted with the DON (Director Of Nursing) concerning the above incident. The DON said that the incident occurred on 11/12/22 at 4:07 AM. but was not brought to her attention until 11/14/22 by the resident's (Resident #41) daughter. She completed a self report document. She said, "Initially when I saw the resident, I called the administrator." Then they went to the resident's bedside and the daughter showed them the pictures of the bruise on the resident's leg. She said that the nurse said that she forgot to put her note in. The DON said that they should have reported this incident in 2 hours. No changes with (Resident #15, the perpetrator) medications but she appeared more confused.

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Her norm was not going into other people rooms. "She was not redirectable, so she grabbed onto Resident #41s right leg." She said they started the investigation on 11/14/22 and the DON said that she did see a bruise on the resident's leg. She also said that a note was put in Resident #15's chart of her going into Resident #41's room. She said that the outcome of the self reported investigation was that the resident was sent to another facility that had a memory care unit and that Resident #15's daughter said that she was okay with the transfer.

The Policy: Health Services will develop and implement policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, mistreatment, neglect, exploitation, and misappropriation of resident's property. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrence of resident abuse.

Investigate: During an investigation possible indicators such as bruises are abuse triggers and need further assessment. Resident #41 had bruises on her right lower extremity due to Residnet #15 pulling at her legs.

On 12/01/22 received in-service training record dated 11/15/22 at 8:30 AM. Subject: Changes to Reporting Resident Abuse After October 24, 2022, and How to Approach A Dementia Patient, Dated: 11/17/2022.

No written statements from the staff were provided at this time.

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On 12/01/22 at approximately 8:00 p.m., a pre-exit interview was conducted with the administrator, the DON, and the Corporate Consultant. The administrator said that the staff received prior abuse training.

At the conclusion of survey, no other documentation was presented.

3. The facility failed to thoroughly investigate an allegation of neglect for one resident (Resident (R) 99. Review of the facility's policy titled, "Resident Abuse Policy and Procedure," dated 11/07/22 revealed, "The facility must complete a thorough written investigation and must prevent further potential abuse while the investigation is in progress."

During an interview with R99, on 11/30/22 at 9:12 AM, R99 stated that he had been dropped from the mechanical lift last summer. He stated he had told Certified Nurse Aide (CNA) 2 to stop because "it did not feel right" while he was in the mechanical lift. R99 stated "I said this isn't going to work. I wasn't secure to begin with. I told her to stop, and I jerked, and she just kept on." R99 stated CNA 2 did not stop and continued with the transfer. R99 stated, since the fall, "something changed inside me." He stated he had more discomfort and pain since the fall. He stated it felt disrespectful that management had not talked with him about the fall until a week after the fall had occurred.

Review of R99's "Face Sheet" located in the electronic medical record (EMR) under the "Resident Profile" tab, revealed an admission date of 02/25/22 with medical diagnoses of

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Quadriplegia and Anxiety Disorder.

Review of R99's quarterly "Minimum Data Set (MDS)" located in the EMR under the "RAI" tab with an assessment reference date (ARD) of 10 /21/22, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R99 was cognitively intact. The MDS revealed R99 required total assistance from staff for all activities of daily living (ADL).

Review of the "Progress Note" dated 06/10/22 found in the EMR under the "Resident Profile," signed by the Nurse Practitioner revealed, "I found [R99] to be laying on the floor under the Hoyer lift with his head of the bottom leg of the lift. He had the Hoyer sling partially underneath him. He was awake, alert and very shaken by the incident. Staff assisted him back to bed. He states that he hit the back of his head on the metal leg of the lift. He tells me that I tried to tell them that it was not hooked up right. He tells me that when he fell, he was in the sling at approximately the level of his bed. It is unclear exactly what happened."

Review of the event report dated 06/10/22, revealed R99 fell on 06/10/22 at 12:30 PM and revealed R99 had "Swelling left low back of head and mid low back of head." The incident report revealed R99 "Slipped from pad."

Review of the "Statement Form" dated 06/10/22, signed by CNA2, revealed "At 12:30 PM I was helping [CNA 3] putting [R99] back to bed he slide [sic] out of the pad unto the lift he hitted [sic] the legs I called for nurses to looked [sic] at him."

Review of the "Statement Form" dated 06/10/22,

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signed by CNA3, revealed "I went in room around 12:30 [PM] to give [R99] a bath. [CNA2] came in and said [R99] wanted to go to bed. She help [sic] me put him to bed. We were connecting the Hoyer lift (Mechanical Lift) pad to the Hoyer lift and started lifting him when he first got lifted in the air, I heard the Hoyer lift snap like it was about to fall but the recliner chair was still behind him. [CNA2] was still lifting the Hoyer lift and she told me to lower the bed. In the middle of me lifting the bed [R99] said he feel [sic] like he falling [sic] next thing you know he fell and hit his head on the Hoyer lift."

Review of the "Statement Form" dated 06/16/22, signed by the Corporate Infection Preventionist (CIP) revealed "Resident interview after staff reporting [R99] wanted to speak to someone about concerns surrounding fall on 06/10/22 ... [CNA2] did not listen to him when he told her it felt like the leg portion of the sling was not properly secured ...He told [CNA2] please stop it feels like I'm slipping ...[CNA2] was operating the lift controls."

During an interview with the DON, the Vice President of Nursing (VPN), and the Assistant Director of Nursing (ADON) 5 on 11/30/22 at 4:27 PM, the DON stated that CNA 2 should have "listened to the resident. The resident knows if there is a problem," The VPN confirmed that an abuse investigation had not been completed.

During an interview with the Corporate Infection Preventionist (CIP) on 11/30/22 at 4:50 PM, she confirmed she had interviewed R99 on 06/16/22 (six days after the fall). She stated the reason she had interviewed him was because staff "kept hearing from him." She stated this was the first

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F 610	Continued From page 40 time the resident had been interviewed. During an interview with the VPN on 11/30/22 at 6:48 PM, the VPN stated she would begin the investigation. During an interview with the Nurse Practitioner, on 12/01/22 at 4:39 PM, she stated, after R99 fell, she had seen the resident. She stated R99 told her, "I tried to tell them that it was not hooked up right." The Nurse Practitioner stated that after R99 told her this, she had reported the information to staff. Review of the self report document dated 11/30/22, revealed the event date was 06/10/22. The event type was an "Allegation of Neglect." Description of the event revealed that the resident claimed while being transferred with a lift he told the CNAs to stop because he felt he was slipping from the sling. According to [R99] they did not stop, and he slipped from the sling.	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation, the facility staff failed to ensure that 1 of 39 residents (Resident #51) in the survey sample received a complete and accurate assessment Minimum Data Set (MDS). The findings included:	F 641	1) For Resident #51 the MDS ARD 6/10/2022 was modified 12/1/22 to ensure an accurate MDS assessment for Item P0200E related to the Wander/Elopement Alarm. 2) The facility audited 100% of the current residents with a Wander/Elopement alarm	1/16/23

