STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495401	A. BUILDING _____ B. WING _____	C 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYLER'S RETREAT AT IRON BRIDGE	12001 IRON BRIDGE RD CHESTER, VA 23831

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/17/23 through 1/19/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/17/23 through 1/19/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey (VA00057095-substantiated with deficiency). The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 80 at the time of the survey. The survey sample consisted of 30 resident reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		2/14/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/06/2023

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F 578	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review it was determined that the facility staff failed to provide one of 30 residents in the survey sample the opportunity to formulate an advance directive (1); Resident #11. The findings include: For Resident #11 (R11), the facility staff failed to fully review advance directives with the resident and/or the representative, and provide an opportunity to formulate an advanced directive.	F 578	1) Social Services reviewed advance directives with Resident #11, she is her own responsible party (RP). 2) Any resident has the potential to be affected. 100% audit of all current residents to verify advance directives have been reviewed with the resident and or responsible RP with evidence in the medical record. Any variances will be addressed promptly.	

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F 578	Continued From page 2 R11 was admitted to the facility on 2/12/2019. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 12/16/2022, the resident scored 13 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Review of R11's clinical record failed to evidence documentation of advanced directive review. The progress notes documented periodic review of DNR (do not resuscitate) status. The comprehensive care plan for R11 documented in part, "Resident/Responsible party has chosen DNR (do not resuscitate). Date Initiated: 02/16/2019...Interventions/Tasks:...Review code status annually, quarterly and/or PRN (as needed) Date Initiated: 02/16/2019..." On 1/18/2023 at approximately 11:50 a.m., a request was made to ASM (administrative staff member) #1, the administrator, for evidence of review of advanced directive for R11. On 1/18/2023 at 12:49 p.m., an interview was conducted with OSM (other staff member) #3, social services. OSM #3 stated that they reviewed advance directives when they did the quarterly or annual assessments. OSM #3 stated that they interviewed the resident and discussed the code status and asked them if they wanted to change it. OSM #3 stated that as far as the bigger picture of advance directives they did not have those conversations.	F 578	3) The Assistant Director of Nursing or designee will educate Social Services staff on facility policy of ensuring resident rights of being informed and formulating advance directives with evidence in the medical record. Education will be included in new hire orientation. 4) The Social Services Director or designee will audit resident's charts per MDS schedule weekly x 4 weeks then monthly x2 months to verify advance directives have been reviewed with the resident and or RP. The DON or designee will review the audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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F 578	Continued From page 3	F 578		

On 1/19/2023 at 8:00 a.m., ASM #1 provided a social service initial assessment dated 2/16/2019 for R11. The assessment documented in part, "...DNR..." The section which documented, "Advanced directives have been reviewed" was observed to be blank.

On 1/19/2023 at approximately 9:10 a.m., a follow up interview was conducted with OSM #3, social services. When asked about the assessment dated 2/16/2019 for R11, OSM #3 stated that it evidenced that the DNR was reviewed.

The facility policy, "Advance Directives Protocol" documented in part, "...Advance directives will be reviewed at minimum annually according to MDS schedule...Different types of advance directives: Living will...Durable power of attorney...Code Status..."

On 1/18/2023 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the regional director of clinical services and ASM #5, the regional vice president of operations were made aware of the concern.

No further information was presented prior to exit.

(1) Advance directive
What kind of medical care would you want if you were too ill or hurt to express your wishes? Advance directives are legal documents that allow you to spell out your decisions about end-of-life care ahead of time. They give you a way to tell your wishes to family, friends, and health care professionals and to avoid confusion later on. A living will tells which treatments you

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F 578	Continued From page 4 want if you are dying or permanently unconscious. You can accept or refuse medical care. You might want to include instructions on: The use of dialysis and breathing machines. If you want to be resuscitated if your breathing or heartbeat stops. Tube feeding. Organ or tissue donation. A durable power of attorney for health care is a document that names your health care proxy. Your proxy is someone you trust to make health decisions for you if you are unable to do so. This information was obtained from the website: https://medlineplus.gov/advancedirectives.html	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		2/14/23

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F 580	Continued From page 5 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to notify the physician when physician ordered medications were not administered for one of 30 residents in the survey sample, Resident #123 (R123). The findings include: The facility staff failed to notify the physician when antibiotics, antidepressants and	F 580	1) Resident #123 no longer resides in the facility. The nurse caring for Resident #123 that failed to notify the physician of antibiotic that was not administered. The nurse has been be educated on protocol for administering medications and obtaining medications from on-site medication storage and actions to take if medication not available. 2) Any resident has the potential to be affected. An audit of medication	

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F 580	Continued From page 6 medications for cholesterol were not administered per the physician order for R123. On the most recent MDS (minimum data set) assessment, a Medicare five-day assessment, with an assessment reference date of 9/8/2022, the resident scored a "7" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired for making daily decisions. In Section N - Medications the resident was coded as receiving antidepressants and antibiotics during the look back period. The physician orders dated 8/17/2022, documented the following: Lipitor (Atorvastatin) (used to treat high cholesterol) (1) 80 mg (milligrams); give 1 tablet by mouth at bedtime for cholesterol. Mirtazapine (Remeron) (used to treat depression) (2) 7.5 mg; give 1 tablet by mouth at bedtime for Adult Failure to Thrive. Sertraline HCL (hydrochloride) (used to treat depression and anxiety disorders) (3) Capsule 150 mg; give 1 capsule by mouth at bedtime related to anxiety disorder. Ceftriaxone Sodium Solution Reconstituted 2 GM (grams) (used to treat infections) (4), Use 2000 milligrams intravenously every 24 hours related to abscess of liver for 23 days. The August 2022 MAR (medication administration record) documented the above orders. On 8/17/2022, the Lipitor, Mirtazapine and Sertraline were scheduled to be administered at 9:00 p.m. The nurse documented a "19" on the block where it is documented as administered. A "19" indicated, "Other/See Nurses Notes." The August MAR also documented the above order	F 580	administration for past 7 days will be completed to verify medications administered per MD/NP orders. Any variances will be addressed. 3) The Director of Nursing (DON) or designee will educate 100% nurses on their responsibility in ensuring medications are administered per MD/NP orders and protocol for obtaining medications from on-site storage and notification to MD/NP if medication not available. Education will be included in new hire orientation. 4) The DON or designee will audit medication administration during Clinical Morning meeting weekly x 4 weeks then monthly x 2 months to verify medications have been administered per MD/NP orders, any variances will be addressed. The DON or designee will review the audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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F 580	Continued From page 7	F 580		

for Ceftriaxone with a scheduled time of "24h." There was no scheduled time for the administration of the medication. On 8/17/2022, the nurse documented a "19" on the block where it is documented as administered. A "19" indicated, "Other/See Nurses Notes."

The EMAR (electronic medication administration record) note dated 8/17/2022 at 8:45 p.m. documented for all the Lipitor, Sertraline and Mirtazapine, "Awaiting delivery." The EMAR note dated 8/17/2022, for the Ceftriaxone at 7:36 p.m. documented, "Just admitted."

R123 was readmitted to the facility on 9/2/2022. The physician orders documented:
Lipitor 80 mg; give 1 tablet by mouth at bedtime for cholesterol
Sertraline HCL capsule 150 mg; give 1 capsule by mouth at bedtime related to anxiety disorder.
Flagyl (metronidazole) Tablet 500 mg (used to treat infections) (5), Give 1 tablet my mouth every 8 hours related to abscess of liver for 23 days.

The September 2022 MAR documented the above orders. The Lipitor and Sertraline were scheduled to be administered at 9:00 p.m. on 9/2/2022. The nurse documented a "19" on the block where it is documented as administered. A "19" indicated, "Other/See Nurses Notes." The Flagyl was scheduled to be administered on 9/3/2022 at 12:00 a.m. The nurse documented a "19" on the block where it is documented as administered.

The EMAR note dated 9/2/2022 at 8:28 p.m. documented for the Sertraline and Lipitor medications, "On order." The EMAR note for the Flagyl, dated 9/3/2022 at 12:07 a.m. documented,

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"Awaiting delivery."

The comprehensive care plan dated 8/18/2022, documented in part, "Resident has altered cardiac status." The "Interventions" documented in part, "Administer medications as directed by the physician." The care plan further documented in part, "Focus: Resident is on antianxiety therapy related to Anxiety disorder." The "Interventions" documented in part, "Administer antianxiety medications as prescribed by the physician." The care plan further documented in part, "Resident has infection, liver abscess, PICC line." The "Interventions" documented in part, "Administer antibiotics/anti-viral per physician order and monitor side effect."

The on-site emergency pharmacy dispensing machine inventory list was reviewed. The following was documented as being in the pharmacy machine on site:

Atorvastatin 40 mg tablets - PAR level is 10 tablets.
Mirtazapine 7.5 mg tablets - PAR level is 10 tablets.
Sertraline 100 mg tablets - PAR level is 10 tablets.
Sertraline 50 mg tablets - PAR level is 10 tablets.
Metronidazole 500 mg tablets - PAR level is 10 tablets.
Ceftriaxone 1 GM vial 1 EA (each) - PAR level - 5.

An interview was conducted with LPN (licensed practical nurse) #4, the nurse that didn't give the above medications on 9/2/2022, on 1/19/2023 at 9:25 a.m. When asked the process when a new admission comes and it's time for the resident to receive their medications, LPN #4 stated you look

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at the computer, verify the medication, if you don't have the medication you go to the (name of pharmacy dispensing machine. LPN #4 stated if the medications are not in there, you call the doctor and follow their instructions and then notify the responsible party. When asked where the above actions are documented, LPN #4 stated it should be in a nurse's note in (name of computer program). The above medications were reviewed with LPN #4. When asked if these medications would be in the dispensing machine, LPN #4 stated, they are normal medications, they are in the machine.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/19/2023 at 9:36 a.m. When asked the process for a new admission's medications, ASM #2 stated, if the medications have not been delivered by the pharmacy yet, the nurse is to go to the (name of pharmacy dispensing machine) and get which ones she can. If the medications are not in the (name of pharmacy dispensing machine) the nurse must call the physician and see what steps they want to take, hold till available or maybe give a substitute that is available, then the nurse calls the responsible party to inform them what actions they have taken. When asked where is all this documented, ASM #2 stated it should be in a nurse's note.

