STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495391		C 02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBURNIE REHAB & NURSING CENTER	1901 LIBBIE AVE RICHMOND, VA 23226

(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	E 000		
	An unannounced Emergency Preparedness survey was conducted 02/05/2023 through 02/08/2023. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey..			
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility]	E 037		3/21/23

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

Electronically Signed | 03/03/2023

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

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E 037	Continued From page 1 must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures.	E 037		

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E 037	Continued From page 2 (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training.	E 037		

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E 037	Continued From page 3 (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

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E 037	Continued From page 4 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review the facility staff failed to have a complete emergency preparedness plan related to annual training and documentation. The findings include: Facility staff failed to provide evidence of documentation of the facility's annual emergency preparedness training offerings and documentation that facility staff have received annual emergency preparedness training. On 02/07/2023 at approximately 2:00 p.m., the facility's emergency preparedness plan was reviewed. Review of the facility's emergency	E 037	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. E037 EP Training Program 1-The Administrator has completed an in-house emergency preparedness plan as well as completed staff training. The maintenance director or designee will ensure the management software is	

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E 037	Continued From page 5 preparedness plan failed to evidence documentation of the facility's annual emergency preparedness training offerings and documentation that facility staff have received annual emergency preparedness training. On 02/08/2023 approximately 10:30 a.m., interview was conducted with ASM (administrative staff member) #1, administrator. When asked about the annual training regarding the facility's emergency preparedness ASM #1 stated that they did not have evidence of annual emergency preparedness training offerings and documentation that facility staff have received annual emergency preparedness training. No further information was provided prior to exit.	E 037	updated to include all documentation and conducting of drills. 2-Maintenance Director and safety committee has reviewed all training materials and has educated all staff on annual facility-based emergency preparedness drills. 3-An audit will be completed monthly X 3 months to ensure that required drills are completed and annual emergency preparedness drills and training have occurred. Any variances will be corrected with additional training. 4-On-going compliance will be monitored and reviewed at the QAPI meeting process. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5-Date of Completion 3/21/23	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:	E 039		3/21/23

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E 039	Continued From page 6 (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the	E 039		

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E 039	Continued From page 7 patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not	E 039		

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E 039	Continued From page 8 accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an	E 039		

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E 039	Continued From page 9 actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from	E 039		

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E 039	Continued From page 10 engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the	E 039		

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E 039	Continued From page 11 LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that	E 039		

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E 039	Continued From page 12 may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:	E 039		

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	495391		C 02/08/2023

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E 039	Continued From page 13 (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]:	E 039		

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E 039	Continued From page 14 (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. 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 have a complete emergency preparedness plan related to emergency preparedness training exercises. The findings include: Facility staff failed to provide evidence of documentation of the annual tabletop and full scale exercise, the facility's efforts to identify a full scale exercise, exercise analysis, response and how the facility updated its emergency program based on the exercise analysis. On 02/07/2023 at approximately 2:00 p.m., the facility's emergency preparedness plan was reviewed. Review of the facility's emergency preparedness plan failed to evidence documentation of the annual tabletop and full scale exercise, the facility's efforts to identify a full scale exercise, exercise analysis, response and how the facility updated its emergency program	E 039	E039 EP Testing Requirements 1-The life safety committee has completed the first of two in-house emergency preparedness drills. 2-Schedule has been established for completion of second drill in 6 months or the facility will participate in the annual VAHHS Tabletop exercise. Administrator or designee will educate all facility staff on Emergency preparedness process and annual requirements. 3- Maintenance director or designee will audit monthly X 3 months to ensure that required training and drills for Emergency preparedness is being implemented. Any variances will be corrected with additional training. 4. On-going compliance will be monitored and reviewed at the QAPI meeting process. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will	

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E 039	Continued From page 15 based on the exercise analysis. On 02/08/2023 approximately 10:30 a.m., interview was conducted with ASM (administrative staff member) #1, administrator. When asked about the annual tabletop and full scale exercise, the facility's efforts to identify a full scale exercise, exercise analysis, response and how the facility updated its emergency program based on the exercise analysis ASM #1 stated that they did not have it. No further information was provided prior to exit.	E 039	be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5-Date of Completion 3/21/23	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/5/2023 through 2/8/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Ten complaints were investigated during the survey (VA00057590-Substantiated with deficiency; VA00056177-Substantiated with deficiency; VA00055244-Substantiated with deficiency; VA00053805-Substantiated with deficiency; VA-00056682-Substantiated with deficiency; VA00055289-Unsubstantiated; VA00054781- Substantiated with deficiency; VA00054267- Substantiated with deficiency; VA00057712- Substantiated with deficiency and VA00057724- Substantiated with deficiency). The census in this 125 certified bed facility was 115 at the time of the survey. The survey sample consisted of 43 current resident reviews and 15 closed record reviews.	F 000		
F 550	Resident Rights/Exercise of Rights	F 550		3/21/23

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F 550 SS=D	Continued From page 16 CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her	F 550		

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F 550	Continued From page 17 rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services in a dignified manner for two of 58 residents in the survey sample, Residents #128 and #96. The findings include: 1. For Resident #128 (R128), the facility staff failed to change a resident's soiled sock, failed to provide personal privacy, and failed to help him to dress in street clothes. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/22/23, R128 was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). The resident was coded as requiring the extensive assistance of staff for personal hygiene, grooming, and dressing. On each of the following dates and times, R128 was dressed in a hospital gown, and was in a location visible to visitors and staff: 2/5/23 at 3:18 p.m., 3:40 p.m., and 5:12 p.m.; 2/6/23 at 8:16 a.m., 9:40 a.m., 2:56 p.m.; 2/7/23 at 12:10 p.m. On 2/6/23 at 8:16 a.m. and 9:40 a.m., R128 was dressed in a hospital gown, and sitting on the side of the bed, facing away from the door. The resident's hospital gown was tied at the neck, and open from the neck down to the resident's	F 550	F550-Resident Rights/Exercise of Rights 1-Resident # 128 is provided clean and appropriate clothing. 2-All current residents have the potential to be affected. The Interdisciplinary team, or designees will complete an audit of all residents to ensure that they are wearing clean and appropriate clothing and inspect resident rooms to ensure that they are clean and sanitary. 3-The ADON, or designee will educate all Certified Nursing Aides and Licensed Nurses on the provisions of providing respectful and dignified care, to include clean and appropriate clothing and reporting resident rooms that need cleaning to the appropriate Department. The Housekeeping director or designee will educate all housekeeping staff on the process of room cleanliness 4-The Unit Manager, or designee will complete observations of residents to ensure that they are dressed in clean and appropriate clothing on a weekly basis x 8 weeks, then monthly x 2. The Housekeeping Director, or designee will complete resident room inspections on a weekly basis x 8 weeks, then monthly x 2 to check for cleanliness. 5-The results of the audits will be discussed at the monthly QAPI meeting. The committee will determine the need for further audits and/or action. The Administrator or Director of Nursing	

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F 550	Continued From page 18 buttocks. The resident's back was exposed to the view of anyone who looked into the room from the hallway. At least six different staff members passed by the resident's door while they were passing out meal trays during this time. On the following dates and times, R128 was wearing the same bloodstained sock: 2/5/23 at 3:18 p.m., 3:40 p.m., and 5:12 p.m.; 2/6/23 at 8:16 a.m., 9:40 a.m., 2:56 p.m. On 2/6/23 at 2:56 p.m., LPN (licensed practical nurse) #2 and LPN #11 were asked what types of services a resident should receive with morning ADL (activities of daily living) care each day. LPN #2 stated morning care includes washing a resident's face and hands, changing incontinence briefs/assisting with toileting, repositioning a resident up in a chair, and getting a resident dressed for the day. When asked if it is acceptable care for a resident to be dressed all day in a hospital gown, or to still be wearing bloodstained socks from over 24 hours before that, she stated: "No, it is not." LPNs #11 and #2 observed R128 sitting up in the bed, still dressed in a hospital gown, and still wearing the bloodstained sock. LPN #11 stated: "This is not acceptable. Not at all. I will get [R128] changed." When asked what she would do if she observed a resident's back and buttocks were visible from the hallway, she stated she would give the resident a blanket or piece of clothing to cover their back. She stated a resident "deserves their privacy." When asked if R128 had been treated in a dignified manner by the facility staff, both LPN #11 and LPN #2 stated the resident had not. On 2/7/23 at 5:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the	F 550	are responsible for implementation of the plan of correction. 6-Date of Compliance 3/21/23	

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F 550	Continued From page 19 director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. On 2/8/23 at 10:18 a.m., CNA (certified nursing assistant) #5 was interviewed. He stated morning ADL resident care consists of getting a resident up, washing their face, brushing their teeth combing their hair, and getting them dressed in regular clothes. When asked if a resident's dignity is preserved if the resident is left in a hospital gown during the day, and is left wearing a bloodstained sock for more than 24 hours, he stated: "No. That is not dignified at all." A review of the facility policy labeled "Dignity," revealed no information relevant to dignity in resident personal care. No further information was provided prior to exit. 2. For (R96), the facility staff failed to maintain the bathroom in a clean and sanitary manner to promote dignity. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/20/2022, (R96) scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. On 02/05/2023 at approximately 2:30 p.m., and on 02/06/2023 at approximately 8:30 a.m., an observation of (R96's) bathroom revealed loose feces in and on the toilet seat, down the front and side of the toilet bowl, on the floor trailing from the toilet to the bathroom door and extending out into the (R96's) room.	F 550		

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F 550	Continued From page 20 On 02/06/2023 at approximately 8:45 a.m. an interview was conducted with (R96). When asked how long the bathroom was in the condition as described above (R96) stated that it wasn't cleaned in the past couple of days and that they kept the bathroom door closed due to the odor. When asked if they notified any facility staff about the condition of their bathroom (R96) stated that they told facility staff but could not recall who they told or when. On 02/06/2023 at 9:04 a.m. an observation of (R96's) room revealed housekeeping staff OSM (other staff member) #2, housekeeper, standing in the doorway looking into the room and OSM #1, housekeeping manager, who was in the room, cleaning the bathroom. When asked what the dark substance was trailing from the bathroom out into the resident's room OSM #2 stated that the substance looked like feces. On 02/06/2023 at 9:10 a.m., an interview was conducted with OSM #1, director of housekeeping. When asked about the substance they were cleaning in the bathroom on the toilet seat, down the front and side of the toilet bowl, on the floor trailing from the toilet to the bathroom door and extending out into the (R96's) room, OSM #1 stated it was feces. When asked to describe what their department's staffing schedule should be OSM #1 stated three housekeepers on each unit from 7:00 a.m. through 3:00 p.m. every day of the week. When asked how many housekeeping staff were working in the facility Saturday 02/04/2023 and Sunday 02/05/2023 OSM #1 sated there were two housekeepers on each unit. When asked if the weekend was fully staffed OSM #1 stated no. OSM #1 stated that the housekeeping staff are	F 550		

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F 550	Continued From page 21 required to do a 'Walk-through' at the end of their shift to check all the resident's rooms and bathrooms, pick up any trash, clean any spills. When asked if it was dignified for a resident's bathroom to be in the condition described above OSM #1 stated no and that the bathroom should have been cleaned immediately. On 02/07/2022 at approximately 5:00 p.m., ASM (administrative staff member) #1, administrator, ASM # 2, interim director of nursing and ASM # 3, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit.	F 550		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.	F 565		3/21/23

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F 565	Continued From page 22 (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to respond to a resident council concern for one of one resident council meetings; the November 2022 meeting. The findings include: The facility staff failed to respond to the November 2022 resident council's concern regarding call bells not being answered in a timely manner. A review of the 11/28/22 resident council meeting notes revealed the following documentation, "(Name of a resident) and various residents expressed a concern about the call bell response. They are not being answered in a timely manner. Grievance form will be written for the matter." A review of the November 2022 and December 2022 grievances failed to reveal a grievance regarding the resident council's call bell concern. On 2/6/23 at 3:15 p.m., ASM (administrative staff	F 565	F565-Resident/Family Group and response 1-Any concerns mentioned from the most recent Resident Council meeting have been addressed and feedback provided to the residents. 2-All residents have the potential to be affected by resident concerns mentioned in the Resident council meeting not being addressed. The Administrator will review the most recent Resident council meeting minutes and ensure that any noted concerns will be addressed. 3-The Administrator, or designee will educate the Activities Director and the Interdisciplinary Team on communicating resident concerns mentioned in the Resident Council meeting to the Administrator and ensuring feedback of resolution of the concerns to the Residents. 4-The Administrator, or designee will review the Resident council minutes on a	