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F 641	Continued From page 41 Resident #51 was originally admitted to the nursing facility on 03/25/19. Diagnosis for Resident #51 included but are not limited to anxiety and depression. The most recent (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 09/10/22 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 05 out of a possible score of 15, which indicated severe cognitive impairment for daily decision-making. Under section P (under restraints/alarms) was coded for the use of a wander/elopement alarm. A review of the quarterly assessment with an ARD date of 06/10/22 under section P (under restraints/alarms) was not coded for the use of a wander/elopement alarm. Resident #51's comprehensive care plan with a revision date of 09/02/22 identified Resident #51 at risk for wandering. Some of the interventions/approaches the staff would use to accomplish this goal is record behaviors on Behavior Tracking Form, redirect resident when wandering is observed and use wander guard/location monitor daily. During the review of Resident #51's Physician Order Summary (POS) for November 2022 revealed an order for a wander alert to alert staff if resident attempts to exit the facility without assistance. Check placement every shift by staff starting on 04/20/22. A review of Resident #51's Treatment Administration Record (TAR) was reviewed for the month of June 2022. The TAR revealed nurse's initials being signed off daily for the use of a wander guard device.	F 641	to ensure that P0200E was properly coded on the MDS. Any variances were corrected by modified the residents MDS coding in P0200E. 3) The Director of Clinical Revenue Integrity/designee provided education to the MDS team that included a review of the RAI Manual guidance on how to properly code P0200E. 4) The Managed Care Coordinator /Designee will audit 100% of new wander alert orders weekly for 8 weeks to ensure they are properly coded on the residents MDS. The Managed Care Coordinator /Designee will identify any patterns or trends and report to the Quality Assessment and Assurance Committee.	

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F 641	Continued From page 42 On 12/01/22 at approximately 9:35 a.m., Resident #51 was observed sitting in his wheelchair. The wander guard bracelet was observed to his left ankle. An interview was conducted with MDS Coordinator #1 on 12/01/22 at approximately 10:10 a.m. She stated the MDS dated 06/10/22 was coded inaccurately and should have been coded for the use of a wander guard device. A debriefing was held with the Administrator, Director of Nursing, Assistant Director of Nursing, Vice President of Operations and Vice President of Nursing on 12/01/22 at approximately 8:00 p.m., who were informed of the above findings. No further information was provided prior to exit.	F 641		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 686	1) Resident #65 has been evaluated by	1/16/23

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F 686	Continued From page 43 interviews, clinical record review, and review of facility documents, the facility staff failed to provide the necessary treatment and services to prevent development of a sacral pressure ulcer and to promote healing of the sacral pressure ulcer for 1 of 39 residents (Resident #65) which constitued harm. The findings included: On 10/6/22 the sacral pressure ulcer presented as a red, black, and purple wound to the sacrum, measuring 8 cm by 13.0 cm, with a scant amount of drainage and a wound bed with epithelial tissue, which was determined to be an Unstageable - Suspected Deep Tissue (USDT); Injury in Evolution. On 10/10/22 the sacral USDT Injury presented with deterioration; 90% eschar, 10% slough and measured 7.5 centimeters (cm) by 7.0 cm which constituting harm. Resident #65 was originally admitted to the facility 6/14/22 and readmitted 9/16/22 after an acute care hospital stay. The current diagnoses included a-fib, a pacemaker insertion, benign prostatic hypertrophy, requiring use of an indwelling catheter, and renal insufficiency. The 5-day Prospective Payment System Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/21/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #65's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, locomotion on the unit, dressing and	F 686	the wound care physician on 10/28/22 and continues to be seen on a weekly basis. The treatment plan has been adjusted when deemed appropriate and new orders implemented. The provider was informed the muciprion was not administered as ordered in November. The resident is receiving hospice services due to progressive clinical decline related to his diagnosis of CVA. The provider overseeing his care has been educated on the importance of a medical evaluation with a newly developed pressure ulcer to ensure the appropriate treatment is in place to aid in wound healing. 2) The wound Nurse/designee will review the clinical records of current residents with a pressure ulcer to ensure a medical evaluation has been conducted by the provider or wound care provider. The review will include evaluating the need for change in treatment, and ensuring wound care orders are transcribed correctly according to the providers orders. The wound care nurse will be responsible for communicating any deterioration of the wound with the provider/VOHRA provider to ensure an evaluation is conducted and all treatments are in place as needed to aid in wound healing. 3) MDs /NPs/RNs/LPNs/CNAs will be educated on Pressure Ulcer treatment	

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F 686	Continued From page 44 toileting, limited assistance of one person with personal hygiene, with assistance of one person with bathing, and supervision with one person assistance with eating. A review of the facility's matrix coded Resident #65 as having a stage 4 pressure ulcer therefore, an interview was conducted with Resident #65 on 11/30/22 at approximately 10:40 a.m. The resident stated he had a sore to his bottom which was frequently painful, and the nurses take care of it, but he was unable to provide any other information about it. The following two areas of essential care and services were not met which constituted harm for Resident #65: 1. The facility staff failed to ensure a physician and/or practitioner conducted a medical evaluation of a Resident #65's new unstageable pressure ulcer from 10/6/22 through 10/27/22 as evidenced by a 10/18/22 NP progress note which read the sacral wound was showing some improvement per report. The NP progress note dated 10/24/22 stated that the resident was positive for a pressure ulcer. The physician and/or practitioner failed to change the sacral pressure ulcer wound treatment from 10/6/22 through 10/27/22 although the wound continued to show deterioration. As a result of no physician and/or practitioner medical evaluation of a Resident #65's new unstageable pressure ulcer from 10/6/22 through 10/27/22 the initial sacral pressure assessment by a physician and/or practitioner resulted in surgical debridement and a change in treatment. The NP made many visits with the resident from 10/6/22 through 10/27/22 for other health concerns but never to assess the	F 686	and prevention. The Inservice will include but is not limited to the importance of a medical evaluation of a newly developed pressure area to ensure the appropriate treatments and pressure reducing surfaces in place, the role of nutrition in wound healing and importance of communicating wound changes with the provider to determine if a change in treatment is indicated. 4) The Director of Nursing/designee will review the clinical record of 20% of residents with pressure areas weekly for eight weeks to ensure the provider has evaluated the resident for any change in wound, adjusted treatment plan as indicated and ensure treatments have been transcribed according to the physician. The Director of Nursing will review for any trends and report findings to the Quality Assessment and Assurance Committee.	

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resident's sacral pressure ulcer to determine if it was affecting his overall health.

2. The facility staff failed to transcribe and administer a wound care physician order dated 11/9/22 for Mupirocin (antibiotic) ointment apply twice daily for 30 days. As a result of not having the ordered treatment rendered to the resident's wound continued to deteriorate and not respond as expected. Mupirocin is a topical antibiotic used to treat skin infections caused by bacteria https://medlineplus.gov.

A review of the wound care notes revealed the following note dated 10/6/22 at 1:29 p.m. It read; wound nurse in to assess the resident's sacrum with an open area and surrounding dark discoloration and non-blanchable redness. The Nurse Practitioner (NP) was made aware of the area. Resident has been on COVID precautions and resident has been less mobile. Resident stated he has not been eating and has not been offered foods and supplemental nutrition that he states he doesn't want. The NP is aware and stated there was a decline in the resident's overall status with the infection. New orders were received for the sacrum. The resident is aware. Positional changes are encouraged. Offload as tolerated. The sacral pressure ulcer initially presented on 10/6/22 as a red, black, and purple wound to the sacrum, measuring 8 cm by 13.0 cm, with a scant amount of drainage and a wound bed with epithelial tissue, which was determined to be an Unstageable - Suspected Deep Tissue: Injury in Evolution. The sacral treatment order dated 10/6/22, was Iodosorb 0.9% topical gel one time daily and as needed.