A request for a policy for notifying the physician when medications were not available was requested on 1/19/2023 at approximately 10:15 a.m. The facility stated they had no policy on notifying the physician when medications were not available for administration.

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F 580	Continued From page 10 "One of the responsibilities of the nurse administering medications is to check to ensure the medications are available for administration at the times ordered ...verify the physician's order and check the drugs to be sure they are correct ... if medications are not given for any reason the physician must be notified" (6). ASM #1, the administrator, and ASM #2, were made aware of the above on 1/19/2023 at 9:49 a.m. No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a600045.html (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697009.html (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697048.html (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a685032.html (5) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a689011.html. (6) Lippincott Handbook of Nursing Procedures Bethlehem Pa 2008 page 569-570.	F 580		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		2/14/23

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§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health

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or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for

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F 622	Continued From page 13 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to evidence that all required documentation was provided to the receiving facility for hospital transfers for three of 30 residents in the survey sample; Residents #1, #8, and #72. The findings include: 1. For Resident #1, the facility staff failed to evidence that all, if any, required documentation was provided to the receiving facility upon a hospital transfer on 12/8/22. A review of the clinical record was conducted for Resident #1. Resident #1 was transferred to the emergency room on 12/8/22 for further evaluation and treatment for uncontrolled abdominal pain. Further review of the clinical record failed to reveal any evidence that the required documentation was provided to the receiving facility. On 1/19/23 at 9:36 AM an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing. She stated that there was no evidence of what documentation was sent.	F 622	1) The Nurse who transferred Resident #1 to hospital is no longer employed. The nurses who transferred Residents #8 and #72 will be educated on the facility policy on information/documents required to be sent to receiving facility. 2) Any resident has the potential to be affected. A 100% audit will be completed for all transfer/discharges in the past 7 days to verify required paperwork/documents were sent with them to hospital and or to the responsible party; any variances will be addressed as warranted. 3) The Director of Nursing (DON)or designee will educate RN's/LPN's on the facility policy for required documentation and paperwork to be sent to the receiving facility. Education will be included in new hire orientation. 4) The Director of Nursing or designee will audit all transfers/discharges weekly x 4 weeks then monthly x 2 months to verify that receiving documents/paperwork have been sent to the receiving hospital, responsible party and Ombudsmen. The DON or designee will review the audit	

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F 622	Continued From page 14 On 1/19/23 at 10:00 AM an interview was conducted with LPN #2 (Licensed Practical Nurse). She stated that upon a hospital transfer, the facility sends the change of condition note, the facesheet, the transfer form, the care plan, the medication list, a bed hold notice, the Do Not Resuscitate form (if applicable) and the current lab results. She stated that what was sent should be documented in the nurse's notes. She stated that a copy should be retained and left in the unit manager's box. A review of the facility policy "Discharge Planning" that was provided, was conducted. This policy documented, "...6. Information to the Receiving Provider. Information provided to the receiving provider must include a minimum of the following: a. Contact information of the practitioner responsible for the care of the resident. b. Resident representative information including contact information. c. Advance Directive information. d. All special instructions or precautions for ongoing care, as appropriate. e. Comprehensive care plan goals. f. All other necessary information, including a copy of the residents discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care." On 1/19/23 at approximately 10:30 AM, ASM #1 (the Administrator) and ASM #2 were made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #8, the facility staff failed to evidence that all, if any, required documentation was provided to the receiving facility upon a hospital transfer on 12/17/22.	F 622	findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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A review of the clinical record was conducted for Resident #8. Resident #8 was transferred to the emergency room on 12/17/22 for further evaluation and treatment for possible injury after a fall.

Further review of the clinical record failed to reveal any evidence that the required documentation was provided to the receiving facility.

On 1/19/23 at 9:36 AM an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing. She stated that there was no evidence of what documentation was sent.

On 1/19/23 at 10:00 AM an interview was conducted with LPN #2 (Licensed Practical Nurse). She stated that upon a hospital transfer, the facility sends the change of condition note, the facesheet, the transfer form, the care plan, the medication list, a bed hold notice, the Do Not Resuscitate form (if applicable) and the current lab results. She stated that what was sent should be documented in the nurse's notes. She stated that a copy should be retained and left in the unit manager's box.

A review of the facility policy "Discharge Planning" that was provided, was conducted. This policy documented, "...6. Information to the Receiving Provider. Information provided to the receiving provider must include a minimum of the following: a. Contact information of the practitioner responsible for the care of the resident. b. Resident representative information including contact information. c. Advance Directive

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information. d. All special instructions or precautions for ongoing care, as appropriate. e. Comprehensive care plan goals. f. All other necessary information, including a copy of the residents discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care."

On 1/19/23 at approximately 10:30 AM, ASM #1 (the Administrator) and ASM #2 were made aware of the findings. No further information was provided by the end of the survey.
3. For Resident #72 (R72), the facility staff failed to provide evidence that comprehensive care plan goals and medication list were sent to the receiving hospital on 11/3/2022 for a facility-initiated transfer.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/2/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions.

The progress notes for R72 documented in part,
- "11/3/2022 22:10 (10:10 p.m.) Note Text: Resident admitted to [Name of hospital]."
- "11/3/2022 13:22 (1:22 p.m.) Physician/PA/NP (physician assistant/nurse practitioner) progress note...Sent to ER (emergency room) for hypotension, chest pain and SOB (shortness of breath)..."
- "11/3/2022 10:54 (10:54 a.m.) Nursing note. Note Text: PT (patient) transported to [Name of hospital] by EMS (emergency medical services) @ 1048 (10:48 a.m.). Bed policy discussed, Bed hold refused. Husband took patient belongings."

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F 622	Continued From page 17 Further review of the clinical record failed to reveal evidence that the medication list or care plan goals were sent to the receiving facility. On 1/19/2023 at 8:33 a.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of documents sent to the receiving provider for the facility-initiated transfer on 11/3/2022 for R72. On 1/19/2023 at 9:25 a.m., ASM #3, the assistant director of nursing provided the progress note documented above dated 11/3/2022 10:54 a.m. and stated that was all they had. At that time an interview was conducted with ASM #3. ASM #3 stated that the process was for staff to complete a change in condition and transfer form and send those with the resident. ASM #3 stated that the staff were also supposed to write a progress note documenting when the resident left the facility, how they were transported, which hospital they went to, that a bed hold notice, facesheet, care plan, medication list and progress notes were sent with the resident. ASM #3 stated that they did not have any documentation to show that the care plan or medication list were sent with R72. On 1/19/2023 at 9:58 a.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing were made aware of the above finding. No further information was provided prior to exit.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		2/14/23

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

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

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

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility

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F 623	Continued From page 20 must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide written notice of a hospital transfer to the Resident Representative and/or State Long Term Care Ombudsman office for four of 30 residents in the survey sample; Residents #1, #8, #35, and #72. The findings include: 1. For Resident #1, the facility staff failed to evidence a written notification of a hospital transfer was provided to the resident representative and to the State Long Term Care Ombudsman office for a hospital transfer on 10/19/22; and failed to evidence a written notification of a hospital transfer was provided to the resident representative for a hospital transfer on 12/8/22. A. A review of the clinical record was conducted	F 623	1) The Director of Social Services or designee will send written notification to Responsible Party and State Long Term Care Ombudsman for Residents #1 regarding transfers to hospital on 10/19/22 and 12/8/22; Resident #8 for transfer on 12/17/22; Resident #35 for transfer on 10/25/22; Resident #72 for transfer on 11/3/22. 2) Any resident has the potential to be affected. A 100% audit of residents who have been discharged for past 30 days will be completed to verify written notification has been provided to the Responsible Party and sent to State Long Term Care Ombudsmen. 3) The Director of Nursing or designee will educate Social Services staff on the requirements for written notification to Responsible Party (RP)and State Long Term Care Ombudsman of discharge.	

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F 623	Continued From page 21 for Resident #1. Resident #1 was transferred to the emergency room on 10/19/22 for further evaluation and treatment of anemia. The clinical record failed to reveal any evidence that a written notification of this hospital transfer was provided to the resident's legal representative and to the State Long Term Care Ombudsman office. Further review of the clinical record revealed Resident #1 was transferred to the emergency room on 12/8/22 for further evaluation and treatment for uncontrolled abdominal pain. The clinical record failed to reveal any evidence that a written notification of this hospital transfer was provided to the resident's legal representative. On 1/19/23 at 9:06 AM, an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing. She stated that the written notification to the resident's (legal representative / responsible party) was not something that the facility had been doing. On 1/19/23 at 9:27 AM, an interview was conducted with OSM #7 (Other Staff Member), the social worker. She stated that she did not have a written notice to the Ombudsman for 10/19/22, as it was overlooked but should have been done. A review of the facility policy "Discharge Planning" that was provided, was conducted. This policy did not include any direction for the regulatory requirement of notifying, in writing, the resident representative and State Long Term Care Ombudsman office of a hospital transfer. On 1/19/23 at approximately 10:30 AM, ASM #1 (the Administrator) and ASM #2 were made	F 623	Education will be included in new hire orientation. 4) The Director of Nursing or designee will audit all transfers/discharges weekly x 4 weeks then monthly x 3 months to verify required written notification has been provided to the Responsible Party and State Long Term Care Ombudsman. Audit findings will be reported to the QAPI committee monthly x 3 for further review and recommendations.	

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aware of the findings. No further information was provided by the end of the survey.

2. For Resident #8, the facility staff failed to evidence that a written notification of a hospital transfer was provided to the resident representative for a hospital transfer on 12/17/22.

A review of the clinical record was conducted for Resident #8. Resident #8 was transferred to the emergency room on 12/17/22 for further evaluation and treatment for possible injury after a fall. Further review of the clinical record failed to reveal any evidence that a written notification of this hospital transfer was provided to the resident's legal representative.

On 1/19/23 at 9:06 AM, an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing. She stated that the written notification to the resident's (legal representative / responsible party) was not something that the facility had been doing.