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F 565	Continued From page 23 member) #1 (the administrator) was asked to provide evidence that the November 2022 resident council concern regarding call bells was addressed. No further documentation was provided. A review of the resident council meeting notes for 1/24/23 revealed further resident concern regarding call bell response. On 2/7/23 at 10:53 a.m., an interview was conducted with OSM (other staff member) #5 (the director of activities). OSM #5 stated she immediately completes a grievance form when there are concerns voiced at the resident council meetings. OSM #5 stated she provides the grievance form to the director of social services who distributes the grievance to the department responsible for the concern. OSM #5 stated there should have been a grievance form completed for the 11/28/22 resident council concern regarding call bells. On 2/7/23 at 5:02 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Resident Council" documented, "2. The Administrator is responsible for reviewing and signing the (name of company) Resident Council Meeting Minutes and responding in writing to concerns presented by the council on the Administrative Response to Resident Council Form."	F 565	monthly basis x 2 and ensure that any concerns are addressed appropriately. 5-The results of the audits will be discussed at the monthly QAPI meeting. The committee will determine the need for further audits and/or action. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6- Date of compliance 3/21/23	
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,	F 580		3/21/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 24 consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, 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	F 580		

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	495391		C 02/08/2023

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F 580	Continued From page 25 §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 and clinical record review, the facility staff failed to notify the physician and/or the RP (responsible party) of a need to alter treatment for four of 58 residents in the survey sample, Residents #114, #118, #112 and #6. The findings include: 1. For Resident #114 (R114), the facility staff failed to notify the physician when physician ordered medications were not administered to the resident on multiple dates in June 2022. A review of R114's clinical record revealed the following physician's orders: 6/9/22- omeprazole (1) 20 mg (milligrams)- 1 capsule by mouth one time a day for gastroesophageal reflux disease; 6/10/22-mupirocin ointment (2) 2%- apply to sacrum/buttocks rash two times a day for ten days (scheduled at 9:00 a.m. and 9:00 p.m.); 6/21/22-calcium with vitamin D 600 mg/200 units- 1 tablet by mouth one time a day for COVID; 6/21/22-melatonin 3 mg- 1 tablet by mouth at bedtime for COVID; 6/21/22-vitamin C 500 mg by mouth one time a day for COVID 6/21/22 (12:32 a.m.)-zinc sulfate 220 mg (milligrams)- 1 capsule by mouth one time a day for 14 days for COVID (scheduled at 9:00 a.m.).	F 580	F580 Notify of Changes 1-Resident # 6, #112, #114 and #118 no longer reside in the facility. 2-All current residents have the potential to be affected by the RP or MD not being notified of changes in condition or missed medication administration. 3-The ADON, or designee will educate all licensed nurses on the process for notification to MD/RP upon change in condition, and notification to the MD of medications not available for administration. 4-The Unit Manager, or designee will review Resident medication availability and resident changes in condition for proper MD/RP notification on a weekly basis x 8 weeks, then monthly x 2 months. 5-The results of the review will be discussed at the monthly QAPI meeting for determination of further audits and/or action. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Date of compliance: 3/21/23	

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F 580	Continued From page 26 A review of R114's June 2022 MAR (medication administration record) and TAR (treatment administration record) failed to reveal evidence the following medications were administered on the following dates (as evidenced by blank spaces on the MAR and TAR): Omeprazole 20 mg on 6/10/22; Mupirocin 2% on 6/15/22 (9:00 p.m.); Calcium with vitamin D 600 mg/200 units on 6/21/22; Melatonin 3 mg on 6/21/22; Vitamin C 500 mg on 6/21/22; Zinc sulfate 220 mg on 6/21/22. Further review of R114's clinical record, including June 2022 nurses' notes, failed to reveal the facility staff notified R114's physician when the above medications were not administered. On 2/7/23 at 12:00 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated residents' physicians should be notified when a physician ordered medication is not administered, "to see if they want to change something or new orders." LPN #3 stated nurses should document when the physician is notified. On 2/8/23 at 9:50 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Medication Management/Medication Unavailability" documented, "3. If medications are determined to be unavailable for administration, licensed nurse will notify the provider of the unavailability. Licensed nurse will document notification to the	F 580		

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F 580	Continued From page 27 provider of the unavailability in the medical record." References: (1) Omeprazole decreases the amount of acid in the stomach. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a617014.html (2) Mupirocin ointment is an antibiotic used to treat skin infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a688004.html 2. For Resident #118 (R118), the facility staff failed to notify the physician when the physician ordered medication gabapentin (1) was not administered to the resident on 11/5/21. A review of R118's clinical record revealed a physician's order dated 11/5/21 (2:42 p.m.) for Gabapentin 100 mg (milligrams)- 1 capsule by mouth three times a day for right hip osteoarthritis. The medication was scheduled at 6:00 a.m., 2:00 p.m. and 10:00 p.m. A review of R118's November 2021 MAR (medication administration record) failed to reveal the medication was administered on 11/5/21 at 10:00 p.m. A nurse's note dated 11/5/21 documented, "Awaiting order from pharmacy." Further review of R118's clinical record (including progress notes and the November 2021 MAR) failed to reveal the scheduled dose was given and failed to reveal R118's physician was notified. On 2/7/23 at 12:00 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated residents' physicians should be	F 580		

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F 580	Continued From page 28 notified when a physician ordered medication is not administered, "to see if they want to change something or new orders." LPN #3 stated nurses should document when the physician is notified. On 2/7/23 at 5:02 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. Reference: (1) Gabapentin is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694007.html 3. For Resident #112 (R112), the facility staff failed to notify the physician when the physician ordered medication ceftriaxone sodium (1), an antibiotic, was not administered on 1/26/23. A review of R112's clinical record revealed a physician's order dated 1/12/23 for ceftriaxone sodium solution reconstituted 2 grams intravenously every 24 hours for infection for 25 Days. A review of R112's January 2023 MAR (medication administration record) failed to reveal evidence that ceftriaxone sodium was administered to the resident on 1/26/23. A nurse's note dated 1/26/23 documented, "On order." Further review of R112's clinical record (including progress notes and the January 2023 MAR) failed to reveal the scheduled dose was given and failed to reveal R112's physician was notified. On 2/7/23 at 12:00 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated residents' physicians should be	F 580		

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F 580	Continued From page 29 notified when a physician ordered medication is not administered, "to see if they want to change something or new orders." LPN #3 stated nurses should document when the physician is notified. On 2/7/23 at 5:02 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. Reference: (1) Ceftriaxone sodium is used to treat infection. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a685032.html 4. For Resident #6 (R6), the facility staff failed to notify the responsible party of changes in treatment/condition and refusals of care. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/11/2022, the resident scored 1 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. On 2/5/2023 at 4:38 p.m., an interview was conducted with R6's responsible party (RP). The RP voiced concerns regarding the lack of consistent communication with facility staff regarding R6's care. R6's RP voiced concerns regarding having to come to the facility to get information regarding recent antibiotic doses that were missed, medication refusals, a room change for COVID-19 isolation and multiple IV (intravenous) access problems that were not reported to them. The RP stated that they were called and made aware that R6 had tested	F 580		

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F 580	Continued From page 30 positive for COVID-19 but was not informed of a room change until they came to the facility to check on them and then found our they had been moved and started on IV fluids. R6's RP voiced concerns that some of these refusals may have been able to have been prevented if they had been called and were given the opportunity to come in to encourage R6 to allow the staff to provide the treatment. The progress notes for R6 documented in part: - "12/28/2022 01:27 (1:27 a.m.) Note Text: patient is alert and responsive, skin warm and dry to touch. no ss (signs/symptoms) of pain and distress noted patient has an order for 0.9% IV normal (intravenous fluids) one liter. patient has a peripheral live [sic] to her left upper extremity that is not patent, pharmacy was reached to send us IVF (intravenous fluids) and clysis (infusion of fluid usually subcutaneously). which is still pending delivery. attains [sic] to start new line was unsuccessful. IVF is upset [sic] up in patients' room. patient had her dinner and took her medications as ordered." - "12/28/2022 14:32 (2:32 p.m.) Several attempts were made to start an IV access but was unsuccessful. Call placed to pharmacy concerning Clysis kit authorization was signed and faxed. Awaiting arrival of supplies." - "12/29/2022 10:42 (10:42 a.m.) Started Clysis to Abdomen infusing NS (normal saline) @ 100ml/hr (milliliter per hour) noted no s/s (signs/symptoms) of complications." - "12/29/2022 18:32 (6:32 p.m.) Pt (patient) (family member) was updated on positive covid status and start of clysis." - "12/29/2022 19:25 (7:25 p.m.) Note Text: resident's (family member) (name of family member) presented at desk inquiring how	F 580		

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F 580	Continued From page 31 resident was doing and if resident was moved. Advised RP that resident has been moved to (Room number), new orders received and noted this evening and resident would be placed on isolation x 14 days. RP vocalized understanding and thanks for notification." - "1/8/2023 04:53 (4:53 a.m.) Note Text: resident's IV line was removed due to infiltration. resident had swelling to the right hand. on call NP (nurse practitioner-name) was called. warm compresses are to be given for comfort. resident receives scheduled Tylenol for pain. will continue to monitor for any change in condition." - "1/16/2023 12:44 (12:44 p.m.) Note Text: Resident is skilled for Multiple Fracture of ribs, right side subsequent encounters for fractures with routine healing. Resident up and dressed sitting in her w/c (wheelchair). Resident is awake but confused at times. Resident refused to eat her breakfast. Resident is incontinent of bowel and bladder. Resident voiced no complaints of pain or discomfort. Resident ambulating earlies [sic] in hallways with therapy." - "1/20/2023 06:50 (6:50 a.m.) patient is alert and responsive, skin warm and dry to touch, no s/s of pain and distress, IV placement is still pending. unable to collect urine sample, she will be encouraged again today. she took her medications as ordered." - "1/22/2023 22:10 (10:10 p.m.) Residents IV infiltrated. It was removed & [Name of Vendor] is scheduled to replace it tomorrow. MD (medical doctor) notified." - "1/23/2023 18:41 (6:41 p.m.) refused to take medication." - "1/23/2023 19:16 (7:16 p.m.) ...Skilled Nursing Focus: Resident in bed resting voiced no complaints of pain or discomfort. Resident refused to eat meals today. MD was notified.	F 580		

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F 580	Continued From page 32 Resident ambulated with therapy this morning. [Name of Vendor] was in facility to obtain an IV access. Resident received IV access to left lower arm. IV access is no longer working. [Name of Vendor] has been notified to put a central access in this shift." - "1/24/2023 06:30 (6:30 a.m.) Piperacillin-Tazobactam (antibiotic) in Dex Solution 2-0.25 GM (gram)/50ML (mililiter), Use 2.25 gram intravenously every 8 hours for infection for 7 Days start PIV (peripheral intravenous access). Refused." - "1/26/2023 07:01 (7:01 a.m.) Piperacillin-Tazobactam in Dex Solution 2-0.25 GM/50ML, Use 2.25 gram intravenously every 8 hours for infection for 4 Days via Picc (peripherally inserted central catheter) line. resident refused." Review of the eMAR (electronic medication administration record) for R6 dated 1/1/2023-1/31/2023 documented in part, "Piperacillin-Tazobactam in Dex Solution 2-0.25 GM/50ML, Use 2.25 gram intravenously every 8 hours for infection for 7 Days start PIV. Order Date: 01/20/2023 1404 (2:04 p.m.) D/C (discontinue) date: 01/25/2023 1500 (3:00 p.m.)." The eMAR further documented, "Piperacillin-Tazobactam in Dex Solution 2-0.25 GM/50ML, Use 2.25 gram intravenously every 8 hours for infection for 4 Days via Picc line. Order Date: 01/25/2023 1334 (1:34 p.m.)." The eMAR documented R6 refusing the medication on 1/23/2023 at 10:00 p.m. and 1/26/2023 at 6:00 a.m. The eMAR further documented R6 not receiving the medication on 1/20/2023 at 10:00 p.m., 1/21/2023 at 6:00 a.m. and 10:00 p.m., 1/22/2023 at 6:00 a.m., 2:00 p.m., and 10:00 p.m., 1/23/2023 at 6:00 a.m. and 10:00 p.m.,	F 580		

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F 580	Continued From page 33 1/24/2023 at 6:00 a.m. and 2:00 p.m., and 1/25/2023 at 6:00 a.m. and 10:00 p.m. Review of the clinical record failed to evidence RP notification for the refusals, missed medications and changes in status/treatment for R6 as documented above. On 2/7/2023 at 4:01 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that they were supposed to call the responsible party when medications were not administered as ordered or when they were refused. LPN #8 stated that the notification would be documented in the nurses notes. LPN #8 stated that they would not normally call the RP for an IV infiltration they would only notify the physician. LPN #8 stated that they would not normally call the RP for an IV order or an IV antibiotic but they would call for R6 because their family was very involved and wanted to be notified. LPN #8 stated that R6 had refused to let them start the IV antibiotic and would not let them touch the IV so they had documented it as refused. LPN #8 stated that they had not notified the family at the time. On 2/8/2023 at 8:17 a.m., an interview was conducted with LPN #2. LPN #2 stated that it was the expectation for the RP to be notified prior to any new order or treatment being started and there should be documentation to support it. LPN #2 stated that R6 had very small veins and they had multiple problems getting and maintaining an IV due to the location of the IV and R6 picking at them. LPN #2 stated that they had kept reinforcing the dressing at the site but several IV's had infiltrated and had to be removed. LPN #2 stated that R6 often refused their medications	F 580		