Iodosorb Gel is a sterile antimicrobial dressing

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formulation of Cadexomer Iodine. When applied to the wound, Iodosorb absorbs fluids, removing exudate, slough and debris and forming a gel over the wound surface. As the gel absorbs exudate, iodine is released, killing bacteria, and changing color as the iodine is used up. Iodosorb Gel is used in treating wet ulcers and wounds such as venous stasis ulcers, pressure sores, diabetic foot ulcers, and infected traumatic and surgical wounds. (https://www.smith-nephew.com/professional/products/advanced-wound-management/iodosorb--iodoflex/iodosorb-gel/)

The 10/10/22 sacral wound assessment read; the overall wound decreased in size but, the eschar area increased. Scant drainage was noted. The NP was aware, the current treatment was continued (Iodosorb 0.9% topical gel one time daily and as needed) as well as offloading as tolerated. A new order for supplements (Liquacell protein supplement 30 ml every day) was obtained related to wound healing. The resident was made aware. The sacral wound measured 7.5 cm by 7.0 cm by 0.1 cm. The documentation further stated the wound was black and red, contained 90% eschar, 10% slough, and had a small amount of serous drainage. It was determined to be Unstageable because of Slough and/or Eschar.

The 10/17/22 sacral wound assessment read; improvement noted with discoloration. Serosanguineous drainage noted. Continue with same treatment and offloading as tolerated. The sacral wound measured 4.5 cm by 6.5 cm, no depth was documented. The documentation also stated the wound was red and yellow, contained 90% slough, 10% granulation tissue, and a

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medium amount of serosanguineous drainage.

The 10/24/22 sacral wound assessment read; decline noted and NP aware. Serosanguineous drainage noted. The wound bed is brown and yellow towards the middle and outer right of the wound with redness to the left of the wound. The wound edges were noted with purplish and deep red discoloration. Continue with current treatment and offloading as tolerated. The sacral wound measured 5.5 cm by 8.0 cm, no depth was documented. The documentation further stated the wound was black, red, purple, and yellow, contained 70% slough, 20% eschar and 10% granulation tissue, and a large amount of serosanguineous drainage.

On 10/25/22 an order was obtained to consult (a group of wound care physicians). On 10/28/22 the wound care physician assessed Resident #65's sacral pressure ulcer. This was the first documentation that the wound was visualized, assessed, and documented on by a physician and/or practitioner. The wound care physician's documentation revealed the resident's sacral pressure ulcer etiology was pressure, it measured 7.5 cm by 8.5 cm and the depth wasn't measurable. The wound contained 40% thick adherent black necrotic tissue (eschar), 40% thick adherent devitalized necrotic tissue, 20% granulation tissue and light serous drainage. The wound required surgical excisional debridement of the necrotic tissue to establish the margins of viable tissue and remove the thick adherent eschar and devitalized tissue. The wound care physician's treatment plan was as follows: sodium hypochlorite solution (Dakin's) apply once daily for 30 days, Santyl (a chemical debrider), apply once daily for 30 days, a secondary dressing,

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superabsorbent silicone border and faced apply once daily for 30 days and skin prep, apply once daily for 30 days to the periwound. The wound care physician also recommended a low air mattress; off-load the wound and repositioning per the facility's protocol.

The resident was reassessed by the wound care physician on 11/2/22. The assessment revealed the sacral pressure ulcer measured 8.0 cm by 8.0 cm and the depth was not measurable. This was an increase in the length and there was no change in the tissue composition and exudate; 40% thick adherent black necrotic tissue (eschar), 40% thick adherent devitalized necrotic tissue, 20% granulation tissue and light serous drainage. The wound care physician's treatment plan was as follows: continue sodium hypochlorite solution (Dakin's) apply once daily for 25 days, Santyl, apply once daily for 25 days, a secondary dressing, superabsorbent silicone border and faced apply once daily for 25 days and skin prep, apply once daily for 25 days to the periwound. The wound care physician also recommended off-loading the wound and repositioning per the facility's protocol. The pressure ulcer remained Unstageable.

The resident was reassessed by the wound care physician on 11/9/22. The assessment revealed the sacral pressure ulcer measured 7.0 cm by 7.0 cm and the depth was not measurable. This was a decrease in length and width, but the wound was deteriorating the periwound radius was with erythema and odor, the wound presented with 30% thick adherent black necrotic tissue (eschar), 70% thick adherent devitalized necrotic tissue. The wound care physician's treatment plan was as follows: continue sodium hypochlorite

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solution (Dakin's) apply once daily for 18 days, Santyl, apply once daily for 18 days, a secondary dressing, superabsorbent silicone border and faced apply once daily for 18 days, skin prep, apply once daily for 18 days to the peri wound and add Mupirocin ointment (an antibiotic) twice daily for 30 days. The wound care physician also recommended off-loading the wound and repositioning per the facility's protocol. The sacral wound was reclassified as a Stage 4 pressure ulcer.

The resident was reassessed by the wound care physician on 11/16/22. The assessment revealed the sacral pressure ulcer measured 6.5 cm by 6.0 cm by a depth of 2.5 cm. This is a decrease in size but an increase in depth. The wound presented with 30% thick adherent black necrotic tissue (eschar), 20% thick adherent devitalized necrotic tissue, 20% granulation tissue, 30% viable tissue (fascia, muscle, bone) and moderate serous drainage. The wound care physician's treatment plan was as follows: continue sodium hypochlorite solution (Dakin's) apply once daily for 11 days, Santyl, apply once daily for 11 days, a secondary dressing, superabsorbent silicone border and faced apply once daily for 11 days, skin prep, apply once daily for 11 days to the periwound and add Mupirocin ointment (an antibiotic) twice daily for 23 days. The wound care physician also recommended off-loading the wound and repositioning per the facility's protocol.

The resident was assessed by the wound care nurse on 11/23/22. The assessment revealed the sacral pressure ulcer measured 6.5 cm by 6.0 cm by a depth of 3.0 cm. This is an increase in depth. The wound presented with 30% eschar, 20% devitalized necrotic tissue 20% granulation

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tissue, 30% viable tissues (fascia, muscle, bone), a medium amount of serous drainage and bright red and/or blanches to touch surrounding tissue. The wound care note stated the wound was stable and to continue with the current treatment orders. Continue to offload as tolerated.

The resident was reassessed by the wound care physician on 11/30/22. The assessment revealed the sacral pressure ulcer measured 5.0 cm by 5.3 cm by a depth of 2.5 cm. This is a decrease in size and depth. The wound presented with 20% thick adherent black necrotic tissue (eschar), 50% granulation tissue, 30% viable tissues (fascia, muscle, bone) and moderate serosanguinous drainage. The wound care physician's treatment plan was as follows: sodium hypochlorite solution (Dakin's) cleanse wound bed with only; apply once daily for 30 days, Gentamicin (antibiotic) ointment apply once daily for 30 days, Alginate calcium apply once daily for 30 days; a secondary dressing, superabsorbent silicone border and faced apply once daily for 30 days, skin prep, and apply once daily for 30 days to the periwound. The wound care physician also recommended off-loading the wound and repositioning per the facility's protocol.

The wound care physician also documented on 11/30/22 that the resident was evaluated as a candidate for wound treatment using a skin substitute to the full thickness, chronic stage 4 sacral pressure wound. The wound care physician also documented the wound had been present for greater than (>) 32 days and had failed to respond appropriately for over 30 days despite standard management. This includes mitigation of contributing factors, appropriate preventive strategies for pressure reduction and

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any indicated lower extremity compression therapy. The wound has no signs of infection or osteomyelitis. The patient is not a smoker, is not receiving medications that may significantly impact wound healing and is without an uncontrolled autoimmune disease.