A review of the facility policy "Discharge Planning" that was provided, was conducted. This policy did not include any direction for the regulatory requirement of notifying, in writing, the resident representative and State Long Term Care Ombudsman office of a hospital transfer.

On 1/19/23 at approximately 10:30 AM, ASM #1 (the Administrator) and ASM #2 were made aware of the findings. No further information was provided by the end of the survey.

3. For Resident #35, the facility staff failed to evidence that a written notification of a hospital

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transfer was provided to the resident representative for a hospital transfer on 10/25/22.

A review of the clinical record was conducted for Resident #8. Resident #8 was transferred to the emergency room on 10/25/22 for further evaluation and treatment for possible injury after a fall. Further review of the clinical record failed to reveal any evidence that a written notification of this hospital transfer was provided to the resident's legal representative.

On 1/19/23 at 9:06 AM, an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing. She stated that the written notification to the resident's (legal representative / responsible party) was not something that the facility had been doing.

A review of the facility policy "Discharge Planning" that was provided, was conducted. This policy did not include any direction for the regulatory requirement of notifying, in writing, the resident representative and State Long Term Care Ombudsman office of a hospital transfer.

On 1/19/23 at approximately 10:30 AM, ASM #1 (the Administrator) and ASM #2 were made aware of the findings. No further information was provided by the end of the survey.

4. For Resident #72 (R72), the facility staff failed to provide evidence that written notification of transfer was provided to the resident and/or the representative for a facility-initiated transfer on 11/3/2022.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/2/2022, the resident scored

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15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions.

The progress notes for R72 documented in part,
- "11/3/2022 10:54 (10:54 a.m.) Nursing note. Note Text: PT (patient) transported to [Name of hospital] by EMS (emergency medical services) @ 1048 (10:48 a.m.)..."

Further review of the clinical record failed to reveal evidence that written notification of transfer was provided to the resident and/or the representative for a facility-initiated transfer on 11/3/2022

On 1/19/2023 at 8:33 a.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of written notification of transfer was provided to R72 and/or the representative for a facility-initiated transfer on 11/3/2022.

On 1/19/2023 at 9:25 a.m., ASM #3, the assistant director of nursing provided the progress note documented above dated 11/3/2022 10:54 a.m. and stated that was all they had. At that time an interview was conducted with ASM #3. ASM #3 stated that they did not have any documentation to show that written notification of transfer was provided to R72 and/or the representative for a facility-initiated transfer on 11/3/2022. ASM #3 stated that nursing had not been sending a written notice of discharge and they had begun discussing a new process to put into place. ASM #3 stated that no one in the facility had been providing a written notice of discharge to the resident or the representative, that it was only

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F 623	Continued From page 25 verbal notification. On 1/19/2023 at 9:58 a.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing were made aware of the above finding. No further information was provided prior to exit.	F 623		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		2/14/23

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F 656	Continued From page 26 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to develop and/or implement a comprehensive care plan for five of 30 residents in the survey sample, Residents #123, #23, #1, #21 and #68. The findings include: 1. For R123, the facility staff failed to implement the comprehensive care plan for the administration of medications per the physician order. On the most recent MDS (minimum data set) assessment, a Medicare five-day assessment, with an assessment reference date of 9/8/2022, the resident scored a "7" on the BIMS (brief interview for mental status) score, indicating the	F 656	1) Resident #123 no longer resides in the facility. The nurse caring for Resident #123 has been educated on following comprehensive care plan. Resident #23 order for skin prep left heel has been activated by the Unit Manager and has fall mat is in place on left side of bed while in bed, round conducted to verify placement. Resident #1's oxygen flowrate has been checked to verify rate is on correct flowrate per physician's orders. Resident #21's fall mats have been put in place and verified via rounds. Resident #68 care plan was revised to include management of her dialysis fistula. 2) Any resident has the potential to be affected. A 100% audit has been conducted to verify fall mats in place, oxygen flowrate per physician orders,	

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F 656	Continued From page 27 resident was severely impaired for making daily decisions. In Section N - Medications the resident was coded as receiving antidepressants during the look back period. The comprehensive care plan dated 8/18/2022, documented in part, "Resident has altered cardiac status." The "Interventions" documented in part, "Administer medications as directed by the physician." The care plan further documented in part, "Focus: Resident is on antianxiety therapy related to anxiety disorder." The "Interventions" documented in part, "Administer antianxiety medications as prescribed by the physician." The care plan further documented in part, "Resident has infection, liver abscess, PICC line." The "Interventions" documented in part, "Administer antibiotics/anti-viral per physician order and monitor side effect." The physician orders dated 8/17/2022, documented the following: Lipitor (Atorvastatin) (used to treat high cholesterol) (1) 80 mg (milligrams); give 1 tablet by mouth at bedtime for cholesterol. Mirtazapine (Remeron) (used to treat depression) (2) 7.5 mg; give 1 tablet by mouth at bedtime for Adult Failure to Thrive. Sertraline HCL (hydrochloride) (used to treat depression and anxiety disorders) (3) Capsule 150 mg; give 1 capsule by mouth at bedtime related to anxiety disorder. Ceftriaxone Sodium Solution Reconstituted 2 GM (grams) (used to treat infections) (4), Use 2000 milligrams intravenously every 24 hours related to abscess of liver for 23 days. R123 was readmitted to the facility on 9/2/2022. The physician orders documented:	F 656	management of dialysis site and wound provider weekly assessment recommendations activated and nurses following care plan. 3) The Director of Nursing or designee will educate nursing staff on following physician's orders and care plan interventions to ensuring to fall mats in place, 02 flowrate per order, management of dialysis site, and following wound provider assessment recommendations and orders. Education will be included in new hire orientation. 4) The Director of Nursing or designee will conduct weekly audits to verify care plan interventions are being followed for but not limited to placement of fall mats, 02 flowrate per order, management of dialysis site, wound provider recommendations and orders x 4 weeks then monthly x 2 months. The audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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Lipitor 80 mg; give 1 tablet by mouth at bedtime for cholesterol
Sertraline HCL capsule 150 mg; give 1 capsule by mouth at bedtime related to anxiety disorder.
Flagyl (metronidazole) Tablet 500 mg (used to treat infections) (5), Give 1 tablet my mouth every 8 hours related to abscess of liver for 23 days.

The August 2022 MAR (medication administration record) documented the above orders.
On 8/17/2022, the Lipitor, Mirtazapine and Sertraline were scheduled to be administered at 9:00 p.m. The nurse documented a "19" on the block where it is documented as administered. A "19" indicated, "Other/See Nurses Notes." The August MAR also documented the above order for Ceftriaxone with a scheduled time of "24h." There was no scheduled time for the administration of the medication. On 8/17/2022, the nurse documented a "19" on the block where it is documented as administered. A "19" indicated, "Other/See Nurses Notes."

The EMAR (electronic medication administration record) note dated 8/17/2022 at 8:45 p.m. documented for all the Lipitor, Sertraline and Mirtazapine, "Awaiting delivery." The EMAR note dated 8/17/2022, for the Ceftriaxone at 7:36 p.m. documented, "Just admitted."

The September 2022 MAR documented the above orders. The Lipitor and Sertraline were scheduled to be administered at 9:00 p.m. on 9/2/2022. The nurse documented a "19" on the block where it is documented as administered. A "19" indicated, "Other/See Nurses Notes." The Flagyl was scheduled to be administered on 9/3/2022 at 12:00 a.m. The nurse documented a "19" on the block where it is documented as

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administered.

The EMAR note dated 9/2/2022 at 8:28 p.m. documented for the Sertraline and Lipitor medications, "On order." The EMAR note for the Flagyl, dated 9/3/2022 at 12:07 a.m. documented, "Awaiting delivery."

The on-site emergency pharmacy dispensing machine inventory list was reviewed. The following was documented as being in the pharmacy machine on site:
Atorvastatin 40 mg tablets - PAR level is 10 tablets.
Mirtazapine 7.5 mg tablets - PAR level is 10 tablets.
Sertraline 100 mg tablets - PAR level is 10 tablets.
Sertraline 50 mg tablets - PAR level is 10 tablets.
Metronidazole 500 mg tablets - PAR level is 10 tablets.
Ceftriaxone 1 GM vial 1 EA (each) - PAR level - 5.

On 1/18/2023 at 2:51 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the purpose of the care plan was to let staff know what was needed to care for the resident. LPN #3 stated that the care plan was there to help them take care of the residents and help to avoid any incidents.

On 1/18/2023 at 3:47 p.m., an interview was conducted with RN (registered nurse) #3, unit manager. RN #3 stated that the purpose of the care plan was to plan the residents care and to have a document for staff to reference to help prevent incidents. RN #3 stated that they used the care plans to alert the staff to the resident's individualized needs.

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The facility policy, "Comprehensive Care Planning Policy," documented in part, "PROCEDURE: A) "The facility must develop a comprehensive Person Centered Care Plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessments...D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented."

ASM #1, the administrator, and ASM #2, the director of nursing, were made aware of the above on 1/19/2023 at 9:49 a.m.

No further information was obtained prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a600045.html
(2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697009.html
(3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697048.html
(4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a685032.html
(5) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a689011.html.
2. For Resident #23 (R23), the facility staff failed

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to implement the comprehensive care plan to A. provide pressure ulcer treatment as ordered and B. place a fall mat to the left side of the bed.

On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 12/15/2022, the resident scored 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. The assessment documented R23 having one Stage 3 pressure injury and not having any falls since the prior assessment.

A. The comprehensive care plan for R23 documented in part, "Risk for impaired skin integrity r/t (related to) impaired mobility and peripheral neuropathy. Actual impaired skin integrity: Hx of Chronic rash under abd (abdominal) fold. 6/3/22 DTI (deep tissue injury) left heel (resolved 1/10/23)..." Under "Interventions/Tasks" it documented in part, "...Treatments per order. Date Initiated: 03/19/2015."

The wound physician progress note dated 1/10/2023 for R23 documented in part, "...Resolved stage 3 PI (pressure injury) at left heel -- contributing factors are poor mobility, poor intake, dementia, restless legs causing friction, fragile skin. Care for prevention x2/weeks (for two weeks) to left heel as follows: - Apply skin prep/barrier film to wound bed. - Provide this care daily..."