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F 580	Continued From page 34 and the family was able to get them to take them at times. LPN #2 stated that the nurses should notify the RP any time there was a change in orders, a new order or a order discontinued. LPN #2 stated that the nurses should be documenting the RP notification in the medical record. On 2/8/2023 at 9:20 a.m., an interview was conducted with LPN #1. LPN #1 stated that they notified the RP at the time of new orders or new treatments. LPN #1 stated that any new medications, antibiotics or IV fluids would constitute a call to the RP. LPN #1 stated that when residents refuse treatment or medications they also notified the RP. The facility policy "Documentation and Notification" dated 11/01/19 documented in part, "...The Charge Nurse is responsible for notifying the Physician (MD) and/or the Responsible Party (RP) whenever there is a change related to the care of the patient. Notification will occur when there is a: change in the patient ' s condition; change in the medication regimen; room change...Whenever there is a notification of the MD/RP, the Charge Nurse will include this information in the Shift Report and document the notification on the appropriate forms. The Unit Manager is ultimately responsible to ensure that notification of the MD/RP has occurred and has been documented accurately. The Unit Manager will review the Shift Report daily to ensure that appropriate notification has occurred..." On 2/8/2023 at approximately 11:30 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional director of clinical services were made aware of the concern.	F 580		

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F 580	Continued From page 35	F 580		
	No further information was provided prior to exit.			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.	F 583		3/21/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide personal privacy for two of 58 residents in the survey sample, Residents #128 and #98 The findings include: 1. For Resident #128 (R128), the facility failed to cover exposed body parts visible from the hallway on 2/6/23. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/22/23, R128 was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). The resident was coded as requiring the extensive assistance of staff for personal hygiene, grooming, and dressing. On 2/6/23 from 8:16 a.m. until 9:40 a.m., R128 was dressed in a hospital gown, and sitting on the side of the bed facing away from the door. The resident's hospital gown was tied at the neck, and open from the neck down to the resident's buttocks. The resident's back was exposed to the view of anyone who looked into the room from the hallway. At least six different staff members passed by the resident's door while they were passing out meal trays during this time. On 2/6/23 at 2:56 p.m., LPN (licensed practical nurse) #11 was interviewed. When asked what she would do if she observed a resident's back	F 583	F583 Personal Privacy/Confidentiality of Records □ 1-Residents # 128 no longer resides in the facility. Resident #98 has a privacy curtain in place. 2-All residents have the potential to be affected. All resident rooms will be inspected by the Housekeeping Director, or designee to ensure a privacy curtain in place. The Interdisciplinary Team will audit all residents during room rounds to ensure that resident dignity is provided. 3-The ADON, or designee will educate all licensed nurses and CNAs on the Right of residents to have personal privacy during care and/or when not dressed appropriately. The Housekeeping Director, or designee will educate housekeeping staff on the requirements of having privacy curtains in place for each resident. 4-The Unit Manager, or designee will complete observations of residents to ensure privacy and dignity is provided weekly x 8, then monthly x2. 5- The results of the audits will be discussed at the monthly QAPI meeting. The committee will determine the need for further audits and/or action. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Date of Compliance 3/21/23	

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	495391		C 02/08/2023

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F 583	Continued From page 37 and buttocks were visible from the hallway, she stated she would give the resident a blanket or piece of clothing to cover their back. She stated a resident "deserves their privacy." On 2/7/23 at 5:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. On 2/8/23 at 10:18 a.m., CNA (certified nursing assistant) #5 was interviewed. When asked what he would do if he observed a resident's back and buttocks were visible from the hallway, he stated: "I would find something and help them cover up." He stated a resident should be provided privacy, and should not be allowed to sit with any body part exposed to visitors, staff, or other residents. A review of the facility policy, "Patient Rights," revealed, in part: "The Health and Rehabilitation Center promotes the education and exercising of the legal rights of all patients...Patients are informed before and/or on admission both orally and in writing in a language he/she understands of their legal rights...Patient Rights are posted in the Center in a public location at eye level." No further information was provided prior to exit. 2. For Resident #98 (R98), the facility failed to promote privacy. R98 did not have a privacy curtain in place to separate their bed and their roommates bed. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 11/16/2022, the resident scored 15 out of 15 on the BIMS (brief	F 583		

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F 583	Continued From page 38 interview for mental status) assessment, indicating they were cognitively intact for make daily decisions. On 2/5/2023 at 4:05 p.m., an observation was made of R98's room. R98's room was observed to be semi-private with two beds in place. A resident was observed to be in bed closest to the doorway and R98 was observed lying in bed closest to the window. The area between the two beds contained a ceiling track with hooks but no curtain in place. At that time, an interview was conducted with R98. When asked about the curtain, R98 stated that the staff had taken it down about two weeks before to wash it and had never put it back up. R98 stated that there was a curtain on the other side of their roommates bed but it did not extend past the foot of the roommates bed so there was no way for the staff to use it when providing care to them. R98 stated that they would like to have a curtain in place to have privacy when they were washing up or just wanted to have it pulled. Additional observations on 2/6/2023 at 8:10 a.m. and 4:10 p.m. revealed no curtain in place between the two beds. On 2/8/2023 at 9:08 a.m., an interview was conducted with OSM (other staff member) #1, the director of housekeeping and laundry. OSM #1 stated that all privacy curtains were washed prior to new admissions coming into the room and observed daily for being soiled. OSM #1 stated that if privacy curtains were found to be soiled they were removed and washed and brought back up the same day. OSM #1 stated that there were extra privacy curtains available for use if needed. OSM #1 observed R98's room without a	F 583		

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F 583	Continued From page 39 privacy curtain between the two beds and stated that there should be a curtain in place. OSM #1 stated that they thought that maintenance had to add some hooks but would check and replace the curtain right away to maintain the residents privacy. On 2/08/2023 at 11:06 a.m., an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 stated that privacy was provided during care by pulling the privacy curtain and closing the door. CNA #3 stated that if there was no curtain in place they would try to take the resident to the bathroom for care or move the other resident out of the room during care. CNA #3 stated that they report any missing curtains to housekeeping to replace them. On 2/8/2023 at approximately 11:30 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit.	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		3/21/23

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F 584	Continued From page 40 possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that facility staff failed to maintain resident's rooms in good repair, and in a clean and sanitary manner for three of 12 resident rooms observed. The findings include:	F 584	F584 Safe/Clean/Comfortable/Homelike Environment 1- Resident rooms #211, #217, # 219 are being maintained in good repair and properly cleaned. 2-All current resident rooms have the potential to be affected. The Maintenance Director, or designee will inspect all	

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F 584	Continued From page 41 1a. For resident room #219, the facility staff failed to maintain the bathroom and the bedroom free of feces. On 02/05/2023 at approximately 2:30 p.m., and on 02/06/2023 at approximately 8:30 a.m., an observation of resident room #219's bathroom revealed loose feces in and on the toilet seat, down the front and side of the toilet bowl, on the floor trailing from the toilet to the bathroom door and extending out into the room. On 02/06/2023 at 9:04 a.m. an observation of resident room #219 revealed housekeeping staff OSM (other staff member) #2, housekeeper, standing in the doorway looking into the room and OSM #1, housekeeping manager, who was in the room, cleaning the bathroom. When asked what the dark substance was trailing from the bathroom out into the resident's room OSM #2 stated that the substance looked like feces. On 02/06/2023 at 9:10 a.m., an interview was conducted with OSM #1, director of housekeeping. When asked about the substance they were cleaning in the bathroom on the toilet seat, down the front and side of the toilet bowl, on the floor trailing from the toilet to the bathroom door and extending out into the resident's room, OSM #1 stated it was feces. When asked to describe what their department's staffing schedule should be OSM #1 stated three housekeepers on each unit from 7:00 a.m. through 3:00 p.m. every day of the week. When asked how many housekeeping staff were working in the facility Saturday 02/04/2023 and Sunday 02/05/2023 OSM #1 sated there were two housekeepers on each unit. When asked if the weekend was fully staffed OSM #1 stated no.	F 584	resident rooms to ensure the rooms are properly cleaned and in good repair. 3-The Administrator, or designee will educate housekeeping and maintenance staff on proper cleaning and maintenance of resident rooms. 4-The Administrator, or designee will complete audits of resident rooms on a weekly basis x8 and monthly x2 to ensure rooms are properly cleaned and maintained. 5- The results of the audits will be discussed at the monthly QAPI meeting. The committee will determine the need for further audits and/or action. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Date of compliance 3/21/23	

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F 584	Continued From page 42 OSM #1 stated that the housekeeping staff are required to do a 'Walk-through' at the end of their shift to check all the resident's rooms and bathrooms, pick up any trash, clean any spills. When asked if it was dignified for a resident's bathroom to be in the condition described above OSM #1 stated no and that the bathroom should have been cleaned immediately. The facility's policy "Cleaning and Disinfecting Residents' Rooms" documented in part, "Purpose: The purpose of this procedure is to provide guidelines for cleaning and disinfecting residents' rooms. General Guidelines: 1. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 2. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled." On 02/07/2023 at approximately 5:00 p.m., ASM (administrative staff member) #1, administrator, ASM # 2, interim director of nursing and ASM # 3, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. 1b. For resident room #219, the facility staff failed to replace the cove base trim and repair the dry wall across from the A-side bed, the wall at the foot of the B-side bed, and the short wall next to the bathroom door. Observations of resident room #219 on 02/05/2023 at approximately 2:30 p.m., on 02/06/2023 at 8:30 a.m., on 02/06/2023 at 11:10	F 584		

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F 584	Continued From page 43 a.m., and on 02/07/2023 at 2:10 p.m., revealed approximately three feet of the base of the wall across from the A-side bed was missing cove base (trim) and was chipped and peeling; and approximately two-and-a-half feet of the base of the wall at the foot of the B-side bed was missing cove base and was chipped and peeling; and approximately two-and-a-half feet of the base of the wall next to the bathroom door was cracked, chipped, peeling and missing cove base. On 02/08/2023 at approximately 8:30 a.m., an interview and observation of resident room #219 was conducted with OSM (other staff member) #8, regional maintenance director. When asked if they were the maintenance director for the building OSM #8 stated that they cover several nursing facilities and that they had hired a maintenance director two days ago. After observing the damage to the walls and stated above, OSM #8 stated that they [maintenance] were aware of the repair for about a month. OSM #8 further stated that they had a "Blitz team" that was made up of maintenance personnel from other nursing facilities to conduct large project repairs. When asked when resident room #219 would receive repairs to the walls OSM #8 stated that it may take a month. When asked if the conditions of resident room #219 presented a homelike environment OSM #8 stated no. On 02/08/2023 at approximately 10:30 a.m., ASM (administrative staff member) #1, administrator, was made aware of the above findings. No further information was provided prior to exit. 2. For resident rooms #211 and #217, the facility staff failed to replace and install ceiling tiles.	F 584		

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F 584	Continued From page 44 Observations of resident room #211 on 02/05/2023 at approximately 3:40 p.m., on 02/06/2023 at approximately 8:20 a.m., on 02/06/2023 at approximately 11:00 a.m.; and on 02/07/2023 at approximately 2:00 p.m., revealed 3 two-foot by two-foot ceiling tiles missing, revealing the piping, electrical wiring, and duct work. Observations of resident room #217 on 02/05/2023 at approximately 3:45 p.m., on 02/06/2023 at approximately 8:25 a.m., on 02/06/2023 at approximately 11:05 a.m., and on 02/07/2023 at approximately 2:05 p.m., revealed 9 two-foot by two-foot ceiling tiles missing, revealing the piping, electrical wiring and duct work. Further observation revealed 2 two-foot by two-foot ceiling tiles completely discolored with a rust color stain covering the tile; 2 twelve-inch by two-foot ceiling tile discolored with a rust color stain covering the tile; 2 three inch by two-foot ceiling tile discolored with a rust color stain covering the tile all indicating water damage. Another two-foot by two-foot ceiling tile was observed to be cracked in half and partially split open hanging on the ceiling track. On 02/08/2023 at approximately 8:30 a.m., an interview and observations of Resident rooms #211 and #217 was conducted with OSM #8. After observing the missing ceiling tiles OSM #8 stated that the ceiling should not be open and the tiles should have been put in place. In regard to the stained ceiling tiles OSM #8 stated that the tiles appeared to have water damage and should have been replaced. When asked if the conditions of resident room #211 and #217 presented a homelike environment OSM #8	F 584		

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F 584	Continued From page 45 stated no. On 02/08/2023 at approximately 10:30 a.m., ASM (administrative staff member) #1, administrator, was made aware of the above findings. No further information was provided prior to exit.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:	F 585		3/21/23

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F 585	Continued From page 46 (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and	F 585		