The nutritional support assessment by the Registered Dietician wasn't initiated until 10/21/22 - It read (name of the resident) presents with unintentional weight loss of 7% in 30 days. He has an unstageable area to sacrum, 1+ edema on bilateral lower extremities (BLE), receiving Normal Saline 0.9% at 60 milliliters per hour for hydration. Height: 71 inches Weight: 197 pounds, body mass index (BMI) 27.5 - overweight/ 114 percent of ideal body weight (IBW). Medical prescription (Rx): vitamin C, zinc, Liquacell every day and Boost twice per day were added for wound healing. (name of the resident) had COVID recently. Diagnoses of heart failure, chronic kidney disease, unintentional weight loss, poor intake at times and new pressure areas, recommend review for PCM. Add snack every day.

The resident's Braden assessment dated 7/13/22 revealed a score of 19. This indicated he had no risk for pressure ulcer development. A review of the Braden categories are as follows: FRICTION AND SHEAR no apparent problems, NUTRITION Usual- food intake pattern; adequate, MOBILITY Ability to change and control body position; slightly limited, ACTIVITY Degree of physical activity; Walks Occasionally, MOISTURE Degree to which skin is exposed to moisture; Rarely Moist, SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort; No.

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Resident #65's care plan revealed the following: 10/11/22 - Problem (name of Resident) is at risk of pressure ulcer. Unstageable slough/eschar (Re-assessed 11/10/22: Stage 4) Goal: (name of Resident) will remain free of skin breakdown through next review. Interventions: Check skin for redness, skin tears, swelling, or pressure areas. Report any signs of skin breakdown. Perform nutritional screening. Adjust diet/supplements as indicated to reduce the risk of skin breakdown. Use pillows, pads, or wedges to reduce pressure on heels and pressure points. Turn/reposition. Do not massage skin over pressure areas. 10/6/2022 Sacrum wound with treatment orders. 10/27/2022 Low air loss mattress as indicated. 10/27/2022 (wound care practice) consult as indicated.

A wound care observation was made on 12/1/22 at approximately 10:39 p.m. The resident was repositioned on his right side by the wound care nurse and CNA #15 providing extensive assistance. He was lying on a low air loss mattress which was ordered 10/27/22, twenty-one days after presenting with skin impairment. Observation of the wound revealed a clean non-odorous sacral pressure ulcer with a small amount of serosanguinous drainage and approximately 25% eschar.

An interview was conducted with Certified Nursing Assistant (CNA) #15 on 12/1/22 at approximately 11:45 a.m. CNA #15 stated the resident has difficulty hearing but usually answers appropriately when he hears what's said to him and he will ask to go to the hospital if he doesn't feel good. CNA #15 also stated the resident usually feeds himself, helps with turning and

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positioning but the staff baths and dresses the resident. CNA #15 stated the resident goes to therapy and enjoys being out of bed in his wheelchair but lately in a reclining chair.

The facility's policy titled Pressure Ulcer Treatment Program with a revision date of 3/6/12 read; a comprehensive treatment program should be provided for residents with pressure ulcers. The goal of the treatment program includes efforts to stabilize, reduce or remove underlying risk factors to monitor the impact of the interventions and to modify the interventions as appropriate based on the individual needs of the resident.

On 12/1/22 at approximately 8:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultants. The Corporate Vice President of Nursing stated the facility staff had done all that was possible to promote healing of Resident #65's sacral pressure ulcer.

Dakin's solution is a strong topical antiseptic widely used to clean infected wounds, ulcers, and burns. (https://www.ncbi.nlm.nih.gov/books/NBK507916/)

A Deep Tissue Injury is a pressure-related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise, and they may herald the subsequent development of a Stage III-IV pressure ulcer (https://www.ncbi.nlm.nih.gov/books/NBK2650/table/ch12.t2/)

Unstageable pressure injury is a Full thickness

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F 686	Continued From page 54 tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed. (https://www.ncbi.nlm.nih.gov/books/NBK2650/table/ch12.t2)	F 686		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 791		1/16/23

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F 791	Continued From page 55 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews and clinical record review, the facility staff failed to ensure 1 out of 39 residents (Resident #4) in the survey sample received the services needed to meet their dental needs. The findings included: The facility staff failed to follow-up with a dental visit recommended by the dentist on 07/31/22 for Resident #4. Diagnosis for Resident #4 included but not limited to Major Depressive Disorder. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 9/01/22 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15, which indicated no cognitive impairment for daily decision-making. The MDS coded Resident #4 supervision with oversight, encouragement or cueing with eating. Under section L0200 (Dental), nothing was coded for Resident #4. An interview was conducted with Resident #4 on 11/30/22 at approximately 11:10 a.m. She said	F 791	1) Resident #4 is scheduled to be been by Family Dental of Hampton on February 13, 2023. The resident has experienced no negative outcomes. 2) The Director of Nursing/designee will review the past 30 days of dental notes for current residents to ensure any follow up appointments and services have been provided and /or scheduled as indicated. The Charge nurse/designee on each unit will be responsible for reviewing dental consults and scheduling needed appointments to ensure residents receive dental services as indicated. 3) LPNs/RNs will be educated and trained on Dental Services. The training will include the importance of the review of the Dental consults for orders and follow up and scheduling appointments to ensure resident receive needed services timely. 4) The Director of Nursing/designee will	

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that she had two bad teeth in the back of her mouth that needed to be pulled. She also said that a dentist came to visit 4 or 5 months ago saying that her teeth need to be pulled and she should have a follow-up appointment. "My teeth have cracks in them and pieces of my teeth have broken off." She was asked if she was having trouble eating but said the broken teeth do not keep her from eating. The resident currently denied any pain or discomfort at this time.

On 12/01/22 at approximately 5:00 PM., the DON (Director of Nursing) presented a dental note dated 9/14/22. In summary it read that resident had a cleaning. A concern from the resident was "of #11, 14 and decay with #10, but no pain." The dental note also indicated that Resident #4 needed to have her teeth extracted (#11,#14) due to her teeth being broken and tooth #10 is decayed.

On 12/01/22 at approximately 5:18 PM., an interview was conducted with the SW (Social Worker/OSM/Other Staff Member #6) concerning the above issue. She said that the nursing staff or the ADON (Assistant Director of Nursing) was responsible for making the dental appointment.

On 12/01/22 at approximately 6:10 PM., a phone call was made to the ADON (Administrative Staff #5) concerning the above. A voice message was left.

On 12/01/22 at approximately 6:15 PM., a phone call was made to the ADON (ASM/Administrative Staff Member #6) concerning the above. She said that there are two ADON's, but ASM #5 (Administrative staff #5) was responsible for making the dental referral for Resident #4.

review all dental consult reports weekly for eight weeks to ensure any follow up services are addressed. The Director of Nursing will correct any variances and report finding to the Quality Assessment and Assurance Committee at least quarterly.