Review of the physician orders failed to evidence an order for the skin prep to the left heel as documented in the wound physician progress note on 1/10/2023.

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Review of the eTAR (electronic treatment administration record) dated 1/1/2023-1/31/2023 for R23 failed to evidence a treatment to the left heel after 1/11/2023.

On 1/18/2023 at 3:47 p.m., an interview was conducted with RN (registered nurse) #3, unit manager. RN #3 stated that the purpose of the care plan was to plan the residents care and to have a document for staff to reference to help prevent incidents. RN #3 stated that they used the care plans to alert the staff to the resident's individualized needs. RN #3 reviewed the wound physician progress note dated 1/10/2023, R23's physician orders and eTAR and stated that there was no order put in for the skin prep. RN #3 stated that they must have missed the order and did not put it in.

B. On 1/17/2023 at 11:49 a.m., an observation was made of R23 in bed in their room. No fall mat was observed to the left side of R23's bed.

Additional observations on 1/17/2023 at 3:52 p.m. and 1/18/2023 at 8:48 a.m. revealed R23 in bed with no fall mat on the left side of the bed.

The comprehensive care plan for R23 documented in part, "Hx of actual falls- Risk for further falls related to weakness, visual/hearing impairment, and dementia. Date Initiated: 05/11/2016..." Under "Interventions/Tasks" it documented in part, "...Fall mat on left side of bed when in bed. Date Initiated: 03/28/2022..."

The physician orders for R23 documented in part, "Fall mat on left side of resident bed when resident in bed every shift for for safety. Order

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Date: 03/27/2022."

On 1/18/2023 at 2:51 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that the purpose of the care plan was to let staff know what was needed to care for the resident. LPN #3 stated that the care plan was there to help them take care of the residents and help to avoid any incidents. LPN #3 stated that the care plan was updated when there were any incidents like a fall or any new interventions or orders put into place. LPN #3 stated that they were not implementing the care plan if they were not keeping the fall mat down when R23 was in bed.

On 1/18/2023 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the regional director of clinical services and ASM #5, the regional vice president of operations were made aware of the concern.

No further information was provided prior to exit.

3. For Resident #1, the facility staff failed to implement the comprehensive care plan for the administration of oxygen per the physician's order.

A review of the clinical record revealed a physician's order dated 10/20/22 for "Oxygen 3LPM (liters per minute) via nasal cannula every shift..."

On 1/17/23 at 12:00 PM and at 2:25 PM, observations of the resident revealed the oxygen rate on the oxygen concentrator flow meter was

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set at 1.5 liters as evidenced by the ball of the flow meter centered on the line between the 1 and 2 liter marks.

A review of the comprehensive care plan revealed one dated 8/27/21 for "Resident is receiving continuous oxygen therapy." This care plan included an intervention dated 8/27/21 for "Administer oxygen as ordered."

On 1/19/23 at 10:00 AM an interview was conducted with LPN #2 (Licensed Practical Nurse). She stated that when she checked, the oxygen was set at the correct rate. She stated that if it was not at 3 liters when it was observed, then the care plan was not being followed. She stated that for this resident, it is important the oxygen be at the right rate because the resident gets hypoxic.

A review of the facility policy "Comprehensive Care Planning Policy" that was provided, was conducted. This policy documented, "...D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented...."

On 1/19/23 at approximately 10:30 AM, ASM #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey
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4. For Resident #21, the facility staff failed to implement the comprehensive care plan to ensure that bilateral fall mats were in place.

A review of the comprehensive care plan revealed one dated 3/23/21 for "Actual fall; Risk

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for further falls..." This care plan included an intervention dated 7/19/21 for "Fall mats on both sides of bed."

A review of the clinical record revealed the January 2023 eTAR (electronic treatment administration record.) This document included an item dated 7/20/21 for "Fall Matts [sic] to each side of the bed for safety while in bed every shift for preventative." This document identified "Day" "Evening" and "Night" as three opportunities each day for staff to sign off that placement of the fall mats had been verified. Staff had completed this sign off each day through 1/18/23.

Observations of Resident #21 on 1/17/23 at 10:57 AM, 1/17/23 at 2:30 PM, 1/18/23 at 11:49 AM, 1/18/23 at 3:51 PM, and 1/19/23 at 8:38 AM, all revealed Resident #21 in the bed. There were no fall mats down and no evidence of fall mats anywhere in the room.

On 1/19/23 at 10:00 AM an interview was conducted with LPN #2 (Licensed Practical Nurse). She stated that the fall mats should have been down. She stated that it was her fault because she had taken them up over the weekend to have them cleaned and never replaced them. When asked if the care plan was being followed, she stated it was not.

A review of the facility policy "Comprehensive Care Planning Policy" that was provided, was conducted. This policy documented, "...D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented...."

On 1/19/23 at approximately 10:30 AM, ASM #1 (the Administrator) and ASM #2 (the Director of

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Nursing) were made aware of the findings. No further information was provided by the end of the survey.

5. The facility failed to develop a complete comprehensive care plan for dialysis fistula functioning monitoring for Resident #68.

Resident #68 was admitted to the facility on 12/28/22 with diagnosis that included but not limited to: end stage renal disease..

The most recent MDS (minimum data set) assessment, a Medicare five-day assessment, with an ARD (assessment reference date) of 1/3/23, coded Section O-special procedures/treatments coded the resident as dialysis "yes".

A review of the comprehensive care plan dated 12/29/22, revealed, "FOCUS: Resident receives dialysis treatments 3 times weekly. ESRD (end stage renal disease). LUE (left upper extremity) fistula. INTERVENTIONS: Bleeding occurs from dialysis site, apply pressure. Call 911, if needed. Fluid restrictions as ordered. Meds as ordered. Monitor labs and report to physician any abnormalities. Monitor shunt/vascular catheter site for bleeding or signs /symptoms of infection. No labs/BP (blood pressure) in shunt arm. Assess/monitor dressing to shunt. Replace dressing if dressing should come off while not in dialysis. Assess/Monitor for signs /symptoms of bleeding due to anticoagulant therapy. Assist with transfer needs when going to dialysis. Maintain communication with dialysis staff and physician per routine. Dialysis per orders. Report any changes in condition to the nursing/physician."

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F 656	Continued From page 37 An interview was conducted on 1/17/23 at 2:15 PM with Resident #68. When asked whether staff monitor her fistula, Resident #68 stated, "No, they do not monitor it here. They do at the dialysis center." An interview was conducted on 1/18/23 at 2:00 PM with LPN (licensed practical nurse) #2. When asked the purpose of the baseline care plan, LPN #2 stated, it is to initiate the plan of care for the resident based on their needs. When asked what should be included on the baseline care plan for a dialysis resident, LPN #2 stated, it should include monitoring their fistula for bleeding, bruit and thrill. If they are on a fluid restriction, monitoring the intake and to communicate with the dialysis center and physician if any changes occur. When asked if the care plan did not include monitoring the fistula for bruit and thrill, was it a complete care plan, LPN #2 stated it was not. On 1/18/23 at approximately 4:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, assistant director of nursing, ASM #4, the regional director of clinical services and ASM #5, the regional vice president for operations were made aware of the findings. No further information was provided prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		2/14/23

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F 657	Continued From page 38 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan for one of 30 residents in the survey sample, Resident #10. The findings include: For Resident #10 (R10), the facility staff failed to review and revise the comprehensive care plan after a self-harm incident on 7/22/2022. On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD	F 657	1) Resident #10's care plan has been reviewed and updated to reflect history of suicidal ideations. 2) Any resident has the potential to be affected. The MDS or designee will conduct 100% audit of current resident care plans to verify any changes in condition have been updated. 3) The DON or designee will educate the MDS staff, Social Services, Activities, Registered Dietician and Unit Managers on facility protocol to ensure care plans	

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F 657	Continued From page 39 (assessment reference date) of 12/23/2022, the resident scored 5 of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section E documented no behaviors. The progress notes for R10 documented in part, - "7/22/2022 21:30 (9:30 p.m.) Nursing note. Note Text: While doing rounds CNA (certified nursing assistant) found patient in his room crying and making an apparent attempt to commit suicide. Patient had a small cutting tool resembling a pocket knife and had cut two superficial wounds into his left forearm. Patient was visibly upset, crying and shaking and yelling "I just want to go! I just want to go! I'm going to kill myself!" EMS (emergency medical services) was notified and patient assessed for other injuries. No other injuries noted; Vital signs stable. T (temperature) 97.3 P (pulse) 88 R (respirations) 22 BP (blood pressure) 164/70. After assessing resident, EMS left facility but police officers remained on scene. Officers then stated that they were waiting to hear back from [Name of county] Mental Health Crisis Center. After several minutes, police stated they spoke with the crisis center and were told that [R10] does not meet the criteria for removal from the facility. DON (director of nursing) and administrator immediately notified of situation and resident placed on 1:1 (one to one) observation to maintain safety. Son [Name of son] notified. ADON (assistant director of nursing) on site to follow up with crisis center for possible evaluation." - "7/22/2022 23:47 (11:47 p.m.) Nursing note. Note Text: ADON stated that there will not be any intervention from crisis center at his [sic] time. Resident will remain on 1:1 observation in order	F 657	have been reviewed and revised to reflect resident's current status. Education will be included in new hire orientation. 4) The MDS or designee will audit 5 resident charts (including but not limited to new admits, re-admits, new orders, change in condition) weekly x 4 weeks then monthly x 2 months to verify residents care plans have been reviewed and revised to reflect resident's current status. The DON or designee will review the audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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to maintain safety until further notice. Will continue to monitor."
- "7/23/2022 05:59 (5:59 a.m.) Nursing note. Note Text: Resident rested well, no c/o (complaints of) voiced, continue on 1:1 supervision due to suicide attempt no problems noted will continue to monitor."
- "7/23/2022 10:25 (10:25 a.m.) Nursing note. Note Text: Resident's son in to transport resident to hospital.
Resident was on 1:1 until son arrived."
- "7/29/2022 14:36 (2:36 p.m.) Physician/PA/NP (physician assistant/nurse practitioner) Progress note...Readmitted on 7/29/22 after being sent out due to suicidal attempt where he cut his wrist. States he had romantic feelings toward a staff member and reportedly felt depressed after he was told the staff is married with children and has plans on moving to another state. He was sent to [Name of psychiatric hospital] for observation - medications adjusted and behavior improved and was sent back to to the facility..."