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F 585	Continued From page 47 as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and facility document review, the facility staff failed to evidence a response to a resident grievance for one of 58 residents in the survey sample, Resident #36. The findings include: For Resident #36 (R36), the facility staff failed to evidence a response to a grievance regarding missing clothes. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment	F 585	F585-Grievances Did not provide a prompt response addressing missing clothing grievance noted in the Resident Council meeting. 1- The missing clothes for Resident #36 has been addressed by the Administrator. 2-All current residents have the potential to be affected. The Administrator, or designee will review grievances from the past 30 days to ensure that all have been appropriately addressed. 3-TheThe Administrator, or designee will educate the Interdisciplinary team on the proper procedure in addressing resident	

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F 585	Continued From page 48 reference date) of 1/2/23, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately cognitively impaired for making daily decisions. A complaint/grievance report for R36 dated 11/28/22 documented, "Stated still has missing clothes from laundry. Stated does not want the facility to do clothes..." The findings of investigation section documented, "Check laundry for missing clothes with negative results. Notified admin (administrator) & staff that we won't wash clothes." The resolution section including if the grievance was resolved and if the complainant was satisfied was blank. On 2/7/23 at 9:22 a.m., an interview was conducted with R36. R36 stated the clothes are still missing. R36 stated the facility staff did not find the clothes, replace the clothes, or do anything to resolve the grievance. On 2/7/23 at 3:00 p.m., an interview was conducted with OSM (other staff member) #3, the director of social services. OSM #3 stated the social services department is ultimately responsible for grievances because their department houses the grievance forms. OSM #3 stated that generally speaking, whoever writes the grievance provides it to the correct staff person to address it and should make sure it's resolved then the social services staff looks at the grievance, puts it in a book or immediately takes it to the administrator or director of nursing if needed. On 2/7/23 at 5:02 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the	F 585	grievances and providing follow up regarding any grievances. 4- The Administrator, or designee will complete weekly audits of resident grievances weekly x 8 weeks and then monthly x 2 to ensure that resident grievances are appropriately addressed. 5- The results of the review will be discussed at the monthly QAPI meeting to determine any needed audits or action. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Date of compliance 3/21/23	

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F 585	Continued From page 49 above concern. The facility policy titled, "Grievances" documented, "The patient has the right to voice/file grievances/complaints (orally, in writing or anonymously) without fear of discrimination or reprisal. The Administrator serves as the grievance official of the Center and is responsible for overseeing the grievance process and for receiving and tracking to their conclusion."	F 585		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not 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	F 622		3/21/23

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F 622	Continued From page 50 resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (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)	F 622		

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F 622	Continued From page 51 (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide evidence of the required transfer/discharge documents upon discharge/transfer for four of 58 resident in the survey sample, Residents #46, #116, #50, and #79. The findings include: 1. For Resident #46 (R46) the facility staff failed to evidence sending any documentation to the hospital for a transfer on 12/27/2022. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 12/28/2022, the resident scored a 13 out of 15 on the BIMS (brief	F 622	F622 Failed to send transfer documents 1-Resident #46 and #116 no longer reside in the facility. Residents #50 and #79 have not had any hospital transfers. 2-All current residents have the potential to be affected. The DON, or designee will review residents transferred out to the hospital in the past 14 days to determine if the necessary transfer documents have been sent at the time of the transfer. 3-The ADON, or designee will educate all licensed nurses on transfer documents required to be completed when transferring a resident out to the hospital. 4-The Unit Manager, or designee will audit resident transfers weekly x 8 weeks, then monthly X 2 months to ensure that the necessary transfer documents are	

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F 622	Continued From page 52 interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions. The nurse's note dated, 12/27/2022 at 7:00 p.m., documented in part, "Writer called to residents room by cna (certified nursing assistant) after writer had given resident her 5pm medications upon entering room, writer observed resident with a nose bleed. Writer applied pressure and a cold compress to the residents (sic) nose. Resident denies picking her nose or hitting her face or nose on anything. Writer instructed resident to continue to apply pressure and apply cold pack. On call MD (medical doctor) notified and order given to pack nose with cotton or gauze. Upon reentering the residents (sic) room, writer observed the resident with several blood clots in a washcloth. Writer proceeded to clean the residents face and pack nose with gauze. MD notified of clots and order given to send resident to ED (emergency department) for eval (evaluation) and treatment. RP (responsible party) is aware and consenting." Further review of the clinical record failed to evidence any documentation as to what documents were sent with the resident to the emergency department on 12/27/2022. An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 2/7/2023 at 11:50 a.m. When asked what documents were sent to the hospital with a resident upon transfer, LPN #3 stated, the care plan, bed hold policy, medication list and face sheet. When asked where is this documented, LPN #3 stated on the "Transfer Out To The Hospital" form in the computer.	F 622	completed at the time of the hospital transfer. 5 The results of the audits will be discussed at the monthly QAPI meeting. The committee will determine the need for further audits and/or action. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Compliance date 3/21/23	

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F 622	Continued From page 53 Further review of the clinical record failed to evidence a "Transfer Out To The Hospital" form. The facility policy, "Patient Transfer Form" documented, "A Patient Transfer Form (eINTERACT) must be sent with the patient when transporting to a hospital or acute care setting. This process will provide a format of all pertinent information regarding the patient's medical status when the patient requires additional hospital care and treatment. PROCEDURE: 1. A physician's order is obtained and written for the patient transfer. 2. The Patient Transfer Form (eINTERACT) is completed by a licensed nurse when the patient is being transferred to the hospital for care and services. 3. Place a copy of the Patient Transfer Form (eINTERACT), copies of the current face sheet, current MAR (medication administration record), current TAR(treatment administration record), Progress Notes for 24 hour, care plan, Physician Progress notes, and DDNR (durable do not resuscitate) or POST form (as applicable) in the designated INTERACT envelope and send with the patient to the acute care center or hospital. 4. The Patient Transfer Form (eINTERACT) is part of the medical record. It is not necessary to duplicate the information contained within the Patient Transfer form (eINTERACT) into the Progress Note." ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #4. the regional director of clinical services were made aware of the above concern on 2/7/2023 at 5:20 p.m. No further information was provided prior to exit.	F 622		

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F 622	Continued From page 54 2. For Resident #116, the facility staff failed to evidence sending any documentation to the hospital for a transfer on 3/26/2022. On the most recent MDS assessment, an admission assessment, with an assessment reference date of 3/26/2022, the resident scored a 15 out of 15 indicating the resident was not cognitively impaired for making daily decisions. A nurse's note dated, 3/26/2022 at 4:27 p.m. documented, "Family of resident entered facility cursing, being aggressive and very disrespectful towards writer. Family members wanted resident medical records. Writer explained to family, medical records must be requested in writing. Resident's family called 911 to take out of facility." The nurses who documented the above notes were no longer employed at the facility and not available for interview. Review of the clinical record failed to evidence documentation of what documents were sent with the resident upon transfer to the hospital, by ambulance. An interview was conducted with RN (registered nurse) #2, on 2/7/2023 at 10:30 a.m. When asked if a family call 911 for their loved one, what documents do you provide to the EMS (emergency medical services) when they arrive, RN #2 stated, the face sheet, EMAR (electronic medication administration record), pertinent laboratory work, and notes. When asked if she sent the care plan also, RN #2 stated, not typically. When asked if there is no order to send the resident out and the family or resident calls,	F 622		

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F 622	Continued From page 55 do you send paperwork, RN #2 stated, we should provide EMS with the appropriate documents with them, it's not like they are signing out AMA (against medical advice), they still need appropriate paperwork to go with them. An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 2/7/2023 at 11:50 a.m. When asked what documents were sent to the hospital with a resident upon transfer, LPN #3 stated, the care plan, bed hold policy, medication list and face sheet. When asked where is this documented, LPN #3 stated on the "Transfer Out To The Hospital" form in the computer. When asked if this changes if a resident's family calls 911, LPN #3 stated, "No." Further review of the clinical record failed to evidence a "Transfer Out To The Hospital" form. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #4. the regional director of clinical services were made aware of the above concern on 2/7/2023 at 5:20 p.m. No further information was provided prior to exit. 3. The facility staff failed to evidence provision of required resident information to a receiving facility at the time of transfer for Resident #50. Resident #50 was transferred to the hospital on 1/16/23. Resident #50 was admitted to the facility on 10/11/17 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease), dementia and anxiety disorder.	F 622		

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F 622	Continued From page 56 The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 12/12/22, coded the resident as scoring a 01 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. There was no evidence of clinical documents sent with the resident to the hospital on 1/16/23. A review of the nursing progress note dated 1/16/23, revealed "Description of the fall/vital signs/injuries if any:: Resident observed on floor by nursing staff, laying on back, at the foot of bed, with blanket on top of her, one shoe on left foot, underwear on left side, pants on only on left side, underwear and clothing dry, denied toileting needs, unable to state what she was attempting to do, ROM (range of motion) assessed weakness present to bilateral lower extremities, neuro checks initiated, clothing placed on resident, attempted to re-orient patient to call for assistance, call bell within resident reach. Physician and RP (responsible party) made aware." A review of the nursing progress note dated 1/16/23 at 7:07 PM, revealed "Writer notes resident Xray results received, resident has a noted Acute intertrochanteric fracture with shortening, resident POA (power of attorney) made aware. On call physician contacted, wants patient sent to ER (emergency room) for further evaluation and treatment." A review of the eINTERACT (interventions to reduce acute care transfers) dated 1/16/23, revealed the "Acute Care Document Transfer	F 622		

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F 622	Continued From page 57 Checklist" as blank. A request for clinical documents sent to the facility with the resident was made on 2/7/23 at 9:15 AM. On 2/7/23 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the findings and ASM #1 stated, we do not have any evidence of the clinical documents sent for this resident. A review of the facilities "Patient Transfer Form" policy revealed, "Place a copy of the Patient Transfer Form (eINTERACT), copies of the current face sheet, current MAR (medication administration record), current TAR (treatment administration record), Progress Notes for 24 hour, care plan, Physician Progress notes, and DDNR (durable do not resuscitate) or POST (physician orders for scope of treatment) form (as applicable) in the designated INTERACT envelope and send with the patient to the acute care center or hospital." No further information was provided prior to exit. 4. For Resident #79, the facility staff failed to evidence that all required documentation was provided to the receiving facility upon a hospital transfer on 11/27/22. A review of the clinical record was conducted for Resident #79. Resident #79 was transferred to the emergency room on 11/27/22 for further evaluation of a gastrostomy tube blockage or displacement.	F 622		

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F 622	Continued From page 58 Further review revealed two different transfer forms that were completed. One was called "SNF/NF (skilled nursing facility / nursing facility) Hospital Transfer Form" and one called "eInteract Transfer Form V5." Both forms contained basic demographic information, reason for the transfer, contact information, and general status / basic medical information. Neither form evidenced that a medication list or care plan goals were sent with the resident. The "SNF/NF Hospital Transfer Form" included a page called "Acute Care Transfer Document Checklist." This page listed several items that were to be sent with the resident to the hospital and documented at the top "Copies of Documents Sent with Resident/Patient (check all that apply)" none of which were checked off as being sent. One item, the "Current Medication List" was not information that was contained anywhere else on the transfer form, and therefore, was not evidenced as being provided to the hospital since it was not checked off. The list did not include a requirement to send the comprehensive care plan goals and there was no other evidence that the care plan goals were sent. In addition to the above forms, a review of the nurse's notes failed to reveal any evidence of any documents being sent to the hospital, as none were listed / identified in a nurse's note. On 2/7/23 at 9:30 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 2/7/23 at 11:50 AM, an interview was	F 622		

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F 622	Continued From page 59 conducted with LPN #3 (Licensed Practical Nurse). When asked what documents are sent with the resident when transferred to the hospital. She stated that they send the care plan, bed hold policy, med list and face sheet. On 2/7/23 at 1:40 PM, in a follow up interview with LPN #3 she stated that the documentation for what items are sent to the hospital is documented on the transfer out to hospital summary. A review of the facility policy "Patient Transfer Form" that was provided documented, "3. Place a copy of the Patient Transfer Form (eINTERACT), copies of the current face sheet, current MAR, current TAR, Progress Notes for 24 hour, care plan, Physician Progress notes, and DDNR or POST form (as applicable) in the designated INTERACT envelope and send with the patient to the acute care center or hospital..." On 2/7/23 at 5:00 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator ASM #2 the interim Director of Nursing, and ASM #3 the Regional Director of Clinical Services, were made aware of the findings. No further information was provided by the end of the survey.	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. 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	F 623		3/21/23

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F 623	Continued From page 60 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. §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;	F 623		

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	495391		C 02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBURNIE REHAB & NURSING CENTER	1901 LIBBIE AVE RICHMOND, VA 23226

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F 623	Continued From page 61 (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 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	F 623		