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F 791	Continued From page 57 On 12/01/22 at approximately 8:00 p.m., a pre-exit interview was conducted with the administrator, the DON and the Corporate Consultant. The DON said that the Nurse Practitioner should have been informed of the residents dental findings.	F 791		
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, resident and staff interviews, the facility staff failed to ensure sufficient staff were available to carry out the functions of the food and nutrition services. The findings included:	F 802	1) Residents have received breakfast as written on the dietary menus after Easter Sunday 4/17/2022. 2) The facility has identified all residents as having the potential to be affected by this alleged deficient practice.	1/16/23

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F 802	Continued From page 58 The facility failed to have sufficient staff on 04/17/22 to carry out the functions of the food and nutrition services. During an interview on 11/30/22 at 1:37 PM Resident #82 voiced concern about food. Resident voiced concerns about the facility not having enough staff to serve and prepare food. Resident #82 stated the facility served the residents a granola bar, a carton of juice and a cup of fruit for breakfast a few months ago because the facility did not have enough staff. During an interview on 12/01/22 at 9:58 AM Dietary Aide #1 stated on the morning of April 17, 2022 which was Easter Sunday, she was the only dietary staff on duty. Dietary Aide #1 stated she did the best she could to provide a breakfast meal to the residents. The meal consisted of granola bar, a carton of juice and a cup of fruit for those residents on a regular diet. For residents on a puree, mechanical soft or chopped diet, they were given a cup of apple sauce and a carton of milk. The census of the facility was 134 on this date. Dietary Aide #1 was asked if this has happened before and she stated, yes. "I tried to do all that I could for the residents." Dietary Aide #1 was asked if she had called and informed the administrator or Dietary Manager of the staffing issues and she stated, "yes." During an interview on 12/1/22 at 9:48 AM the Director of Dining and Nutrition stated, "we have been down with the kitchen staff for months. Some days we only had three staff for the entire day. At times we have asked the Certified	F 802	3) 1. The Administrator, or the designee will review the dietary schedule one week in advance to identify potential staffing challenges. The Administrator will work with the dietary staff to schedule adequate staffing for the meals and services required. 2. In the event of kitchen staff calling off for a scheduled shift, the following actions will be taken; a. The Kitchen Manager, or their designee, will attempt to identify a substitute team member to cover the open shift. b. If a Substitute cannot be found, the Kitchen Manager or their designee will cover the open shift. 3. The Administrator, or their designee, will audit worked schedules every week to ensure staffing was adequate for the period being reviewed 4. The Administrator or designee will reeducate dining service staff on policy and procedure for call offs. 4) The Administrator/Designee will discuss any trends or patterns identified at the Quality Assurance and Assessment Committee meeting. All trends or patterns identified will be addressed and corrective action plan revised if applicable.	

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F 802	Continued From page 59 Nursing Assistants (CNA'S) to help with dish washing. The required staffing is between 11-12 staff. We have been running the kitchen with only three staff. I have developed a "Root Cause Analysis & Action Plan." The Director of Dining and Nutrition was asked if she was aware of the Easter Sunday staffing problems and she stated that she was informed the next day. A revised Dining Service, Food Service and Meal Distribution Policy dated 10/11/22 indicated: Policy-Dining services will meet the individual nutritional needs of each resident. Menus are planned to provide each resident with a resident specific, nourishing, palatable, and well-balanced diet. Service and distribution will be conducted in a manner that meets federal, state and local guidelines. Dining Service Staff: Sufficient, competent dining services staff are employed to carry out the functions of the dinning services department.	F 802		
F 803 SS=F	Complaint Deficiency Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance;	F 803		1/16/23

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F 803	Continued From page 60 §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility staff failed to ensure menus were followed as pre-planned. The findings included: The facility staff failed to ensure menus were followed as planned on 4/17/22 due to having insufficient staff. During an interview on 11/30/22 at 01:37 PM Resident #82 voiced concern about food. Resident voiced concerns about the facility not having enough staff to serve and prepare food. Resident #82 stated the facility served the residents a granola bar, a carton of juice and a cup of fruit for breakfast a few months ago because the facility did not have enough staff. A review of the facility menu dated 4/17/22 for	F 803	1) Resident # 82 was interviewed regarding the breakfast served on April 17, 2022 and no additional corrections were needed for Resident #82. 2) All residents have the potential to be affected by this deficient practice. 3) All dining staff will be reeducated regarding adherence to the menu for all diets and procedure for any substitutions made to the menu and use of emergency menus. 4) Dietitian/designee will audit 5 random meals each week for 8 weeks to ensure that residents are receiving the correct menu items. All substitutions will be approved by the dietitian. A summary of the audits will be presented to the Quality	

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F 803	Continued From page 61 breakfast indicated: Juice/cranberry PC, Cereal Chex Rice PC, Muffin Blueberry RTS, sausage link, 2 each, milk 2% 8 ounces, and 8 ounces of coffee. During an interview on 12/01/22 at 9:58 AM Dietary Aide #1 stated on the morning of April 17, 2022 which was Easter Sunday, she was the only dietary staff on duty. Dietary Aide #1 stated she did the best she could to provide a breakfast meal to the residents. The meal consisted of granola bar, a carton of juice and a cup of fruit for those residents on a regular diet. For residents on a puree, mechanical soft or chopped diet, they were given a cup of apple sauce and a carton of milk. Dietary Aide #1 was asked if the facility had an emergency back up breakfast menu and she stated, " no, not at that time." During the Group Meeting conducted 11/29/22 at 3:30 PM, the residents stated the shrimp that was on the lunch menu for the day was burnt, hard and over cooked. The french fries were cold and not edible and the menu did not match what was served. During an interview on 12/1/22 at 9:48 AM the Director of Dining and Nutrition stated, there were no emergency menus in place until she developed them in May of 2022. A Dining Service, Food Service and Meal Distribution Policy and Procedure dated 10/11/22 indicated: Policy: Menus are planned to provide each resident with a resident specific, nourishing, palatable, and well-balanced diet. Service and distribution will be conducted in a manner that meets federal, state and local guidelines.	F 803	Assurance and Assessment committee by dietitian/designee. Thereafter, the Quality Assurance and Assessment Committee will determine the need to continue audits. In the event there is a needed change on the approved menu, the dining services manager or administrator will be contacted.	

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F 804	Continued From page 62	F 804		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, resident and facility staff interview, the facility staff failed to prepare food that conserves nutritive value, flavor and appearance. The findings included: During an interview on 11/30/22 at 9:16 AM Resident #82 voiced concern about his food. Resident #82's concern was how his breakfast food was prepared and presented. Resident #82's breakfast tray was observed to included scrambled eggs, french toast and two sausage patties. The scrambled eggs were observed to be runny and juicy. The sausage patties were observed to be blacken in color. Resident #82 stated the sausage patties were to hard to eat. The French toast sticks were observed to be about 1/4 thick and unrecognizable. During an observation and interview with Resident #99 on 11/30/22 at 9:12 AM, Resident #99 received his breakfast tray with large portion of unseasoned scrambled eggs, one patty of sausage which was black in color and	F 804	1) Dietary cooks and aides have been in-serviced on foods being prepared that conserve nutritive value, flavors and appearance. Dietary cooks and aides have been in-serviced on preparing food and drink that is palatable, attractive and served at a safe temperature. 2) The facility has identified all residents as having the potential to be affected by this alleged deficient practice. 3) 1. The Administrator/Designee will receive a test tray of at least 1 meal, 5 days per week for eight weeks to ensure meals meet acceptable standards. Mealtimes and nursing units will be rotated to ensure nutritive value, appearance, palpability and proper temperature. Results will be documented on the Virginia Health Services Tray assessment form. Results will be provided to the administrator daily to ensure	1/16/23