Review of the facility investigation dated 7/22/2022 documented a summary of the incident, staff statements, nursing notes, social services contact, the psychiatric evaluation dated 7/25/2022 and behavioral health assessments for R10 dated 8/11/2022, 8/25/2022 and 9/1/2022.

The comprehensive care plan for R10 failed to evidence a review or revision related to the self-harm attempt on 7/22/2022.

Review of the clinical record failed to evidence any self-harming behavior prior to 7/22/2022.

On 1/18/2023 at 2:51 p.m., an interview was conducted with LPN (licensed practical nurse) #3.

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LPN #3 stated that the purpose of the care plan was to let staff know what was needed to care for the resident. LPN #3 stated that the care plan was there to help them take care of the residents and help to avoid any incidents.

On 1/18/2023 at 3:47 p.m., an interview was conducted with RN (registered nurse) #3, unit manager. RN #3 stated that the purpose of the care plan was to plan the residents care and to have a document for staff to reference to help prevent incidents. RN #3 stated that they used the care plans to alert the staff to the resident's individualized needs. RN #3 stated reviewed R10's care plan and stated that they did not see any information regarding the self-harm attempt on 7/22/2022 and that the care plan should have been revised after the incident.

On 1/18/2023 at 3:10 p.m., an interview was conducted with ASM (administrative staff member) #3, the assistant director of nursing. ASM #3 stated that they were the staff member on call on 7/22/2022 and they had come in when staff had called them. ASM #3 stated that they had checked R10's room to make sure there was nothing in the room that they could use to hurt themselves with. ASM #3 stated that R10 was already on 1:1 when they arrived and they had spoken with the police officers and the local mental health authority but they had advised that the resident could not be taken for evaluation. ASM #3 stated that they had made sure a staff member was with R10 the entire night and the son had come to take them for evaluation at the psychiatric hospital the next morning. ASM #3 stated that the onsite psychiatry services and social worker followed R10 closely.

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F 657	Continued From page 42 On 1/18/2023 at 4:09 p.m., an interview was conducted with OSM (other staff member) #3, social services. OSM #3 stated that they followed R10 closely. OSM #3 stated that when the incident happened on 7/22/2022 they focused on keeping the resident safe and getting them the help they needed and had forgotten to update the care plan when they came back from the hospital. OSM #3 stated that it needed to be done. The facility policy, "Comprehensive Care Planning Policy" revised 7/19/2019 documented in part, "...Residents who have returned from the hospital in the past week. Their previous MDS and Care Plan must be reviewed and updated..." On 1/18/2023 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the regional director of clinical services and ASM #5, the regional vice president of operations were made aware of the concern. No further information was obtained prior to exit.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to follow	F 658	1) Resident #123 no longer resides in the facility. The nurse caring for Resident #123 that failed to notify the physician of	2/14/23

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F 658	Continued From page 43 professional standards of practice for medication administration. to clarify a physician order for one of 30 residents in the survey sample, Resident #123 (R123). The findings include: The facility staff failed to clarify a physician order for the administration time of an IV (intravenous) antibiotic for Resident #123 (R123). On the most recent MDS (minimum data set) assessment, a Medicare five-day assessment, with an assessment reference date of 9/8/2022, the resident scored a "7" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired for making daily decisions. In Section N - Medications the resident was coded as receiving antidepressants and antibiotics during the look back period. The physician order dated, 8/17/2022, documented, "Ceftriaxone Sodium Solution Reconstituted 2 GM (grams) (used to treat infections) (1), Use 2000 milligrams intravenously every 24 hours related to abscess of liver for 23 days." The August 2022 MAR documented the above order with a scheduled time of "24h." There was no scheduled time for the administration of the medication. The comprehensive care plan dated 8/18/2022, documented in part, "Resident has infection, liver abscess, PICC line." The "Interventions" documented in part, "Administer antibiotics/anti-viral per physician order and monitor side effect."	F 658	antibiotic not administered has been be educated on following professional standards of practice to notify the physician for clarification of an order. 2) Any resident has the potential to be affected. An audit of medication administration records for the past 7 days will be reviewed for clarity and timely execution of orders. Any variances will be addressed. 3) The Director of Nursing (DON) or designee will educate 100% nurses on their responsibility in clarifying physician orders to include the five rights of drug administration. Education will be included in new hire orientation. 4) The DON or designee will audit medication administration records during weekly x 4 weeks then monthly x 2 months to verify medication orders are clear according to the five rights of drug administration, any variances will be addressed. The audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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An interview was conducted with LPN (licensed practical nurse) #4, on 1/19/2023 at 9:25 a.m. When asked if a new admission arrives with an order for intravenous antibiotics, how does the order get onto the MAR, LPN #4 stated she would have looked on the paperwork from the hospital to see when it was last given and then assign that time on the MAR at the facility. The above MAR was reviewed with LPN #4. When asked if the order needed to be clarified, LPN #4 stated, yes.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/19/2023 at 9:36 a.m. When asked the process for when a new admission comes with physician orders for IV antibiotics, ASM #2 stated if the medication is scheduled and it hasn't come in from the pharmacy, ASM #2 stated they check the (name of pharmacy dispensing machine). If it's not there you call the doctor and follow their instructions. When asked where this is documented, ASM #2 stated it should be in a nurse's note. The time documented on the MAR for the above medication was reviewed with ASM #2, ASM #2 stated there should be a time documented for the administration. When asked what time should be documented, ASM #2 stated, if it's given every 24 hours then our scheduled time is 9:00 a.m. but I would have checked when it was last given at the hospital prior to transfer and follow that time.

Per Fundamentals of Nursing, Lippincott, Williams & Wilkins, "Always clarify with the prescriber any medication order that is unclear or seems inappropriate." (2)

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F 658	Continued From page 45 ASM #1, the administrator, and ASM #2, were made aware of the above on 1/19/2023 at 9:49 a.m. No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a685032.html (2) Fundamentals of Nursing, Lippincott, Williams & Wilkins, page 553.	F 658		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The	F 661		2/14/23

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F 661	Continued From page 46 post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence a complete discharge summary for one of 30 residents in the survey sample, Resident #70. The findings include: For Resident #70 (R70), the facility staff failed to evidence a discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status at the time of discharge, reconciliation of all pre-discharge medications with the resident's post discharge medications, and a post discharge plan of care for the discharge on 10/27/2022. On the most recent MDS (minimum data set), a discharge assessment with an ARD (assessment reference date) of 10/27/2022, the resident was coded as being severely impaired for making daily decisions. The progress notes for R70 documented in part, "10/27/2022 11:31 (11:31 a.m.) Note Text: Resident discharged home left via transportation van with attendant. Resident took all her belongings with her at discharge." The comprehensive care plan for R70 documented in part, "Canceled: Resident plans to return to the community. Date Initiated:	F 661	1) Resident #70 discharge summary has been completed. 2) Any resident has the potential to be affected. A 100% audit of discharged residents in the past 30 days will be completed to verify discharge requirements have been completed per facility policy. 3) The Director of Nursing or designee will educate 100% nurses on the facility policy on requirements for discharge. Education will be included in new hire orientation. 4) The Director of Nursing or designee will review all discharges weekly x 4 weeks then monthly x 2 months to verify all requirements have been addressed per facility discharge planning policy. The DON or designee will review the audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months. The audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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10/24/2022...Interventions/Tasks: CANCELED: Provide resident/family with written instructions upon discharge. Date Initiated: 10/24/2022...CANCELED: Upon discharge resident/family will receive written discharge instructions to enable a safe return to the community. Date Initiated: 10/24/2022..."

Further review of the clinical record failed to evidence a discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status at the time of discharge, reconciliation of all pre-discharge medications with the resident's post discharge medications and a post discharge plan of care for the discharge on 10/27/2022.

On 1/19/2023 at 8:33 a.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of discharge instructions provided to the resident and the discharge summary that included a recapitulation of the resident's stay for the discharge on 10/27/2022.

On 1/19/2023 at 9:47 a.m., ASM #3, the assistant director of nursing stated that they did not have any evidence of discharge instructions or a recapitulation of the resident's stay for the discharge on 10/27/2022. At that time an interview was conducted with ASM #3. ASM #3 stated that the process was for the discharge nurse to educate the resident and/or the representative on the medications and discharge instructions using the discharge summary completed under assessments in the computer. ASM #3 stated that the nurse should document a progress note regarding who they educated and what they educated them on, when and how they

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went home and whether they had any questions or concerns about the discharge instructions. ASM #3 reviewed R70's clinical record and stated that there was no discharge assessment completed for them.