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F 623	Continued From page 62 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, facility document review, and clinical record review, it was determined the facility staff failed to give written notification to the resident and/or responsible party and failed to notify the Office of the State Long-Term Care Ombudsman upon transfer from the facility for four of 58 residents in the survey sample, Residents #46, #116, #50 and #79. The findings include: 1. For Resident #46 (R46) the facility staff failed to evidence where the resident and/or responsible party was given a written notification for the reason the resident was being transferred to the hospital and failed to notify the ombudsman of the transfer to the hospital that occurred on 12/27/2022. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 12/28/2022, the resident scored a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions. The nurse's note dated 12/27/2022 at 7:00 p.m.,	F 623	F623 Notice Requirements before transfer/discharge 1-Resident #46 and #116 no longer reside in the facility. Residents #50 and #79 have not had any hospital transfers. 2-All current residents have the potential to be affected. The Social Services Director will audit residents transferred or discharged in the past 30 days to ensure the RP and Ombudsman received notification of the transfer. 3-The Administrator, or designee will educate Social Services staff on the requirements to provide written notification to the RP and Ombudsman for resident transfers. 4-The Social Services Director, or designee will audit resident transfers weekly x 8, then monthly x 2 to ensure that written notification provided to the RP and Ombudsman. 5-The results of the review will be discussed at the monthly QAPI meeting to determine further audits or action is needed. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6- Date of compliance 3/21/23	

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F 623	Continued From page 63 documented in part, "Writer called to residents (sic) room by cna (certified nursing assistant) after writer had given resident her 5pm medications upon entering room, writer observed resident with a nose bleed. Writer applied pressure and a cold compress to the residents (sic) nose. Resident denies picking her nose or hitting her face or nose on anything. Writer instructed resident to continue to apply pressure and apply cold pack. On call MD (medical doctor) notified and order given to pack nose with cotton or gauze. Upon reentering the residents (sic) room, writer observed the resident with several blood clots in a washcloth. Writer proceeded to clean the residents face and pack nose with gauze. MD notified of clots and order given to send resident to ED (emergency department) for eval (evaluation) and treatment. RP (responsible party) is aware and consenting." Further review of the clinical record failed to evidence any documentation of a written notice provided to the resident and/or responsible party or notification of the ombudsman of the transfer. An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 2/7/2023 at 11:50 a.m. When asked if the resident and/or responsible party are given a written notification of the reason why the resident is being transferred to the hospital, LPN #3 stated, no, they call the family and let them know of the change in condition as to why they are being sent out. There is nothing written, typed, or printed out that we would give to the resident and/or responsible party. When asked where the notification to the responsible party is documented, LPN #3 stated in the, "Transfer Out to the Hospital" form in the computer.	F 623		

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F 623	Continued From page 64 An interview was conducted with OSM (other staff member) #3, the director of social services, on 2/7/2023 at 3:00 p.m. When asked if she is responsible for sending the ombudsman notifications, OSM #3 stated, yes. OSM #3 was asked if there was a notification to the ombudsman for the transfer of R46 on 12/27/2022. OSM #3 stated, "No, there was no notification. If a resident goes to the ER (emergency room) and comes back, I don't report it. It wasn't an actual discharge from the facility so I didn't report it to the ombudsman." The facility policy, "Notice of Transfer/Discharge" documented in part, "Provide proper advance written notification of the transfer/discharge to the patient and family member/legal representative utilizing the (initials of corporation) Notice of Transfer/Discharge form...Provide designated copies of the completed (initials of corporation) Notice of Transfer/Discharge form to each of those specified on the form, which includes the Ombudsman." ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #4. the regional director of clinical services were made aware of the above concern on 2/7/2023 at 5:20 p.m. No further information was provided prior to exit. 2. For Resident #116 (R116), the facility staff failed to evidence that the resident and/or responsible party was given a written notification for the reason the resident was being transferred to the hospital, and failed to notify the ombudsman of the transfer to the hospital that	F 623		

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F 623	Continued From page 65 occurred on 3/26/2022. On the most recent MDS assessment, an admission assessment, with an assessment reference date of 3/26/2022, the resident scored a 15 out of 15 indicating the resident was not cognitively impaired for making daily decisions. A nurse's note dated, 3/26/2022 at 4:27 p.m. documented, "Family of resident entered facility cursing, being aggressive and very disrespectful towards writer. Family members wanted resident medical records. Writer explained to family, medical records must be requested in writing. Resident's family called 911 to take out of facility." Further review of the clinical record failed to evidence any documentation of a written notice provided to the resident and/or responsible party or notification of the ombudsman of the transfer. An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 2/7/2023 at 11:50 a.m. When asked if the resident and/or responsible party are given a written notification of the reason why the resident is being transferred to the hospital, LPN #3 stated, no, they call the family and let them know of the change in condition as to why they are being sent out. There is nothing written, typed, or printed out that we would give to the resident and/or responsible party. When asked where the notification to the responsible party is documented, LPN #3 stated in the "Transfer Out to the Hospital" form in the computer. An interview was conducted with OSM (other staff member) #3, the director of social services, on 2/7/2023 at 3:00 p.m. When asked if she is	F 623		

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F 623	Continued From page 66 responsible for sending the ombudsman notifications, OSM #3 stated, yes. OSM #3 was asked if there was a notification to the ombudsman for the transfer of R116 on 3/26/2022. OSM #3 stated, "No, there was no notification. At that time, the assistant that I had, did not include her in the report sent to the ombudsman. That was an error, they should have been reported to the ombudsman." ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #4. the regional director of clinical services were made aware of the above concern on 2/7/2023 at 5:20 p.m. No further information was provided prior to exit. 3. The facility staff failed to evidence provision of required written RP (responsible party) notification at the time of discharge for Resident #50. Resident #50 was transferred to the hospital on 1/16/23. The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 12/12/22, coded the resident as scoring a 01 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. There was no evidence of written RP notification when the resident was sent to the hospital on 1/16/23. A review of the nursing progress note dated 1/16/23 at 7:07 PM, revealed "Writer notes resident Xray results received, resident has a noted Acute intertrochanteric fracture with	F 623		

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F 623	Continued From page 67 shortening, resident POA (power of attorney) made aware. On call physician contacted, wants patient sent to ER (emergency room) for further evaluation and treatment." A request for evidence of written RP notification was made on 2/7/23 at 9:15 AM. An interview was conducted on 2/7/23 at 3:00 PM, with OSM (other staff member) #3, the director of social services, who stated, there is nothing sent in writing to the RP, we would need to check with the DON (director of nursing) to see if nursing does. On 2/7/23 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the finding and ASM #2 stated, nursing does not send written RP notification. A review of the facilities "Notice of Transfer Discharge" policy revealed, "Provide proper advance written notification of the transfer/discharge to the patient and family member/legal representative utilizing the Notice of Transfer/Discharge form. Under federal and state law: i. If a transfer/discharge is voluntary a discharge can be coordinated as soon as practicable. ii. If a transfer/discharge is involuntary and for the following reasons, notification shall be made as soon as reasonably possible: 1) The patient's welfare and needs cannot be met in the Center; 2) The patient's health has improved, and they no longer require the services provided by the Center; 3) The safety of individuals in the Center is	F 623		

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F 623	Continued From page 68 endangered; 4) The health of individuals in the Center would be endangered; or 5) The patient has not resided in the Center for thirty (30) days." No further information was provided prior to exit. 4. For Resident #79, the facility staff failed to evidence that a written notice of a hospital transfer was provided to the resident representative upon transfers on 11/27/22 and 12/6/22. A review of the clinical record was conducted for Resident #79. Resident #79 was transferred to the emergency room on 11/27/22 and again on 12/6/22 for further evaluation of a gastrostomy tube blockage or displacement. Further review of the clinical record failed to reveal any evidence that a written notification for these hospital transfers was provided to the resident's legal representative. On 2/7/23 at 9:30 AM an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing. She stated that there wasn't any written notice to the resident representative, that the facility had not been doing that. On 2/7/2023 at 11:50 AM, an interview was conducted with LPN #3 (Licensed Practical Nurse). When asked if a written notification is given to the resident and/or resident representative, she stated that they call the family and let them know the change of condition and why the resident is being sent out. She stated there is nothing written, typed or printed out that	F 623		

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F 623	Continued From page 69 would be given to resident or resident representative. On 2/7/23 at 2:34 PM an interview was conducted with OSM #3 (Other Staff Member) the Director of Social Services. When asked if she sends written notice to the resident representative of hospital transfers, she stated that she does not. A review of the facility policy "Patient Transfer Form" that was provided did not address the requirements of written notification to the resident representative. On 2/7/23 at 5:00 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator ASM #2 the interim Director of Nursing, and ASM #3 the Regional Director of Clinical Services, were made aware of the findings. No further information was provided by the end of the survey.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 625		3/21/23

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F 625	Continued From page 70 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence that bed hold notification was provided when one out of 58 residents in the survey sample was transferred to the hospital; Residents #50. The findings include: The facility staff failed to evidence provision of bed hold notification at the time of discharge for Resident #50. Resident #50 was transferred to the hospital on 1/16/23. Resident #50 was admitted to the facility on 10/11/17 with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), dementia and anxiety disorder. The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 12/12/22, coded the resident as scoring a 01 out of 15 on the	F 625	F625 Notice of Bed hold policy before/upon transfer 1-Resident #50 has not been transferred to the hospital. 2-All current residents have the potential to be affected. The DON, or designee will audit resident transfers to the hospital in the past 14 days to ensure that the bed hold notice was provided at the time of transfer. 3-The DON, or designee will educate all licensed nurses on the process for transferring/discharging residents with bed hold policy and provided evidence that this was done. 4-The Unit Manager, or designee will conduct weekly audits x 8 weeks, then monthly x2 to verify residents with hospital transfers were provided the bed hold notice at the time of the transfer. 5-The results of the review will be discussed at the monthly QAPI meeting to determine the need for continued audits	

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F 625	Continued From page 71 BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. There was no evidence of a bed hold sent with the resident to the hospital on 1/16/23. A review of the nursing progress note dated 1/16/23 at 7:07 PM, revealed "Writer notes resident Xray results received, resident has a noted Acute intertrochanteric fracture with shortening, resident POA (power of attorney) made aware. On call physician contacted, wants patient sent to ER (emergency room) for further evaluation and treatment." An interview was conducted on 2/7/23 at 3:00 PM, with OSM (other staff member) #3, the director of social services, who stated, there is no bed hold for this resident. On 2/7/23 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the findings. A review of the facility's "Bed Reserve" policy revealed, "Hospitalization/Observation - Medicare and Medicaid programs do not pay to hold beds in the facility when a patient is hospitalized overnight. Consequently, whenever any patient (regardless of payor source) is transferred from the facility and is admitted for overnight hospitalization/observation (defined as being absent from the facility for more than 24 hours), the patient and or the responsible representative (or hospital) must pay to hold the bed if the patient wishes to ensure that he/she can return to the bed he/she has been occupying. If the patient	F 625	or action. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6- Date of compliance 3/21/23	

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F 625	Continued From page 72 or his/her representative does not elect to hold the bed, he/she will be readmitted to the next available bed in the facility following the patient's discharge from the hospital and the facility can safely and adequately provide appropriate medical, nursing and support services. To make this arrangement the patient and/or responsible representative must (1) promptly complete and sign a formal "Voluntary Bed Retention Agreement" and (2) provide private payment to the facility for the requested days. This arrangement can be made at the time of transfer, or by the close of the business day on which the hospitalization occurs, but no later than 10:00 a.m. on the day following the hospitalization." No further information was provided prior to exit.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication.	F 636		3/21/23

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F 636	Continued From page 73 (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)	F 636		

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F 636	Continued From page 74 (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete an admission MDS (minimum data set) assessment within the required time frame for one of 58 residents in the survey sample, Resident #112. The findings include: For Resident #112 (R112), the facility staff failed to complete an admission MDS assessment. R112 was admitted to the facility on 1/12/23. A review of R112's clinical record revealed an admission MDS assessment was not complete. On 2/7/23 at 3:11 p.m., an interview was conducted with LPN (licensed practical nurse) #5 (a MDS coordinator). LPN #5 reviewed R112's clinical record. LPN #5 stated R112 was admitted on 1/12/23 so the admission MDS assessment should have been completed by the 14th day after admission. LPN #5 stated it looked like the assessment was partially completed but there were sections that were outstanding. LPN #5 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when completing MDS assessments. The CMS RAI manual documented an admission MDS assessment should be completed no later than the 14th calendar day of the resident's admission. On 2/7/23 at 5:02 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the	F 636	F636 Comprehensive Assessment & timing 1-The Admission MDS assessment for Resident # 112 was completed. 2-All current residents have the potential to be affected. Residents admitted in the past 30 days will have their clinical record audited by the MDSC, or designee to verify their admission MDS was completed. 3-The Regional Director of Reimbursement, or designee will educate the MDSC staff on the requirements for completing admission MDS assessments. 4-The MDS staff or designee will conduct weekly audits x 8 weeks, then monthly x2 to verify new resident admissions have an Admission MDS assessment completed. 5-The results of the review will be discussed at the monthly QAPI meeting for needed continued audits or action. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Date of compliance 3/21/23	