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F 804	Continued From page 63 approximately three French toast sticks, one was approximately "1/8 inch" thick and unrecognizable. Resident #99's family member was feeding the resident. She stated she was not sure what the sausage patty was and both stated, "it is not edible." A Group Meeting attended by five residents was conducted 11/29/22 at 3:30 PM, the residents stated the shrimp that was on the lunch menu for the day was burnt, hard and over cooked. She said the french fries were cold and not edible and the menu did not match what was served. During observations of the kitchen on 11/30/22 at 11:48 AM, white rice that was prepared for lunch appeared dry and was noted with a dark brown crust on the outer edges. Gravy that was prepared for lunch appeared lumpy and congealed. During an interview on 11/30/22 at 11:52 AM the main cook stated, the rice was a bit over cooked and the gravy needed some water to thin out the lumps. A Dining Service, Food Service, and Meal Distribution Policy dated 10/11/22 indicated: Dining services will meet the individual nutritional needs of each resident. Menus are planned to provide each resident with a resident specific, nourishing, palatable, and well-balanced diet. Service and distribution will be conducted in a manner that meets federal, state and local guidelines.	F 804	compliance with this Plan of Correction. 2. The Registered Dietitian will observe one tray line service for 1 day weekly for the next eight weeks and educate staff as needed. 3. Resident interviews to include 1 resident per unit and 1 resident from the dining room for 3 meals for eight weeks and results to be provided to the QAA committee. Additional feedback to be requested during resident council meetings and brought to the QAA committee. 4) The Administrator/Designee will discuss any trends or patterns identified at the Quality Assurance and Assessment Committee meeting. All trends or patterns identified will be addressed and corrective action plan revised if applicable.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		1/16/23

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F 812	Continued From page 64 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility staff failed to store and serve food under sanitary conditions. The findings included: During the kitchen observations on 11/29/22 at 11:27 a.m., the left wall next to the four burner stove and two door oven, was noted to have copious amounts of burnt grease and food particles. Behind the stove was burned food particles and food crumbs. Food and debris was observed behind the standing two part oven.	F 812	1) 1. All deficient areas concerning cleaning and sanitation were addressed. 2. All deficient maintenance issues have been logged in the facility maintenance portal and scheduled for repair. 3. Items suggested for replacement are on order. 2) The facility has identified all residents as having the potential to be affected by this alleged deficient practice. 3) The Dining Services Manager/designee will reeducate dietary staff on the dietary policy and procedures, sanitation practices and food storage	

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F 812	Continued From page 65 The wall next to the eight burner stove was observed to have a hole that measured an estimated 10 inches long and 3 inches wide. Rust and corrosion was noted on the electrical sockets next to the deep fryer. The wall behind the three compartment sink was observed to have food and debris. The drain hole under the prep severing table was observed to have black like matter. The wall behind the ice machine was observed to have an estimated 8 inch by 3 inch hole. The plaster was observed to be coming off. Trash and debris was observed behind the ice machine. The kitchen floor was noted to have a brown film on it. In the dish wash room food and debris were observed on the floor. In the walk in refrigerator food and trash were observed on the floors. In the walk in freezer, food and trash was observed on the floor. A heavy build up of ice was observed coming from the sprinkle nozzle in the freezer. The dry storage room was observed with trash, food and debris. Rusted racks over the three compartment sink used to store clean, drying food storage containers were observed. A November 17, 2021 Local health department citation indicated the same uncorrected observation. The wall leading into the dinning room was observed to have a hole measuring approximately 6 inches by 4 inches. The wall was observed to have rotten wood and	F 812	4) 1. The Dining Services Manager will maintain daily, weekly and monthly cleaning schedules which will be audited weekly by the administrator/designee. 2. The Dietitian will conduct weekly sanitation audits utilizing the Virginia Health Services audit tool and report findings to administrator. 3. The Administrator/Designee will discuss any trends or patterns identified at the Quality Assurance and Assessement Committee meeting. All trends or patterns identified will be addressed and corrective action plan revised if applicable.	

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F 812	Continued From page 66	F 812		

crumbling plaster.

During an interview on 12/01/22 at 9: 48 AM the Director of Dining and Nutrition stated, "we have been working on these issues for a few months. We have been trying to get things repaired."

A Cleaning and Organization Task List dated 9/22/22 indicated: Need to implement significant plan for improvement. Kitchen shut down for 2-3 days for cleaning and organization.
Repairs to base and floor.
Organization of walk in freezer.
Power wash floors in walk-in
Power wash floors in prep area
Power wash all carts-utility and serving
Removing all pans to deep clean shelving
Remove all items under tray line for deep clean
Clean toaster
Deep clean stove and oven
Deep clean/power wash under three compartment sink
Clean all vents
Clean and replace any missing lights
Repair missing titles
Deep clean walls.

A Dining Service, Food, Service and meal Distribution Policy Indicated: Service and distribution will be conducted in a manner that meets federal, state and local guidelines. Food Service- Food is stored, prepared, distributed and served to residents under sanitary conditions in accordance with professional standards.

Repairs: Any repairs needed in the dietary department are to be reported promptly to the dinning service manager or supervisor and or administrator/designee.

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F 812	Continued From page 67 Effective procedures are established for the cleaning and sanitizing of all equipment and work areas.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interview the facility staff failed to ensure garbage and refuse was disposed properly. The findings included: On 12/01/22 at 2:10 PM two of three outside garbage and refuse containers were observed with open container doors. The area around the refuse containers were observed with trash and debris. Two chairs and a sofa was observed in the area around the dumpster. A dresser drawer was observed in the area along with a pile of old wooden fencing. The area outside the kitchen door was observed to have pools of standing water, leaves, trash and debris. The administrator who accompanied the surveyor during the observations stated, "the areas will be cleaned up immediately and the outside service for the dumpers will be called to replace the dumpster due to the doors not closing properly."	F 814	1) 1. All items including furniture and old fencing outside the refuse containers have been disposed. 2. Waste Management replaced the damaged refuse container on 12/15/2022. 3. The area outside the kitchen back door has been cleaned and all debris removed. 2) The facility has identified all residents as having the potential to be affected by this alleged deficient practice. 3) 1. The Dining Services Manager, or designee, will maintain daily, weekly and monthly cleaning schedules. 2. The Administrator/designee will conduct weekly audits of the delivery area/waste management and make corrective actions as needed. 4) The Administrator/Designee will discuss any trends or patterns identified at the Quality Assurance and Assessment	1/16/23

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F 814	Continued From page 68	F 814	Committee meeting. All trends or patterns identified will be addressed and corrective action plan revised if applicable.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will	F 867		1/16/23

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systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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F 867	Continued From page 70 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 867		