The facility policy, "Discharge planning policy" revised 9/24/2020 documented in part, "...4. Discharge Summary/Instructions. When a discharge is anticipated, [Facility] will develop a discharge summary/instructions that includes, but is not limited to, the following:
a. Summary of Stay. A summary of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
b. Final Summary Available for Release. A final summary of the resident's status to include, the resident's needs, strengths, goals, life history and preferences (as identified in the MDS) at the time of the discharge
that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. c. Medication Reconciliation. Reconciliation of all pre-discharge medications with the resident's postdischarge medications (both prescribed and over-the-counter). d. Post-Discharge Plan of Care. A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care will indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. A copy of the post-discharge plan will be provided to the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 49 resident and, with the resident's consent, the resident representative(s), the receiving provider, if applicable, and a copy will be filed in the resident's medical record..." On 1/19/2023 at 9:58 a.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing were made aware of the above finding No further information was provided prior to exit.	F 661		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent 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 clinical record review, staff interview and facility document review it was determined that the facility staff failed to obtain a physician order and provide treatment to promote non-recurrence of a healed pressure injury for one of 30 residents in the survey sample, Resident #23.	F 686	1) Resident #23 recommendation from wound care provider for application of skin prep to resolved pressure injury left heel has been activated. 2) Any resident has the potential to be affected. An audit of wound care provider recommendations for past week has been	2/14/23

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F 686	Continued From page 50 The findings include: For Resident #23 (R23), the facility staff failed to transcribe orders and provide treatment for a healed Stage 3 pressure injury (1). On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 12/15/2022, the resident scored 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. Section M documented R23 having one Stage 3 pressure injury. The progress notes for R23 documented in part, - "1/10/2023 07:00 (7:00 a.m.) Note Text: Wound type is pressure. Stage: 3 Wound Location L (left) heel...Treatment: Wound care to left heel as follows: apply skin prep q (every) shift. Area is resolved skin prep q shift ppx (prophylaxis)." The weekly wound assessment for R23 documented in part, - "1/10/2023 07:00 (7:00 a.m.) ...Wound Type: Pressure; Stage: 3; Wound Location: L heel...Area is resolved skin prep q shift ppx." The wound physician progress note dated 1/10/2023 for R23 documented in part, "...Resolved stage 3 PI (pressure injury) at left heel -- contributing factors are poor mobility, poor intake, dementia, restless legs causing friction, fragile skin. Care for prevention x2/weeks (for two weeks) to left heel as follows: - Apply skin prep/barrier film to wound bed. - Provide this care daily..." The weekly skin assessment for R23 dated	F 686	reviewed to verify recommendations activated. Any variances will be addressed promptly. 3) The DON or designee will educate 100% nurses on their responsibility in ensuring wound care treatment orders are transcribed and carried out according to physicians orders. Education will be included in new hire orientation. 4) The DON or designee will audit wound care provider treatment recommendations weekly x 4 weeks then monthly x 2 months to verify wound care treatment recommendations have been transcribed and carried out. The DON or designee will review the audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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1/17/2023 documented in part, "Left heel scar tissue..."

Review of the physician orders failed to evidence an order for the skin prep to the left heel as documented in the wound physician progress note on 1/10/2023.

Review of the eTAR (electronic treatment administration record) dated 1/1/2023-1/31/2023 for R23 failed to evidence a treatment to the left heel after 1/11/2023. The eTAR documented R23's use of heel lift boots at all times, no shoe on the left foot and heels floated while in bed.

The comprehensive care plan for R23 documented in part, "Risk for impaired skin integrity r/t (related to) impaired mobility and peripheral neuropathy. Actual impaired skin integrity: Hx of Chronic rash under abd (abdominal) fold. 6/3/22 DTI (deep tissue injury) left heel (resolved 1/10/23)..."

On 1/18/2023 at 3:47 p.m., an interview was conducted with RN (registered nurse) #3, unit manager. RN #3 stated that the wound physician came in once a week and they rounded with them. RN #3 stated that the wound physician sent them their progress notes with new orders for treatments in them by email and they reviewed them and made changes to the orders based on the notes. RN #3 stated that they were not able to transcribe the orders during the wound physician rounds as they moved quickly from room to room so they waited to have the progress note in front of them to go through and make the changes. RN #3 stated that R23's left heel pressure injury had healed and the wound physician had recommended they use skin prep

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F 686	Continued From page 52	F 686		

as a prophylactic treatment to the area. RN #3 reviewed the wound physician progress note dated 1/10/2023, R23's physician orders and eTAR and stated that there was no order put in for the skin prep. RN #3 stated that they must have missed the order and did not put it in.

The facility policy "Skin and Wound Care Best Practices" revised 6/10/2022 documented in part, "...Purpose: To provide evidence based preventive skin care and wound treatment to prevent unavoidable skin complications....Pressure injuries and wounds will be treated with evidence-based interventions as ordered by the provider..."

On 1/18/2023 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the regional director of clinical services and ASM #5, the regional vice president of operations were made aware of the concern.

No further information was provided prior to exit.

(1) Pressure Ulcer
A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue

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F 686	Continued From page 53 below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to implement fall interventions per the plan of care for two of 30 residents in the survey sample; Residents #21 and #23. The findings include: 1. For Resident #21, the facility staff failed to ensure bilateral fall mats were in place per the plan of care. A review of the comprehensive care plan revealed one dated 3/23/21 for "Actual fall; Risk for further falls..." This care plan included an intervention dated 7/19/21 for "Fall mats on both	F 689	1) Resident #21 fall mats have been put in place per care planned. 2) Any resident has the potential to be affected. A 100% audit will be completed to verify fall mats are in place per care plan, any variances will be addressed. 3) The Director of Nursing or designee will educate 100% nursing staff on ensuring fall mats are in place per care plan. Education will be included in new hire orientation. 4) The Director of Nursing or designee will random rounds weekly x 4 weeks then monthly 2 months to verify fall mats in	2/14/23

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F 689	Continued From page 54 sides of bed." A review of the clinical record revealed the January 2023 eTAR (electronic treatment administration record) which included an item dated 7/20/21 for "Fall Matts [sic] to each side of the bed for safety while in bed every shift for preventative." This document identified "Day" "Evening" and "Night" as three opportunities each day for staff to sign off that placement of the fall mats had been verified. Staff had completed this sign off each day through 1/18/23 (the date of survey review). Observations of Resident #21 on 1/17/23 at 10:57 AM, 1/17/23 at 2:30 PM, 1/18/23 at 11:49 AM, 1/18/23 at 3:51 PM, and 1/19/23 at 8:38 AM, revealed Resident #21 in the bed however there were no fall mats next to the bed and no evidence of fall mats anywhere in the room. On 1/19/23 at 10:00 AM an interview was conducted with LPN #2 (Licensed Practical Nurse). She stated that the fall mats should have been down. She stated that it was her fault because she had taken them up over the weekend to have them cleaned and never replaced them. A review of the facility policy "Fall Prevention and Management Policy" that was provided, was conducted. This policy documented, "Residents will be assessed for fall risk[s] on admission, quarterly, after any fall, and as needed. If risks are identified, preventive measures will be put in place and care planned. All falls will be reviewed and investigated...Individualized interventions will be implemented based on this assessment and care planned accordingly..."	F 689	place per care plan. Audit findings will be reviewed and reported to the QAPI committee for further review and recommendations monthly x 3 months.	

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F 689	Continued From page 55	F 689		

On 1/19/23 at approximately 10:30 AM, ASM #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey.

2. For Resident #23 (R23), the facility staff failed to implement fall mats as ordered.

On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 12/15/2022, the resident scored 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. The assessment documented R23 not having any falls since the prior assessment.

On 1/17/2023 at 11:49 a.m., an observation was made of R23 in bed in their room however no fall mat was observed to the left side of R23's bed.

Additional observations on 1/17/2023 at 3:52 p.m. and 1/18/2023 at 8:48 a.m. revealed R23 in bed with no fall mat on the left side of the bed.

The physician orders for R23 documented in part, "Fall mat on left side of resident bed when resident in bed every shift for for safety. Order Date: 03/27/2022."

The comprehensive care plan for R23 documented in part, "Hx of actual falls- Risk for further falls related to weakness, visual/hearing impairment, and dementia. Date Initiated: 05/11/2016..." Under "Interventions/Tasks" it documented in part, "...Fall mat on left side of bed when in bed. Date Initiated: 03/28/2022..."

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F 689	Continued From page 56 On 1/18/2023 at 2:51 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that staff were made aware of residents needs for fall mats by physician orders and their care plans. LPN #3 stated that they kept a list of residents who utilized fall mats at the nurses station and the supervisor would check the rooms at times to ensure that the mats were in place as ordered. LPN #3 stated that residents were assessed for fall risk and the care plan was updated when there were any falls. LPN #3 stated that they implemented interventions like fall mats for residents who were at risk for falls or had a history of falls. LPN #3 was made aware of the observations on 1/17/2023 and 1/18/2023 at 8:48 a.m. and stated that the mat should have been in place at all times when the resident was in bed. On 1/18/2023 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the regional director of clinical services and ASM #5, the regional vice president of operations were made aware of the concern. No further information was provided prior to exit.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		2/14/23

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F 695	Continued From page 57 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to administer oxygen per physician's orders for one of 30 residents in the survey sample; Resident #1. The findings include: For Resident #1, the facility staff failed to administer oxygen at 3 liters per minute as per the physician's order. A review of the clinical record revealed a physician's order dated 10/20/22 for "Oxygen 3LPM (liters per minute) via nasal cannula every shift..." On 1/17/23 at 12:00 PM and at 2:25 PM, observations of the resident revealed the oxygen rate on the oxygen concentrator flow meter was set at 1.5 liters as evidenced by the ball of the flow meter centered on the line between the 1 and 2 liter marks. A review of the comprehensive care plan revealed one dated 8/27/21 for "Resident is receiving continuous oxygen therapy." This care plan included an intervention dated 8/27/21 for "Administer oxygen as ordered." On 1/19/23 at 10:00 AM an interview was conducted with LPN (Licensed Practical Nurse) #2 . She stated that when she checked, the oxygen was set at the correct rate. She stated	F 695	1) Resident #1□s oxygen flowrate was adjusted to reflect physicians order upon discovery. 2) Any resident has the potential to be affected. A 100% audit will be completed to verify oxygen is at prescribed flowrate. Any variances will be addressed. 3) The Director of Nursing (DON) or designee will educate 100% nurses on their responsibility of following medical provider orders for prescribed oxygen flowrate. Education will be included in new hire orientation. 4) The DON or designee will round on 3 residents weekly x 4 weeks then monthly x 2 months to verify oxygen flowrate is at prescribed rate. Audit findings will be reported to the QAPI committee for further review and recommendations monthly x 3 months.	