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F 636	Continued From page 75 director of nursing) were made aware of the above concern.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to complete an accurate MDS (minimum data set) assessment for two out of 58 residents in the survey sample, Residents #48 and #51. The findings include: 1. The facility staff failed to complete an accurate MDS (minimum data set) annual assessment for Resident #48. Resident #48 was admitted to the facility on 4/13/20 with diagnoses that included but were not limited to: diabetes mellitus, atrial fibrillation and depression. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/6/22, 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.. A review of the annual MDS dated 2/8/22, coded Section J-Health Conditions "Tobacco Use-No".	F 641	F641 Accuracy of Assessments. 1-The MDS assessment for Resident #48 was corrected for tobacco usage. Resident # 51 was corrected to exclude Hospice. 2-All current residents that utilize tobacco products have the potential to be affected. All residents have the potential to be affected. The MDSC, or designee will audit residents utilizing tobacco to ensure that this is reflected accurately on the MDS assessment. 3-The Regional Director of Reimbursement, or designee will educate all MDSC staff on accurately coding usage of Tobacco on the MDS assessment 4-The MDS staff or designee will audit residents with Tobacco usage to ensure this is coded correctly on the MDS assessment on a weekly basis x 8 weeks, then monthly x2. 5-The results of the audits will be discussed at the monthly QAPI meeting. The committee will determine the need for further audits and/or action. The Administrator or Director of Nursing are responsible for implementation of the	3/21/23

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F 641	Continued From page 76 A review of the comprehensive care plan dated 5/17/22 and revised 1/2/23, revealed, "FOCUS: Resident chooses to smoke -will smoke off facility grounds. Understands smokefree facility, declines smoking cessation and independent smoker. The resident prefers to smoke..." On 2/6/23 at 2:50 PM, Resident #48 was observed smoking on the far side of the white fence at the corner of the entrance to the facility parking lot and the road leading into the shopping center. When asked how often he comes out to smoke, Resident #48 stated three to four times per day. An interview was conducted on 2/8/23 at 8:30 AM, with LPN (licensed practical nurse) #5, the MDS Coordinator. When asked to review the 2/8/22 annual MDS Section J, tobacco use; LPN #5 stated, "The MDS was coded incorrectly. That is an error. I will correct that. He is a smoker." When asked what reference she uses to complete the MDS, LPN #5 stated, the RAI (resident assessment instrument) is the reference. On 2/7/23 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the findings. No further information was provided prior to exit. 2. For Resident #51 (R51), the facility staff inaccurately coded the quarterly MDS (minimum data set) assessment for hospice care. (R51) was admitted to the facility with diagnoses that included but were not limited to: debility (1).	F 641	plan of correction. 6-Date of Compliance 3/21/23	

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F 641	Continued From page 77 On the most recent MDS, a quarterly assessment with an ARD (assessment reference date) of 12/11/2022, (R51) scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded (R51) for "Hospice care." The physician's orders for (R51) dated documented in part: "(Name of Hospice) related to protein calorie malnutrition. Status: Discontinue. End Date: 5/27/2022." "Order Date: 11/9/2022. Comfort care. No weights, No vitals, No labs, No diagnostic tests, No hospitalization." Review of the (R51's) comprehensive care plan with a revision date of 01/05/2023 documented in part, "Focus. Hospice d/c'd (discontinued) 5/27 w/ (with) transition to LTC (long term care) d/t (do to) stability on Comfort Care measures per orders." On 02/08/23 at approximately 8:40 a.m., an interview was conducted with LPN (licensed practical nurse) #5, MDS coordinator regarding the coding of hospice care for (R51) on the quarterly MDS assessment with the ARD of 12/11/2022. LPN #5 stated that there was an error in the coding for hospice care. When asked to describe the procedure for completing the MDS LPN #5 stated that they follow the RAI (resident assessment instrument) manual. On 02/08/2023 at approximately 10:30 a.m., ASM (administrative staff member) #1, administrator, was made aware of the above findings.	F 641		

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F 641	Continued From page 78 No further information was provided prior to exit. References: (1) Lack of strength. Debility is due to loss of muscle bulk and reduction in the efficiency of the heart and respiratory system from disease or disuse. This information was obtained from the website: Debilities | definition of debilities by Medical dictionary (thefreedictionary.com).	F 641		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655		3/21/23

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F 655	Continued From page 79 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to develop and/or implement the baseline care plan for four of 58 residents in the survey sample, Residents #117, #114, #112 and #365. The findings include: 1. For Resident #117 (R117), the facility staff failed to develop a baseline care plan to address the resident's activities of daily living and the care for a colostomy. On the most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 1/29/2022, the resident scored a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for	F 655	F655 Baseline care plan 1-Residents #117, #114, #112 and #365 were discharged from the facility. 2-All current residents have the potential to be affected. All admissions in the last 30 days will be audited to ensure Baseline Care Plans are in place for each resident, to include provisions for ADL care, PICC line, Colostomy care and Insulin. 3-The ADON, or designee will educate all licensed nurses on the process for completion of a baseline care plan assessment. 4-The DON, or designee will conduct weekly audits x 8 weeks and then monthly x 2 to verify new admitted residents have base line care plans to include provisions for PICC line, colostomy care, Insulin and ADL care as applicable. 5-Results of the audits will be presented	

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F 655	Continued From page 80 making daily decisions. In Section G - Functional Status, R117 was coded as requiring extensive assistance of one staff member for most of their ADLs (activities of daily living) except eating in which they only required supervision after set up assistance provided. In Section H - Bladder and Bowel, the resident was coded as having a colostomy. The baseline care plan dated, 1/28/2022, documented a focused care area of nutrition. There were no other care areas addressed on the care plan. An interview was conducted with LPN (licensed practical nurse) #1, on 2/8/2023 at 9:18 a.m. When asked who develops the baseline care plan, LPN #1 stated the nurses on the floor start it with the admission. It starts on the day the resident is admitted. When asked what areas should be addressed on the baseline care plan, LPN #1 stated, fall risk, mobility, constipation, and pain. When asked should the care plan address ADL status and colostomy care, LPN #1 stated, "I would think so." When asked where the baseline care plan is (on paper or in the computer), LPN #1 stated it was in the computer, when the resident is admitted, on the admission assessment, and it brings an area over onto the care plan. The care plan for R117 was reviewed with LPN #1. When asked if she saw any reference to the resident's ADL status or having a colostomy, LPN #1 stated, no. The facility policy, "Care Planning" documented in part, "POLICY: A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective,	F 655	to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

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F 655	Continued From page 81 person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient. PROCEDURE: 1. The computerized baseline Care Plan is initiated and activated within 48 hours. 2. The Center will provide the patient and representative(s) with a summary of the baseline care plan that includes but is not limited to: The initial goals of the patient. A summary of the patient's medications list. The patient's dietary instructions. Any services and treatments to be administered by the Center and personnel acting on behalf of the Center. Any updated information based on the details of the comprehensive care plan." ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #4. the regional director of clinical services were made aware of the above concern on 2/7/2023 at 5:20 p.m. No further information was provided prior to exit. 2. For Resident #114 (R114), the facility staff failed to implement the resident's baseline care plan for ADL (activities of daily living) assistance. R 114 was admitted to the facility on 6/9/22. R114's baseline care plan dated 6/21/22 documented, "ADL Self care deficit related to physical limitations. Assist with daily hygiene, grooming, dressing, oral care and eating as needed..." A review of R114's ADL (activities of daily living) records for June 2022 revealed a blank space for personal hygiene (combing hair, brushing teeth, shaving, washing/drying face and hands) for the	F 655		

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F 655	Continued From page 82 evening shift on 6/24/22. On 2/7/23 at 11:06 a.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated the CNAs document ADL care in the computer system and then on flowsheets if the computer system is not available. CNA #1 stated blank spaces on the ADL records means they haven't been documented on. They say if it wasn't documented, it wasn't done. "I'm not saying it wasn't done but there is nothing to justify or evidence it's been done. They can't physically see that you took care of that client that particular day or shift." On 2/7/23 at 12:00 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the purpose of the care plan is, "so we can let people know what the plan of care is." LPN #3 stated there are people taking care of residents and the care plan should be followed. On 2/7/23 at 5:02 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. 3. For Resident #112 (R112), the facility staff failed to implement the resident's baseline care plan for PICC line (1) medication administration. R112 was admitted to the facility on 1/12/23. R112's baseline care plan created on 1/12/23 documented, "The resident has a PICC Line venous access. Administer medications as ordered..." A review of R112's clinical record revealed a physician's order dated 1/12/23 for ceftriaxone	F 655		

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F 655	Continued From page 83 sodium (2) solution reconstituted 2 grams intravenously every 24 hours for infection for 25 Days. A review of R112's January 2023 MAR (medication administration record) failed to reveal evidence that ceftriaxone sodium was administered to the resident on 1/26/23. A nurse's note dated 1/26/23 documented, "On order." Further review of R112's clinical record, including progress notes and the January 2023 MAR, failed to reveal the scheduled dose was given. On 2/7/23 at 12:00 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the purpose of the care plan is, "so we can let people know what the plan of care is." LPN #3 stated there are people taking care of residents and the care plan should be followed. On 2/7/23 at 5:02 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. References: (1) "A peripherally inserted central catheter (PICC) is a long, thin tube that goes into your body through a vein in your upper arm. The end of this catheter goes into a large vein near your heart." The PICC helps carry nutrients and medicines into your body..." This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000461.htm (2) Ceftriaxone sodium is used to treat infection. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a685032.html 4. For Resident #365 (R365), the facility staff	F 655		

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F 655	Continued From page 84 failed to develop a baseline care plan for the resident's PICC line (1) and insulin. R365 was admitted to the facility on 1/31/23. A review of R365's physician orders revealed the following: "PICC line - flush with 10ml (milliliters) NS (normal saline), then 5ml 10 units/ml heparin (non-valved)." This order was dated 2/2/23. "NovoLOG Injection Solution (Insulin Aspart) Inject 4 units subcutaneously three times a day for DM (diabetes mellitus)." This order was dated 2/3/23. A review of R365's baseline care plan revealed no information related to the PICC line or to the resident's receiving insulin. On 2/7/23 at 5:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. On 2/8/23 at 8:18 a.m., LPN (licensed practical nurse) was interviewed. When asked about the development of the baseline care plan, she stated the admitting nurse is responsible for initiating it, and the MDS (minimum data set) nurse also participates in developing it. She stated a PICC line and insulin should definitely be a part of the resident's baseline care plan. She stated: "They are major parts of a resident's care." No further information was provided prior to exit. (1) "A device used to draw blood and give treatments, including intravenous fluids, drugs, or	F 655		

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F 655	Continued From page 85 blood transfusions. A thin, flexible tube is inserted into a vein in the upper arm and guided (threaded) into a large vein above the right side of the heart called the superior vena cava. A needle is inserted into a port outside the body to draw blood or give fluids. A PICC may stay in place for weeks or months and helps avoid the need for repeated needle sticks. Also called peripherally inserted central catheter." This information is taken from the website https://www.cancer.gov/publications/dictionaries/cancer-terms/def/picc.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		3/21/23

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F 656	Continued From page 86 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and/or responsible party interviews, staff interview, clinical record review, and facility document review it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for three of 58 residents in the survey sample, Resident #6, #93, and #113. The findings include: 1. For Resident #6 (R6), the facility staff failed to implement the comprehensive care plan to provide incontinence care. On the most recent MDS (minimum data set), an	F 656	F656 Develop/Implement Comprehensive Care plan 1-□ Residents # #6 and #113 were discharged. Resident #93 is receiving proper Incontinence care. 2-All current residents have the potential to be affected. The DON, or designee will conduct an audit of current residents to ensure the residents are receiving proper incontinence care and ensuring wound dressings are in place. 3-The DON, or designee will educate all licensed nurses and CNA□s on following the plan of care in providing proper Incontinence care and addressing any wounds that do not have dressings in	

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F 656	Continued From page 87 admission assessment with an ARD (assessment reference date) of 11/11/2022, the resident scored 1 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section G documented R6 requiring extensive assistance from one person for toileting. On 2/5/2023 at 4:38 p.m., an interview was conducted with R6's responsible party (RP). R6's RP voiced concerns regarding the resident being left soiled for extended periods of time and often being found wet when they arrived to visit. R6's RP stated that when they found R6 soiled they would ring the call light and the staff would not answer so they would have to go out to find someone to come in to clean up R6. The comprehensive care plan for R6 documented in part, "The resident is frequently incontinent of bladder and bowels and is not a candidate for a toileting program due to: dementia. Created on: 11/04/2022. Revision on: 11/30/2022." Under "Interventions" it documented in part, "...Check and change briefs frequently as needed. Created on: 11/04/2022. Provide toileting hygiene with brief changes. Created on: 11/30/2022..." Review of the "ADL (activities of daily living)-Toilet Use" documentation for 1/1/2023- 1/31/2023 and 2/1/2023-2/28/2023 failed to evidence incontinence care provided to R6 on the following dates: On day shift on 1/1/2023, 1/2/2023, 1/3/2023, 1/7/2023, 1/8/2023, 1/9/2023, 1/29/2023, 1/30/2023, 2/4/2023 and 2/5/2023. On evening shift on 1/1/2023, 1/2/2023, 1/6/2023, 1/8/2023, 1/9/2023, 1/20/2023, 1/12/2023,	F 656	place. 4-The DON or designee will conduct weekly audits x 8 weeks and then monthly x2 to verify that residents are receiving proper incontinence care and that wounds have dressings in place. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