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	495286	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 867	Continued From page 71 Based on deficiencies determined during this survey the QAA (Quality Assessment and Assurance) and Quality Assurance and Performance Improvement (QAPI) committee failed to develop and implement corrective plans of action and monitoring to ensure the necessary systems were in place and correct identified quality deficiencies related to a fall on 6/10/22 for one resident (Resident #99) out of a survey sample of 39. The findings included: On 12/01/22 at approximately 4:38 p.m., an interview was conducted with the Administrator, Director of Nursing, Vice President (VP) of Operations, Vice President (VP) of Nursing and on the phone was the Vice President of Quality. The VP of Nursing stated the Quality Assurance Plan is used to ensure systems are evaluated, any quality care concerns are addressed and tracked for improvement. The VP of Operations stated Resident #99 fell out of the Hoyer lift during a transfer on 06/10/22. She stated she did not realize the investigation wasn't completed until information related to the fall was requested by Surveyor #1. She said almost everything related to the investigation on Resident #99's fall on 06/10/22 is missing except for a couple pieces of documentation. She stated only eight (8) staff members were educated on how to properly use a Hoyer lift. The VP of Nursing stated the fall was taken to QAPI; however, those who were designated to complete their part of the QAPI plan did not finish the observation, training or completing the fall investigation. The VP of Nursing stated QA should have assigned the task to a specific	F 867	1) Resident #99□s fall on 6/10/2022 was presented and discussed at the December 16th Quality Assurance and Assessment Committee meeting. 2) The facility will review all incidents of current residents in the last 30 days to ensure that they have followed the proper process for fall follow-up. Any variances were immediately corrected. 3) The facility will discuss incident reports as part of their daily morning meeting and assign follow-up accordingly. The Administrator and DON/ADONs were educated by the Vice President of Nursing and the Vice President of Quality on how to conduct a proper investigation, which included the steps needed to identify root causes and plans to correct the problems identified. The Administrator and DON also attended training on how to complete a performance improvement plan and associated metrics. 4) Corporate Management will attend at least 2 morning meetings weekly for 8 weeks to ensure incidents are being discussed timely. The Vice President of Nursing and Vice President of Quality will meet with the Administrator and DON at least monthly for 3 months to review the incident process and ensure follow-up is complete. The Administrator will report to the Quality Assurance and Assessment committee any variances they have noted as a result of their review of the incident reports.	

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F 867	Continued From page 72	F 867		

person and given a direct timeframe when the fall investigation should have been completed. The VP of Nursing stated there was a breakdown in the QA process related to Resident #99's on 06/10/22.

The QAA committee is responsible for identify and correcting identified quality deficiencies. The facility was not able to provide evidence that the facilities QAA meeting had a systematic plan in place to maintain and improve the safety and quality in the facility involving the resident and staff and took the necessary steps to identify the cause and correct the problem.

A debriefing was held with the Administrator, Director of Nursing, Assistant Director of Nursing, Vice President of Operations and Vice President of Nursing on 12/01/22 at approximately 8:00 p.m., who were informed of the above findings. No further information was provided prior to exit.

The facility's policy titled QAPI Plan - Effective 11/17/22.
Addressing Care and Services: The QAPI program will aim for safety and high quality with all clinical interventions and service delivery while emphasizing autonomy, choice, and quality of daily life for residents and family by ensuring our data collection tools and monitoring systems are in place and are consistent for proactive analysis, system failure analysis, and corrective action.

The scope of the QAPI program encompasses all types and segments of care and services that impact clinical care, quality of life, resident choice, and care transitions. These include, but are not limited to, care management and patient safety.

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F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing	F 886		1/16/23

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F 886	Continued From page 74 was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, document review, policy review and review of Centers for Medicare &Medicaid Services (CMS) Quality, Safety & Oversight (QSO) memo, the facility failed to ensure that contact tracing of residents and staff was conducted, after identifying Licensed Practical Nurse (LPN)7 tested positive for Coronavirus Disease (COVID-19). This deficient has the potential to affect all of the residents in the facility. Findings Include: Review of the CMS "QSO-20-38-NH [Nursing Home]" revised 09/23/22 revealed, "an outbreak	F 886	1. A formal investigation including contact tracing and interview with LPN #7 was conducted on November 29, 2022. Reporting of outbreak was completed on November 30th, 2022. Testing was conducted according to the Testing Policy; No new COVID-19 positive cases have been associated with LPN #7□s illness. 2. The Infection Preventionist /Designee has reviewed all COVID-19 positive test results in the last 7 days to ensure investigation, contact tracing, and reporting was done appropriately.	

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F 886	Continued From page 75 investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed ... Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately (but not earlier than 24 hours after the exposure, if known). Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g., facility-wide) testing ... If the facility has the ability to identify close contacts of the individual with COVID-19, they could choose to conduct focused testing based on known close contacts." Review of the facility's policy titled "COVID-19 Testing and Results" dated 11/04/22, revealed, "Outbreak is defined as a new SARS-CoV-2 infection in any healthcare personnel (HCP) or any nursing home-onset SARS-CoV-2 infection in a resident. An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. An outbreak investigation would not be triggered when a resident with known COVID-19 is admitted directly into transmission-based precautions (TBP), or when a resident known to have close contact with someone with COVID-19 is admitted directly into TBP and develops COVID-19 before TBP are discontinued. Otherwise, a new SARS-Cov-2 infection would be considered nursing-home onset." Review of facility policy titled "COVID-19 Testing and Results" dated11/04/22 revealed, "Outbreak testing: An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. If the facility has the ability to identify	F 886	3. Clinical and non-clinical staff will be in-serviced on how to report symptoms and how to report a positive test result to facility leadership. Facility leadership will be in-serviced by the Director of Clinical Support on current testing policy and initiating an Outbreak Investigation. The facility leadership team will designate a backup individual to perform investigation and reporting duties in the event the IP Nurse is not available. 4. The Infection Preventionist/designee will perform daily audits on tests performed on any resident and staff for 2 weeks, then weekly audits for an additional 6 weeks. Audits will include review that test results were reported to facility leadership and investigation was initiated accordingly. Any findings will be reported to Quality Assessment and Assurance Committee.	

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close contacts of the individual with COVID-19, they could choose to conduct focused testing based on contact tracing ....Contact Tracing Approach: Immediately (but not earlier than 24 hours after the exposure, if known) test staff that had a high-risk exposure and all residents that had close contact with a COVID-19 positive individual. If negative, test again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day I (where day of exposure is day 0), day 3, and day 5... If positives are identified, conduct additional contact tracing and testing and consider a change to the broad-based approach ...Employee tests positive...Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered. Initiate contact tracing to identify staff that had higher-risk exposure to and others that had close contact with the staff member while they were contagious."

During an observation conducted on 11/29/22 11:15AM, revealed an education signation on door which indicated that the community rating was high and the last COVID-19 in the building was in October 2021.

During an interview conducted on 11/29/22 12:00 PM, the Director of Nursing (DON) stated that there was one COVID-19 positive resident that was admitted from hospital with COVID-19 and that there was one COVID-19 positive employee, LPN7, as of 11/25/22.

Review of the facility's "testing sheet" identified LPN7 tested positive for COVID-19. Review of the facility's "Outbreak investigation" document

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revealed that LPN7 had only a two-minute interaction with a resident and was wearing Personal Protective Equipment (PPE). The document indicated that resident was not tested due to it not being necessary according to the facility policy.

During an interview conducted on 11/29/22 02:45 PM, Register Nurse (RN1), Vice President of Nursing (VPN) and DON were asked why the facility did not have signage posted indicating the facility was in outbreak status. The VPN stated that they were not in outbreak status. When asked about CMS QSO memo that one resident or one employee puts the facility in outbreak status. The VPN stated that she read another memo that stated that they were not in outbreak status and that she believed that having more than one person counts as being in outbreak status. At this time, the VPN did not show the surveyors the memo nor indicate who the memo was from. When asked why contact tracing was not conducted after LPN 7 tested positive for COVID-19. DON stated that she did not do contact testing because LPN7 did not come within six feet of the resident and was not there for more than two minutes. When asked about when LPN 7 conducted at shift change and the count of controlled medication in the medication cart, LPN7 was in close contact with the outgoing LPN6. The VPN stated that the facility did not believe they were in outbreak status. VPN and DON admitted that they did the outbreak investigation and testing page and created the documents dated11/28/22.