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F 695	Continued From page 58 that if it was not at 3 liters when it was observed, then the physician's orders were not being followed. She stated that for this resident, it is important the oxygen be at the right rate because the resident gets hypoxic. A review of the facility policy "Oxygen Administration" that was provided, was conducted. This policy documented, "Licensed clinicians with demonstrated competence will administer oxygen via the specified route as ordered by a provider." On 1/19/23 at approximately 10:30 AM, ASM #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey .	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review and facility document review, it was determined the facility staff failed to provide dialysis care and services for one of 30 residents in the survey sample, Resident #68. The findings include:	F 698	1) Resident #68 has been discharged home. Visit summaries from dialysis were obtained and scanned into electronic medical record. (EMR) 2) Any resident has the potential to be affected. A 100% audit of current residents receiving dialysis services will	2/14/23

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F 698	Continued From page 59 The facility failed to provide communication to the dialysis facility for 1 of 1 visits in December 2022 (12/30/22) and 3 of 7 visits in January 2023 (1/2/23, 1/4/23 and 1/6/23); and failed to evidence monitoring of the bruit (swishing sound) and thrill (vibration) in the left upper arm fistula. Resident #68 was admitted to the facility on 12/28/22 with diagnosis that included but were not limited to: end stage renal disease, diabetes mellitus, heart failure and paroxysmal atrial fibrillation. The most recent MDS (minimum data set) assessment, a Medicare five-day assessment, with an ARD (assessment reference date) of 1/3/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. Section O-special procedures/treatments coded the resident as dialysis "yes". A review of the comprehensive care plan dated 12/29/22, which revealed, "FOCUS: Resident receives dialysis treatments 3 times weekly. ESRD (end stage renal disease). LUE (left upper extremity) fistula. INTERVENTIONS: Bleeding occurs from dialysis site, apply pressure. Call 911, if needed. Fluid restrictions as ordered. Meds as ordered. Monitor labs and report to physician any abnormalities. Monitor shunt/vascular catheter site for bleeding or signs /symptoms of infection. No labs/BP (blood pressure) in shunt arm. Assess/monitor dressing to shunt. Replace dressing if dressing should come off while not in dialysis. Assess/Monitor for signs /symptoms of bleeding due to anticoagulant therapy. Assist with transfer needs when going to	F 698	be audited to verify visit summary information has been obtained from dialysis provider and scanned into the EMR, any variances will be addressed. 3) The Director of Nursing (DON) or designee will educate 100% nurses on their responsibility to communicate with dialysis provider pre/post treatments and ensuring communication is scanned into the EMR. Education will be included in new hire orientation. 4) The Director of Nursing (DON) or designee will audit all residents receiving dialysis services weekly x 4 weeks then monthly x 2 months to verify communication to dialysis provider pre/post dialysis treatment. The DON or designee will review the audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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F 698	Continued From page 60	F 698		

dialysis. Maintain communication with dialysis staff and physician per routine. Dialysis per orders. Report any changes in condition to the nursing/physician.

A review of physician orders, dated 12/29/22, revealed the following, "Dialysis three times a week, Monday/Wednesday/Friday at 11 AM."

A review of Resident #68's dialysis communication book revealed missing communication to the dialysis facility for 4 of 8 visits from 12/30/22-1/16/23. The missing dates were 12/30/22, 1/2/23, 1/4/23 and 1/6/23.

A review of Resident #68's MAR-TAR (medication administration record-treatment administration record) for December 2022 and January 2023 revealed no evidence of monitoring of bruit/thrill/bleeding at the site.

An interview was conducted on 1/17/23 at 2:15 PM with Resident #68. When asked if she takes her dialysis communication book with her to the dialysis center, Resident #68 stated, "I do not take the book with me all the time. When asked whether staff monitor her fistula, Resident #68 stated, no, they do not monitor it here. They do at the dialysis center.

An interview was conducted on 1/18/23 at 2:00 PM with LPN (licensed practical nurse) #2. When asked the purpose of the dialysis communication forms, LPN #2 stated, it is to provide and receive pertinent information about the resident. We take they vital signs and note if there are any changes in labs or medications and send it to the dialysis center. When asked what care is provided to the dialysis resident, LPN #2 stated, we monitor them

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for bleeding and if they have a fistula, we monitor it for bruit and thrill. When asked where this would be documented, LPN #2 stated it is documented on the MAR-TAR.

A review of the dialysis contract on 1/18/23 at approximately 10:00 AM, revealed the following, "Review of dialysis contract: Facility shall ensure that all appropriate medical, social, administrative and other information accompany all designated residents at the time of transfer to the center. This information, shall include but is not limited to, where appropriate the following:
1. Designated resident's name, address, date of birth and social security number.
2. Name/address/phone number of next of kin.
3. Appropriate medical records including history of resident's illness, including labs and x-ray findings.
4. Treatment presently being provided to the designated resident, including medications and any changes in a patient's condition, change of medication, diet or fluid intake."

On 1/18/23 at approximately 4:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, assistant director of nursing, ASM #4, the regional director of clinical services and ASM #5, the regional vice president for operations were made aware of the findings.

On 1/19/23 at 8:00 AM, communication from the dialysis facility was provided, no additional dialysis communication forms were found.

A review of the facility's "Hemodialysis Care Policy" dated 4/22, revealed the following, "Document assessment in the Dialysis

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F 698	Continued From page 62 Communication Tool. Assessment includes vital signs, pre-treatment weight (unless performed at dialysis), medications administered before treatment, time of last meal, fluid intake, any additional alerts or information and print the tool and send with resident to dialysis (if off-site)." No further information was provided prior to exit.	F 698		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure eight consecutive hours of RN (registered nurse) coverage on three of 34 days reviewed. The findings include: The facility staff failed to ensure eight consecutive hours of RN coverage for three days, 8/13/2022, 9/4/2022 and 9/18/2022.	F 727	1) The DON or designee will educate scheduler on requirements for minimum 8-hour RN coverage. No residents were identified as being affected by the deficient practice. 2) Any resident has the potential to be affected. A review of schedule for next 30 days will be completed to verify a minimum of 8 hours daily RN coverage.	2/14/23

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F 727	Continued From page 63 Review of the PBJ Staffing Data Report for 7/1/2022-9/30/2022 revealed concerns related to the facility's requirement to have a Registered Nurse on duty for at least 8 consecutive hours a day. The report documented no RN hours on 7/31/2022, 8/13/2022, 8/14/2022, 9/4/2022 and 9/18/2022. On 1/17/2023 at approximately 11:14 a.m., during entrance conference, ASM (administrative staff member) #1, the administrator stated that the facility did not have any staffing waivers in place in the facility. On 1/17/2023 at approximately 12:00 p.m., a request was made to ASM #1 for evidence of RN coverage for the dates listed above. On 1/17/2023 at 12:52 p.m., ASM #1 provided time card reports for the dates listed above and stated that they did not have evidence of an RN that clocked in on those dates and would continue to look. Review of the time card reports documented no RN on 7/31/2022, 8/13/2022, 9/4/2022, 9/18/2022. The timecard report documented bonus pay for an RN on 8/14/2022. On 1/18/2023 at 11:30 a.m., an interview was conducted with OSM (other staff member) #2, staffing coordinator. OSM #2 stated that they normally had an RN staffed on the 7:00 a.m.-3:00 p.m. shift each day during the week and on the weekends had an RN on the day shift or either the 11:00 p.m.-7:00 a.m. shift. OSM #2 stated that they also had the unit managers and the assistant director of nursing on call who rotated a schedule and were the last resort to cover staffing as needed if they could not cover with part time	F 727	3) The Director of Nursing or designee will educate scheduler, RN's, Unit Managers and supervisors on requirements for minimum 8-hour RN coverage daily. Education will be included in new hire orientation. 4) The Director of Nursing or designee will review schedule daily during Clinical Morning Meeting to verify schedule includes minimum 8-hour RN coverage requirements are met. Audit findings to be reported to QAPI committee for further review and recommendations monthly x 3 months.	

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F 727	Continued From page 64	F 727		

staff. OSM #2 stated that they would review the dates above and see if there was an RN on duty.

On 1/18/2023 at 1:23 p.m., OSM #2 stated that they had reviewed the timecards and schedules for the dates listed above and provided a timecard evidencing an RN working 8 hours on 7/31/2022. OSM #2 stated that they did not have evidence of an RN for 8 hours on 8/13/2022, 9/4/2022 or 9/18/2022.

The facility policy, "Payroll Based Journal Reporting" undated, documented in part, "...If a salary RN employee works the floor as a nurse, ensure the employee has completed the Weekend Salary RN Transfer form (Attachment 4). You can then move the hours on the time card to reflect the day they worked. Please remember, you cannot pay a salary person over 40 hours per week....There needs to be 8 hours of one of the following job codes 7 days week, DON, ADONRN, MDSRN, RN, VRN, RESTRN, and SUPERRN. There is a report in Time Trak called PBJ Hours 5-7 (RN Only). This report will show you if you have an RN missing. If you do not have an RN in payroll for that day, ensure you meet with the DON to see if a salary day needs adjusted and/or you had an agency RN, in which case that would be tracked on your excel tracking log..."

On 1/18/2023 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the regional director of clinical services and ASM #5, the regional vice president of operations were made aware of the concern.