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F 656	Continued From page 88 1/18/2023, 1/20/2023, 1/22/2023, 1/26/2023, 1/27/2023, 1/29/2023, 1/31/2023 and 2/5/2023. On night shift on 1/6/2023, 1/7/2023, 1/8/2023, 1/10/2023, 1/13/2023, 1/15/2023, 1/20/2023, 1/22/2023, 1/28/2023, 1/29/2023, 1/31/2023, 2/1/2023, 2/2/2023, 2/3/2023, 2/4/2023 and 2/5/2023. On 2/7/2023 at 11:06 a.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated the CNAs document ADL care in the computer system and then on flowsheets if the computer system is not available. CNA #1 stated blank spaces on the ADL records meant that the resident had not been documented on and that it was said that if it was not documented, it was not done. CNA #1 stated that they could not say that it was not done but there was nothing to justify or evidence that it was being done because they could not physically see that the care was being done on that particular day or shift. On 2/8/2023 at 8:17 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the purpose of the care plan was to let the staff know what the goals were for that resident and what they were doing to meet them for the resident. LPN #2 stated that the nurses along with MDS staff were responsible for developing, reviewing and revising the care plan. The facility policy "Care Planning" dated 11/01/19 documented in part, "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or	F 656		

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F 656	Continued From page 89 maintain the highest practical physical, mental, and psychosocial well-being of the patient...6. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment..." On 2/8/2023 at 11:23 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit. 2. For Resident #93 (R93), the facility staff failed to implement the comprehensive care plan to (A) provide incontinence care and (B) provide treatment as ordered to a pressure ulcer. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/2023, the resident was assessed as being independent in making daily decisions. Section G documented R93 requiring extensive assistance from one staff member for toileting. Section M documented R93 having four stage 3 pressure ulcers with three of them present on admission to the facility. (A) The facility staff failed to implement the comprehensive care plan to provide timely incontinence care to R93. On 2/5/2023 at 2:58 p.m., an interview was conducted with R93 in their room. R93 stated that they were incontinent of urine and wore a brief. R93 stated that they called on their call bell when they needed incontinence care and at times	F 656		

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F 656	Continued From page 90 they had to wait an extended period of time because the staff were so busy. On 2/6/2023 at 8:26 a.m., a follow up interview was conducted with R93 in their room. R93 stated that they had used their call bell before 7:00 a.m. to request incontinence care. R93 stated as of 8:26 a.m., no one had come in to provide incontinence care or follow up with them and their brief was saturated. R93 stated that the last time they had been provided incontinence care was on the night shift around 4:00 a.m. On 2/06/2023 at 10:16 a.m., CNA (certified nursing assistant) #2 was observed providing incontinence care to R93. R93's brief was observed to be heavily saturated with a strong urine odor that was present through this observer's N95 mask. R93's pressure ulcer to the left ischium was observed to be uncovered with no dressing present to the area. On 2/06/2023 at 10:17 a.m., an interview was conducted with CNA #2. CNA #2 stated that they worked the 7:00 a.m. to 3:00 p.m. shift and was assigned to R93. CNA #2 stated that the incontinence care provided to R93 at 10:16 a.m. was the first care they had provided to them that morning. CNA #2 stated that they felt that they were able to meet the needs of the residents with the assignment they were given. The comprehensive care plan for R93 dated 10/22/2022 documented in part, "LONG TERM CARE: the resident requires assistance with ADLS (activities of daily living) related to health conditions. Created on: 10/22/2022..." Under "Interventions" it documented in part, "Assist as needed with bed mobility, incontinence care and	F 656		

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F 656	Continued From page 91 toileting, dressing, grooming and bathing. Created on: 10/22/2022..." The care plan further documented, "The resident requires assistance with toileting. Created on: 10/22/2022..." Under "Interventions" it documented in part, "...Check and change briefs frequently as needed. Created on: 10/22/2022..." On 2/6/2023 at 5:36 p.m., an interview was conducted with CNA #7. CNA #7 stated that incontinence care rounds should be made every two hours. On 2/8/2023 at 8:17 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the purpose of the care plan was to let the staff know what the goals were for that resident and what they were doing to meet them for the resident. (B) The facility staff failed to implement the care plan to provide pressure ulcer care as ordered for R93. On 2/6/2023 at 8:26 a.m., an interview was conducted with R93 in their room. R93 stated that they had requested incontinence care before 7:00 a.m. and was still waiting for staff to come to provide the care at 8:26 a.m. R93 stated that the last time they had been provided incontinence care was around 4:00 a.m. On 2/06/2023 at 10:16 a.m., CNA (certified nursing assistant) #2 was observed providing incontinence care to R93. R93's brief was observed to be heavily saturated with a strong urine odor that was present through this observer's N95 mask. R93's pressure ulcer to the left ischium was observed to be uncovered	F 656		

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F 656	Continued From page 92 with no dressing present to the area. The comprehensive care plan for R93 dated 10/22/2022 documented in part, "[R93] was admitted to this SNF (skilled nursing facility) with with 3 Stage 3 pressure ulcers, a surgical wound and other wounds. She is at risk for further alterations in her skin integrity related to impaired mobility, incontinence, diabetes and circulation problems. Created on: 09/29/2022. Revision on: 01/10/2023." Under "Interventions" it documented in part, "...Keep skin clean and dry as possible. Created on: 09/29/2022...Treatments to skin as ordered. Created on: 10/22/2022. Wound care consults and treatment as ordered. Created on: 10/23/2022." The physician orders for R93 documented in part, "Left ischium- cleanse with NS (normal saline) pat dry, apply collagen particles, pack with silver alginate secure with bordered gauze every evening shift. Order Date: 01/19/2023." The orders further documented, "Left ischium- cleanse with NS pat dry, apply collagen particles, pack with silver alginate secure with bordered gauze as needed. Order Date: 01/19/2023." Review of the eTAR (electronic treatment administration record) for R93 dated 12/1/2022-12/31/2022, 1/1/2023-1/31/2023 and 2/1/2023-2/28/2023 failed to evidence treatment completed to the left ischium pressure ulcer on 12/4/2022, 12/5/2022, 12/7/2022, 12/8/2022, 12/26/2022, 1/3/2023, 1/14/2023, 1/16/2023 and 1/28/2023. The dates listed were observed to be blank. On 2/06/2023 at 10:17 a.m., an interview was	F 656		

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F 656	Continued From page 93 conducted with CNA (certified nursing assistant) #2. CNA #2 stated that they worked the 7:00 a.m. to 3:00 p.m. shift and was assigned to R93. CNA #2 stated that the incontinence care provided to R93 at 10:16 a.m. was the first care they had provided to them that morning. CNA #2 stated that they felt that they were able to meet the needs of the residents with the assignment they were given. On 2/08/2023 at 8:17 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that wound care was evidenced as completed by signing off on the eTAR. LPN #2 stated that they could not evidence that the wound care was done if there were blanks on the eTAR. LPN #2 stated that if it was not documented it was not done. LPN #2 stated that the purpose of the care plan was to let the staff know what the goals were for that resident and what they were doing to meet them for the resident. On 2/8/2023 at approximately 11:30 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit. 3. For Resident #113, the facility staff failed to develop a care plan to address the care of a pressure injury. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 9/18/2022, the resident scored an 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the	F 656		

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F 656	Continued From page 94 resident was moderately impaired for making daily decisions. In Section M - Skin Conditions, the resident was coded as having a stage four pressure injury. (Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.)(1) The comprehensive care dated 9/20/2022 failed to evidence documentation related to skin related concerns or a pressure injury. The physician order dated, 9/15/2022, documented, "Dakin's (1/4 strength) Solution 0.125% (Sodium Hypochloride) Apply to right hip topically every day and evening shift for apply for wet to dry dressing on wound." The physician order dated, 9/17/2022, documented, "Wound care: clean right hip pressure ulcer stage four with wound cleanser, apply collagen, pack with silver alginate and	F 656		

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F 656	Continued From page 95 cover with ABD (abdominal) pad daily every day shift for wound care." The physician order dated, 9/21/2022, documented, "Wound care: Clean right hip pressure ulcer stage four with wound cleanser, apply collagen, pack with silver alginate and cover with ABD pad daily every day shift for wound care." The Wound Care Specialist Notes dated, 9/16/2022, documented in part, "Wound Status: Present on admission. Pressure Ulcer - Stage 4." The Wound Care Specialist Notes dated, 9/21/2022, documented in part, "Wound Status: Improving. Pressure Ulcer -Stage 4." The Wound Care Specialist Notes dated, 10/5/2022, documented in part, "Wound Status: Improving bc (because) depth is improving - Pressure Ulcer - Stage 4." An interview was conducted with RN (registered nurse) #2 on 2/7/2023 at approximately 10:30 a.m. When asked the purpose of the care plan, RN #2 stated it is to have goals set for the resident, to follow their care, to make sure they are achieving the goals. Kind of like a standard of care to meet their measurable goals. When asked if resident has pressure injury/ulcer, should that be included on the care plan, RN #2 stated, yes. An interview was conducted with LPN (licensed practical nurse) #3 on 2/7/2023 at 11:50 a.m. When asked the purpose of the care plan, LPN #3 stated, it's to let the people, medical staff, the plan of care for that resident. When asked if a resident has a pressure injury/ulcer, should that be on the care plan, LPN #3 stated, yes,	F 656		

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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 656	Continued From page 96 absolutely. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above findings on 2/7/2023 at 5:20 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		3/21/23

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F 657	Continued From page 97 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 observations, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to review and/or revise the comprehensive care plan for one of 58 residents in the survey sample, Resident #101. The findings include: For Resident #101 (R101), the facility staff failed revise the comprehensive care plan for the use of bed rails. On the most recent MDS (minimum data set) assessment, an admission assessment with an ARD (admission reference date) of 11/29/2022, the resident was assessed as being severely impaired for making daily decisions. On 2/6/2023 at 9:00 a.m., R101 was observed in their room in bed. Bilateral upper bed rails were observed to be up and in place on the bed. Additional observations were made on 2/6/2023 at 4:15 p.m. and 2/7/2023 at 8:54 a.m. of R101 in bed with bilateral upper bed rails in place. The comprehensive care plan for R101 failed to evidence documentation of the use of bed rails. The physician orders for R101 documented in	F 657	F657 Care Plan Timing and Revision 1-The care-plan for Resident #101 has been revised to include the provision for bed rails. 2-All current residents have the potential to be affected. The Unit Manager, or designee will complete an audit of current residents to ensure that the care plan reflects the use of bed rails. 3- The ADON, or designee will educate all Licensed nurses on the process for including the use of bed rails on the care plan. 4- The Unit Manager, or designee will complete weekly audits x 8 weeks, then monthly x 2 to ensure that bed rails in use for residents are reflected on the care plan. 5 Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

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F 657	Continued From page 98 part, - "B (bilateral) 1/4 bed rails to facilitate improving pt (patient) performance in bed mobility, transfers, self-care tasks, repositioning. Order Date: 01/30/2023." On 2/8/2023 at 8:17 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the purpose of the care plan was to let the nurses know what the goals were for that resident and what they were meeting for them. LPN #2 stated that the nurses along with MDS staff were responsible for reviewing and revising the care plan. LPN #2 stated that bed rails should be addressed on the care plan if they were being used. The facility policy "Care Planning" dated 11/01/19 documented in part, "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient...6. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment..." The facility policy "Device Assessment/Bed Safety" dated 11/01/19 documented in part, "A licensed nurse will complete the assessment with input from the Interdisciplinary Care Team, as applicable and entered on the Care Plan..." On 2/8/2023 at 11:23 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the	F 657		

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F 657	Continued From page 99 interim director of nursing and ASM #3, the regional director of clinical services were made aware of the concern. No further information was provided 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, facility document review and clinical record review, it was determined the facility staff failed to clarify physician orders and follow professional standards of practice for three of 58 residents in the survey sample, Residents #113, #463, and #365. The findings include: 1. For Resident #113 (R113), the facility staff failed to clarify two physician orders for the treatment of the same wound. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 9/18/2022, the resident scored an 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired for making daily decisions. In Section M - Skin Conditions, the resident was coded as having a stage four pressure injury (1).	F 658	F 658 Services provided meet professional standards of care 1- Residents #365, #463, #113 were discharged. 2-All residents have the potential to be affected. Current residents with wounds, Dialysis and Insulin orders were reviewed by the DON, or designee to verify accuracy of the orders. 3-The Staff Development Coordinator or designee will educate all licensed nurses on the process for clarifying MD orders. 4-The DON or designee will conduct weekly audits x 8 weeks, then monthly x2 to verify accuracy for residents with wound care, Insulin orders and Dialysis orders. 5 Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction.	3/21/23