During an interview with Infection Preventionist (IP) on 11/30/22 08:15AM when asked about LPN7 testing positive for COVID-19 and whether

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outbreak testing was conducted, the IP stated that she informed administration that they were in outbreak status and that signage needs to go up and that contact tracing and testing needed to be performed. She was informed by the VPN that the facility was not in outbreak status. The IP was told that one employee did not qualify as an outbreak.

During an interview with VPN, RN1 and DON on 11/29/22 01:47 PM. VPN stated, "employee came in and was tested at the facility and was positive for COVID-19 on 11/25/22." VPN, RN1, DON stated that they received a memo from CMS that one person does not qualify as an outbreak status. The VPN could not find the CMS memo that stated that they were not in outbreak status.

During an interview and review of documents on 11/30/22 at 01:38 PM, when asked if they knew for sure that LPN7 did not come into close contact with the resident, VPN and DON could not say LPN7 did not in fact come within 6 ft of the resident.

During an interview on 11/30/22 01:34PM, the IP stated that it is an expectation that the facility would have tested the resident that was in contact with LPN7, and that the facility would then be on outbreak status.

During an interview on 12/01/22 03:57 PM, LPN 7 stated that she and LPN 6 were in close contact with each other for more than 15 minutes. LPN7 stated that she went to the resident's room and asked her if she already received her as needed pain medication. The resident stated that she had received the pain medication and LPN7 then left the room.

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F 919	Continued From page 79	F 919		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and review of facility documents, the facility's staff failed to have an appropriate call bell accessible and functional for a resident with bilateral contractured hands for 1 of 39 residents (Resident #226) in the survey sample. Resident #226 was originally admitted to the facility on 11/22/22 from the community. The current diagnoses included; Quadriplegia and Contracture Right and Left Hands. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/29/22 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long- and short-term memory problems as well as severely impaired for daily decision making. In section "G"(Physical functioning) the resident was coded as total dependence of one person for bathing, dressing, eating, toilet-use, personal hygiene and bathing. Functional Status G0400:	F 919	1) On 11/30/2022 resident #226 was provided a pancake style call bell. On 12/28/2022, the DON assessed that resident #226 was able to demonstrate she could use the call bell pancake with her cheek when she needed assistance. 2) The facility audited 100% of the current residents with a diagnosis of quadriplegia and/or functional limitations in range of motion related to upper extremity impairments on both sides to ensure they had an appropriate call bell that was accessible and functional. 3) The facility provided education to the LPN and RNs conducting a resident admission assessment to ensure they provide proper orientation/assessment to the Call Light, particularly for a resident with bilateral upper extremity limitations and a diagnosis of Quadriplegia. 4) The Clinical Care Coordinator/Designee will audit 100% of	1/16/23

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F 919	Continued From page 80 Functional Limitation In Range of Motion: Resident coded as having impairment on both sides for upper extremities. Problem: The care plan dated 11/22/22 read that Resident #226 has the potential for health and safety concerns. Effective 11/22/22. Goal: Maintain Resident's safety through appropriate assistance and safety measures. Effective 11/22/22. Interventions: Provide communication device. Effective 11/22/22. An addendum to Resident #226 care plan reads: Standard call bell replaced with pancake style due to contractures in both hands. Effective 11/30/22. During the initial tour on 11/29/22 at approximately 2:57 PM., Resident #226 was observed laying on her back in bed with both hands contractured. The call bell was located near her right upper arm. She was asked how was she doing and stated, "My head hurts and that sucks." She was then asked if she could use her call bell to ask for assistance. She stated, " No." On 11/29/22 at approximately 3:10 PM LPN (Licensed Practical Nurse) #11 was informed that the resident needed assistance and couldn't use her call bell. LPN #11 said that they have the flat call bells that can be placed on the resident's chest. She also said that she would have to see if maintenance has one. On 11/30/22 at approximately 11:30 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #7 concerning the resident's call bell (Standard Style). She said that the resident	F 919	newly admitted residents with a diagnosis of Quadriplegia or bilateral upper extremity limitations to ensure they have the proper call bell weekly for 8 weeks. The Clinical Care Coordinator/Designee will identify any patterns or trends and report to the Quality Assessment and Assurance Committee.	

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F 919	Continued From page 81 has only been here since last week (11/22/22). She will look into it. On 11/30/22 at approximately 1:17 PM., an observation was made of Resident #226 resting in bed with a pancake style call bell at her bedside. On 12/01/22 at approximately 6:30 PM., an interview was conducted with LPN #11 concerning the Residents' call bell. She said that she and the DON (Director Of Nursing) plugged in the pancake call bell a few days ago. She was asked if Resident #226 was able to use the pancake device. She said that she was not sure if resident could use it. A review of nursing notes dated 11/30/2022 at 7:46 PM., read: " Staff reported to DON that resident assess for use of call bell by nurse, resident unable to use the current call bell system due to bilateral contractures in both hands pancake call bell system was placed resident will continue to be monitored." On 12/01/22 at approximately 8:00 PM., a pre-exit interview was conducted with the administrator, the DON and the Corporate Consultant. The DON said that when the resident arrived to the unit the staff should have assessed her ability to use the call bell.	F 919		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced	F 925		1/16/23

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JAMES RIVER NURSING AND REHABILITATION CENTER	540 ABERTHAW AVENUE NEWPORT NEWS, VA 23601

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F 925	Continued From page 82 by: Based on observations, resident and staff interview the facility staff failed to maintain an effective pest control program. The findings included: Resident #35 stated during an interview on 11/29/22 at 2:35 PM that she did not like taking showers in the women's shower room on the Huntington Unit because it had drain flies. Observations made on 11/29/22 at 2:45 PM indicated drain flies were noted in the women's shower room. On 11/30/22 at 9:20 AM two live roaches were observed on the Huntington Unit near room 114. During kitchen observations on 11/29/22 at 11:30 AM, 11/30/22 at 11:48 AM and 12/1/22 at 12: 48 PM, drain flies and gnats were observed in the kitchen. During an interview on 12/1/22 at 1:30 PM the Director of Dining and Nutrition stated that pests were on the list of corrections for the kitchen area. During an interview on 12/1/22 at 4:45 PM the Administrator stated that the pest control company comes out every other week to spray and as needed if called.	F 925	1. The pest control contractor was immediately contacted and came out to treat Huntington shower room drain and the kitchen drain. At this time, they also treated Huntington unit. 2. The pest control contractor came out and treated all facility water drains. They also have started a widespread treatment in the ceilings to enhance pest prevention. Administrator/Designee will interview 5 residents and 5 staff members weekly for 8 weeks to ensure they have not observed any pests in the facility. They will also observe the drains in the shower rooms and kitchens weekly, to ensure the areas are free of pests. Any variance identified will be addressed promptly. 3. Administrator/Designee will reeducate staff on prompt identification, documentation in the log and follow-up to ensure an effective pest control program. 4. The Administrator/Designee will review pest control logs 3x weekly for 8 weeks to ensure each identified concern has the proper follow-up to ensure the facility is maintaining an effective pest control program. The Administrator/Designee will identify any patterns or trends and report to the Quality Assessment and Assurance Committee.	