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F 727	Continued From page 65 No further information was presented prior to exit.	F 727		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of	F 732		2/14/23

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F 732	Continued From page 66 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to post daily nurse staffing information prior to the start of the shift for one of three days observed. The findings include: The facility staff failed to post nurse staffing information on 1/18/2023 prior to the beginning of the nursing staff work shift. On 1/18/2023 at 8:03 a.m., and 8:29 a.m., observations of the posted nurse staffing information in the entrance hallway revealed staffing information dated 1/17/2023. On 1/18/2023 at 11:30 a.m., an interview was conducted with OSM (other staff member) #2, staffing coordinator. OSM #2 stated that the nursing schedules were 7:00 a.m.-3:00 p.m., 3:00 p.m.-11:00 p.m. and 11:00 p.m.-7:00 a.m. OSM #2 stated that they worked Monday through Friday beginning at 8:00 a.m. OSM #2 stated that when they came in each day they reviewed the census in the facility, looked at the schedule for the day and filled out the daily staff posting and placed it in the hallway. OSM #2 stated that they did not post it prior to the beginning of the first shift and was not aware of the requirement. OSM #2 stated that when they were not working the manager on duty was responsible for posting the information. The facility policy, "Daily Nurse Staffing Posting	F 732	1) The scheduler has been educated on requirements for posting staffing information at the beginning of the first shift of day. 2) Any resident has the potential to be affected. The Director of Nursing of designee has rounded and verified staff posting was displayed at the beginning of day shift. 3) The Director of Nursing or designee will educate scheduler, Unit Managers and supervisors on requirements of posting staffing by start of day shift daily. Education will be included in new hire orientation. 4) The Director of Nursing or designee will round weekly x 4 weeks then monthly x 2 months to ensure staff posting has been posted prior to start of day shift. The DON or designee will review the audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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F 732	Continued From page 67 Policy" with a revision date of 8/13/2020 documented in part, "...The facility will post the following information on a daily basis, at the beginning of each shift: Facility name; The current date; Resident census; The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (a) Registered nurses (b) Licensed practical nurses or licensed vocational nurses (as defined under State law) (c) Certified nurse aides..." On 1/18/2023 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the regional director of clinical services and ASM #5, the regional vice president of operations were made aware of the concern. No further information was presented prior to exit.	F 732		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined the facility staff failed to ensure one of 30 residents in the survey sample was free of a significant mediation error, Resident #123 (R123). The findings include:	F 760	1) Resident # 123 no longer resides in the facility. The nurse caring for Resident # 123 has been educated on her responsibility to follow medical provider□s orders and actions to take if medication is not available. 2) Any resident has the potential to be	2/14/23

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F 760	Continued From page 68 For R123, the facility staff failed to administer an intravenous (IV) antibiotic on 8/17/2022. On the most recent MDS (minimum data set) assessment, a Medicare five-day assessment, with an assessment reference date of 9/8/2022, the resident scored a "7" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired for making daily decisions. In Section N - Medications the resident was coded as receiving antidepressants and antibiotics during the look back period. The physician order dated, 8/17/2022, documented, "Ceftriaxone Sodium Solution Reconstituted 2 GM (grams) (used to treat infections) (1), Use 2000 milligrams intravenously every 24 hours related to abscess of liver for 23 days." The August 2022 MAR documented the above order with a scheduled time of "24h." There was no scheduled time for the administration of the medication. On 8/17/2022, the nurse documented a "19" on the block where it would be documented as administered. A "19" indicated, "Other/See Nurses Notes." The EMAR (electronic medication administration record) note dated 8/17/2022 at 7:36 p.m. documented, "Just admitted." The MAR from the hospital from which the resident was admitted from, documented the above order. The last dose documented was on 8/16/2022 at 2:00 p.m. There was no documentation of the medication being administered at 2:00 p.m. on 8/17/2022.	F 760	affected. An audit of medication administration for past 7 days will be completed to verify medications have been administered per medical provider order. Any variances will be addressed promptly. 3) The Regional Director of Nursing has educated the Director of Nursing and Assistant Director Nursing on the facility protocol for auditing medication administration during Clinical Morning Meeting. The Director of Nursing (DON) or designee will educate 100% nurses on their responsibility in ensuring medications are administered per medical provider□s orders and protocol for obtaining medications from on-site storage and notification to medical provider if medication not available. Education will be included in new hire orientation. 4) The Director of Nursing or designee will audit medication administration during Clinical Morning meeting weekly x 4 weeks then monthly x 2 months to verify medications have been administered per medical provider□s orders, any variances will be addressed. The DON or designee will review the audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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The comprehensive care plan dated 8/18/2022, documented in part, "Resident has infection, liver abscess, PICC line." The "Interventions" documented in part, "Administer antibiotics/anti-viral per physician order and monitor side effect."

The on-site emergency pharmacy dispensing machine inventory list was reviewed. The following was documented as being in the pharmacy machine on site: Ceftriaxone 1 GM vial 1 EA (each) - PAR level - 5.

An interview was conducted with LPN (licensed practical nurse) #4, on 1/19/2023 at 9:25 a.m. When asked about the process when a new admission comes and it's time for the resident to receive their medications, LPN #4 stated you look at the computer, verify the medication, if you don't have the medication you go to the (name of pharmacy dispensing machine). LPN #4 stated if the medications are not in there, you call the doctor and follow their instructions and then notify the responsible party. When asked where the above actions are documented, LPN #4 stated it should be in a nurse's note in (name of computer program). The above medication was reviewed with LPN #4. LPN #4 stated she believed the medication is in the (name of computer program).

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/19/2023 at 9:36 a.m. When asked the process for a new admission comes with physician orders for IV antibiotics, ASM #2 stated if the medication is scheduled and it hasn't come in from the pharmacy, ASM #2 stated they check the (name of pharmacy dispensing machine). If

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it's not there you call the doctor and follow their instructions. When asked where this is documented, ASM #2 stated it should be in a nurse's note. The time documented on the MAR for the above medication was reviewed with ASM #2, ASM #2 stated there should be a time documented for the administration. When asked what time should be documented, ASM #2 stated, if it's give every 24 hours then our scheduled time is 9:00 a.m. but I would have checked when it was last given at the hospital prior to transfer and follow that time. When asked if the IV antibiotic is considered a significant medication, ASM #2 stated yes, if the resident is requiring IV antibiotics, then it's significant for that resident.

The facility policy, "General Dose Preparation and Medication Administration," failed to evidence documentation related to the administration of intravenous medications and/or medications not available.

Lippincott Handbook of Nursing Procedures included: "One of the responsibilities of the nurse administering medications is to check to ensure the medications are available for administration at the times ordered ...verify the physician's order and check the drugs to be sure they are correct ... if medications are not given for any reason the physician must be notified" (2).

ASM #1, the administrator, and ASM #2, were made aware of the above on 1/19/2023 at 9:49 a.m.

No further information was obtained prior to exit.

Complaint deficiency.

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F 760	Continued From page 71 (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a685032.html (2) Lippincott Handbook of Nursing Procedures Bethlehem Pa 2008 page 569-570.	F 760		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance	F 842		2/14/23

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F 842	Continued From page 72 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate	F 842	1) Resident #21 fall mats have been placed at bedside bilaterally. Nurse was educated on verifying orders were carried	

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	495401	A. BUILDING _____ B. WING _____	C 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 73 clinical record for one of 30 residents in the survey sample; Resident #21. The findings include: For Resident #21, the facility staff failed to ensure accurate documentation regarding the placement of fall mats. Observations of Resident #21 on 1/17/23 at 10:57 AM, 1/17/23 at 2:30 PM, 1/18/23 at 11:49 AM, 1/18/23 at 3:51 PM, and 1/19/23 at 8:38 AM, all revealed Resident #21 in the bed. There were no fall mats down and no evidence of fall mats anywhere in the room. A review of the clinical record revealed the January 2023 eTAR (electronic treatment administration record.) This document included an item dated 7/20/21 for "Fall Matts [sic] to each side of the bed for safety while in bed every shift for preventative." This document identified "Day" "Evening" and "Night" as three opportunities each day for staff to sign off that placement of the fall mats had been verified. Staff had completed this sign off each day through 1/18/23. On 1/19/23 at 10:00 AM an interview was conducted with LPN #2 (Licensed Practical Nurse). She stated that the fall mats should have been down. When asked about documenting that mats were in place when in fact there were not any mats in the room, she stated that it was her fault because she had taken them up over the weekend to have them cleaned and never replaced them. A review of the comprehensive care plan revealed one dated 3/23/21 for "Actual fall; Risk	F 842	out and documented after implementation. 2) Any resident has the potential to be affected. A 100% audit of residents with orders for fall mats will be reviewed to verify fall mats in place with accurate documentation. Any variances will be addressed. 3) The Director of Nursing (DON) or designee will educate nurses on nurse's responsibility to verify orders carried out and document after implementation. Education will be included in new hire orientation. 4) The DON or designee will conduct random rounds weekly x 4 weeks then monthly 2 months to verify fall mats in place and documented accurately per care plan. Audit findings will be reviewed and reported to the QAPI committee for further review and recommendations monthly x 3 months.	

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F 842	Continued From page 74 for further falls..." This care plan included an intervention dated 7/19/21 for "Fall mats on both sides of bed." On 1/19/23 at approximately 10:30 AM, ASM #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		2/14/23

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F 880	Continued From page 75	F 880		

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

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:

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F 880	Continued From page 76 Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain a bedpan in a clean and sanitary manner for one of 30 residents in the survey sample; Resident #35. The findings include: Observations were made of Resident #35 on 1/17/23 at 11:36 AM, 1/17/23 at 2:30 PM, 1/18/23 at 11:49 AM, 1/18/23 at 3:51 PM, and 1/19/23 at 8:38 AM. In the resident's bathroom was a bedpan, unlabeled (whether for Resident #35 or for their roommate), and unbagged, sitting directly on the floor. On 1/18/23 at 4:22 PM, an interview was conducted with LPN #4 (Licensed Practical Nurse). She stated that Resident #35 started using the bedpan upon return from a hospital visit after surgery a couple months prior, and still used it sometimes. On 1/19/23 at 10:00 AM an interview was conducted with LPN #2 (Licensed Practical Nurse). She stated that the bedpan should be in plastic bag in the bathroom, and should be labeled. She stated that being on the floor, not in a plastic bag, is not sanitary. She stated that she does not check the bedpan every day for being bagged and labeled. A review of the facility policy "Bedpan Cleaning" that was provided, was conducted. This policy documented, "To ensure that cleaning is performed after resident bed pan use to reduce and prevent infections. The following procedure will be performed after resident bed pan use...7. Cover clean and dried bedpan with plastic bag or	F 880	1) The bedpan in Room 201 for Resident #35 was replaced, labeled and bagged. 2) Any resident has the potential to be affected. A 100% audit during room rounds will be conducted to verify all personal belongings are labeled and bagged per facility policy. 3) The Infection Control Nurse or designee will educate 100% staff on ensuring infection prevention and control measures to prevent potential spread of infection from personal belongings. Education will be included in new hire orientation. 4) The Infection Control Nurse or designee will conduct random infection control rounds weekly x 4 weeks then monthly 2 months. The DON or designee will review the audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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F 880	Continued From page 77 paper towel..." On 1/19/23 at approximately 10:30 AM, ASM #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey.	F 880		