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F 658	Continued From page 100 The physician order dated, 9/15/2022, documented, "Dakin's (1/4 strength) Solution 0.125% (Sodium Hypochloride) Apply to right hip topically every day and evening shift for apply for wet to dry dressing on wound." The September TAR (treatment administration record) documented the above order. The order was documented to be administered from 9/16/2022 through 9/28/2022. The physician order dated, 9/17/2022, documented, "Wound care: clean right hip pressure ulcer stage four with wound cleanser, apply collagen, pack with silver alginate and cover with ABD (abdominal) pad daily every day shift for wound care." The September TAR documented the above order. The order was documented to be administered from 9/18/2022 through 9/22/2022. The physician order dated, 9/21/2022, documented, "Wound care: Clean right hip pressure ulcer stage four with wound cleanser, apply collagen, pack with silver alginate and cover with ABD pad daily every day shift for wound care." The September TAR documented the above order. The order was documented to be administered from 9/22/2022 through 9/28/2022. An interview was conducted with RN (registered nurse) #2, on 2/7/2023 at approximately 10:30 a.m. The above TAR was reviewed with RN #2. When asked if there were two orders for the same wound, what should a nurse do, RN #2 stated she would go with the newest order. When	F 658	6-Completion date 3/21/23	

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F 658	Continued From page 101 asked if she should call the doctor or nurse practitioner to clarify the order, RN #2 stated the person inputting the new order into the computer system could have written the new order and forgot to discontinue the old order. An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 2/7/2023 at 11:50 a.m. The above TAR was reviewed with LPN #3. When asked if a resident had two orders for the same wound, what should a nurse do, LPN #3 stated, they need to call the doctor for clarification. The facility document, "Nursing Policy and Procedure Manual" documented in part, "Admission Physician's Orders must be provided for every patient at the time of admission or readmission to activate a medical plan of care. PROCEDURE: 1. Upon every patient's admission or readmission or re-entry to the Center, a licensed nurse will notify the physician requesting and/or verifying physician's orders. 2. Upon receiving admission physician's orders from the physician, the nurse will record the order to include: a. Orders - medication and treatment orders must include the five rights: Right name of patient, 1) Right name of medication. 2) Right dosage. 3) Right route. 4) Right time. 5) Include diagnosis/reason for use." The Manual failed to evidence documentation related to clarifying physician orders. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above findings on 2/7/2023 at 5:20 p.m.	F 658		

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F 658	Continued From page 102 No further information was provided prior to exit. (1) Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf 2. The facility staff failed to clarify/obtain a complete physician's order for Resident #463's dialysis treatment. Resident #463 was admitted to the facility on 1/28/23 with diagnosis that included but were not limited to: diabetes mellitus, congestive heart failure, acute respiratory distress and ESRD (end stage renal disease). The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 1/30/23,	F 658		

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F 658	Continued From page 103 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. A review of Section O-Special Procedures coded dialysis-yes. A review of the physician orders, dated 1/28/23, revealed, "Hemodialysis Diagnosis: ESRD Dialysis Days and Time: M, W, F_ Pick up time: __SPECIFY__ Dialysis Center: __SPECIFY__ Phone #: __SPECIFY__ Transport Company: __SPECIFY__ Phone #: __SPECIFY__." An interview wad conducted on 2/7/23 at 3:30 PM with LPN (licensed practical nurse) #4. When asked if this was a complete order, LPN #4 stated, no, it is not. When asked what action she would take, LPN #4 stated, call the physician and clarify the order. An interview was conducted on 2/8/23 at 8:15 AM with LPN #7. When asked to review this order, LPN #7 stated, if that was the dialysis order I received, I would have called to clarify the order of what dialysis center and the pickup time for the resident. On 2/7/23 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the findings. A review of the facility's "Physician Orders" policy dated 3/24/20 revealed, " Upon every patient's admission or readmission or re-entry to the Center, a licensed nurse will notify the physician requesting and/or verifying physician's orders.	F 658		

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F 658	Continued From page 104 Admission orders should include other orders as indicated by patient's condition with specific directions." No further information was provided prior to exit. 3. For Resident #365 (R365) the facility failed to clarify a physician order for Insulin which read to administer teaspoons rather than units. On R365's admission assessment dated 1/31/23, the resident was assessed to be cognitively intact, and oriented to person, place, time, and situation. A review of R365's physician orders revealed the following order dated 1/31/23 and discontinued 2/3/23: "NovoLOG Injection Solution (Insulin Aspart) Inject 4 tsp (teaspoons) subcutaneously three times a day for DM (diabetes mellitus)." A review of R365's January and February 2023 MARs (medication administration records) revealed this order was signed off as given on four opportunities between 1/31/23 and 2/3/23. The nurses who signed off on these administrations were not available for interview during the survey. On 2/7/23 at 5:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. On 2/8/23 at 8:18 a.m., LPN (licensed practical nurse) was interviewed. When asked to review R365's insulin order, she reviewed the order, and stated: "Well that's not right." When asked to	F 658		

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F 658	Continued From page 105 provide more details, she stated four teaspoons of insulin was a dangerous overdose. She stated obviously the resident did not receive that much insulin. She stated the nurses must have administered four units of insulin at each opportunity, instead of administering four teaspoons. She stated the order was put into the electronic medical record incorrectly. She stated the physician should have been contacted immediately to clarify the order. A review of the facility's nursing policy manual revealed, in part: "Admission Physician's Orders must be provided for every patient at the time of admission or readmission to activate a medical plan of care. PROCEDURE: 1. Upon every patient's admission or readmission or re-entry to the Center, a licensed nurse will notify the physician requesting and/or verifying physician's orders. 2. Upon receiving admission physician's orders from the physician, the nurse will record the order to include: a. Orders - medication and treatment orders must include the five rights: Right name of patient 1) Right name of medication 2) Right dosage 3) Right route 4) Right time 5) Include diagnosis/reason for use." No further information was provided prior to exit.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		3/21/23

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F 677	Continued From page 106 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and/or responsible party interview, clinical record review, staff interview, and facility document review it was determined that the facility staff failed to provide ADL (activities of daily living) care to dependent residents for five of 58 residents in the survey sample, Resident #93, #6, #114 #128, and #113. The findings include: 1. For Resident #93 (R93), the facility staff failed to provide timely incontinence care. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/2023, the resident was assessed as being independent in making daily decisions. Section G documented R93 requiring extensive assistance from one staff member for toileting. On 2/5/2023 at 2:58 p.m., an interview was conducted with R93 in their room. R93 stated that they were incontinent of urine and wore a brief. R93 stated that they called on their call bell when they needed incontinence care and at times they had to wait an extended period of time because the staff were so busy. On 2/6/2023 at 8:26 a.m., a follow up interview was conducted with R93 in their room. R93 stated that they had used their call bell before 7:00 a.m. to request incontinence care. R93 stated that a nurse had entered the room and	F 677	F677 ADL Care Provided for Dependent Residents 1-Residents #6, #128, #113 and # 114 were discharged. Resident #93 is receiving proper incontinence care. 2-All current residents have the potential to be affected. Current residents were audited by the DON, or designee to ensure that bathing, incontinence care and proper dressing is provided. 3-The ADON, or designee will educate all certified nursing aides and licensed nurses on providing incontinence care, proper dress and bathing requirements. 4- The Unit Manager, or designee will complete weekly audits x 8 weeks, then monthly x2 to ensure that incontinence care, bathing and that residents are properly dressed. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

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F 677	Continued From page 107 turned the call light off and advised them that their CNA (certified nursing assistant) had not arrived at that time and someone would be in soon to provide incontinence care. R93 stated that as of 8:26 a.m., no one had come in to provide incontinence care or follow up with them and their brief was saturated. R93 stated that the last time they had been provided incontinence care was on the night shift around 4:00 a.m. R93 stated that at times they felt helpless because they were not used to being dependent on someone to have to clean them up and were tired of hearing excuses from staff of being short-staffed and being too busy. R93 stated that they had a wound on their bottom which the staff put a dressing on every couple of days. R93 stated that the wound nurse practitioner came in weekly and told them that the wound was getting better. R93 stated that they were not sure what the schedule was for the wound care but knew that it had changed since it had improved. The following observations were made on 2/6/2023: At 8:31 a.m., a staff member was observed entering R93's room with a meal tray. The staff member exited the room at 8:32 a.m. At 8:47 a.m., a staff member was observed delivering an additional plate into R93's room. The staff member exited the room at 8:47 a.m. At 9:01 a.m., a staff member was observed entering R93's room, the staff member exited the room at 9:02 a.m. At 9:19 a.m., a staff member was observed entering R93's room, the staff member exited the room with R93's meal tray at 9:19 a.m. On 2/06/2023 at 9:26 a.m., an interview was conducted with R93. R93 stated that the staff	F 677		

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F 677	Continued From page 108 members had only come into the room to bring the trays and pick them up. R93 stated that their brief was still wet and they had not been provided any incontinence care since around 4:00 a.m. On 2/06/2023 at 9:41 a.m., two staff members were observed entering R93's room. The staff members stated that they were with therapy and were there to speak with the resident regarding therapy and were not providing any incontinence care. The staff members exited the room at 9:43 a.m. On 2/06/2023 at 9:44 a.m., the call light was observed to be on outside of R93's room. On 2/06/2023 at 9:48 a.m., a staff member was observed entering R93's room to answer the call light. The staff member was observed turning the call light off and told R93 that they were going to let their aide know that they needed a different type of brief and they needed to be cleaned up. On 2/06/2023 at 10:16 a.m., CNA #2 was observed providing incontinence care to R93. R93's brief was observed to be heavily saturated with a strong urine odor that was present through this observer's N95 mask. R93's pressure ulcer to the left ischium was observed to be uncovered with no dressing present to the area. The comprehensive care plan for R93 dated 10/22/2022 documented in part, "LONG TERM CARE: the resident requires assistance with ADLS (activities of daily living) related to health conditions. Created on: 10/22/2022..." Under "Interventions" it documented in part, "Assist as needed with bed mobility, incontinence care and toileting, dressing, grooming and bathing.	F 677		

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F 677	Continued From page 109 Created on: 10/22/2022..." The care plan further documented, "The resident requires assistance with toileting. Created on: 10/22/2022..." Under "Interventions" it documented in part, "...Check and change briefs frequently as needed. Created on: 10/22/2022..." On 2/06/2023 at 10:17 a.m., an interview was conducted with CNA #2. CNA #2 stated that they worked the 7:00 a.m. to 3:00 p.m. shift and was assigned to R93. CNA #2 stated that the incontinence care provided to R93 at 10:16 a.m. was the first care they had provided to them that morning. CNA #2 stated that they felt that they were able to meet the needs of the residents with the assignment they were given. On 2/6/2023 at 5:36 p.m., an interview was conducted with CNA #7. CNA #7 stated that incontinence care rounds should be made every two hours. On 2/7/2023 at 11:50 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that incontinence care rounds should be made every two hours. The facility provided ADL policy "Shift Responsibilities for CNA" dated 11/01/19 documented in part, "Certified Nursing Assistants (CNAs) will be given shift responsibilities/patient assignments at the beginning of each shift. Procedure: ...3. Provide pertinent patient information to the on-coming shift, such as tasks not completed, etc. 4. Perform shift responsibilities/assignments that promote quality of care; make rounds, identify and address any immediate patient needs, promptly respond to call lights and notify the licensed nurse of any	F 677		

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F 677	Continued From page 110 pertinent patient findings (reddened skin, etc.)..." On 2/7/2023 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit. 2. For Resident #6 (R6), the facility staff failed to provide incontinence care. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/11/2022, the resident scored 1 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section G documented R6 requiring extensive assistance from one person for toileting. On 2/5/2023 at 4:38 p.m., an interview was conducted with R6's responsible party (RP). R6's RP voiced concerns regarding the resident being left soiled for extended periods of time and being found wet when they arrived to visit frequently. R6's RP stated that when they found R6 soiled they would ring the call light and the staff did not answer the light and they would have to go out to find someone to come in to clean up R6. Review of the "ADL (activities of daily living)-Toilet Use" documentation for 1/1/2023- 1/31/2023 and 2/1/2023-2/28/2023 failed to evidence incontinence care provided to R6 on the following dates. On day shift on 1/1/2023, 1/2/2023, 1/3/2023, 1/7/2023, 1/8/2023, 1/9/2023,	F 677		

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F 677	Continued From page 111 1/29/2023, 1/30/2023, 2/4/2023 and 2/5/2023. On evening shift on 1/1/2023, 1/2/2023, 1/6/2023, 1/8/2023, 1/9/2023, 1/10/2023, 1/12/2023, 1/18/2023, 1/20/2023, 1/22/2023, 1/26/2023, 1/27/2023, 1/29/2023, 1/31/2023 and 2/5/2023. On night shift on 1/6/2023, 1/7/2023, 1/8/2023, 1/10/2023, 1/13/2023, 1/15/2023, 1/20/2023, 1/22/2023, 1/28/2023, 1/29/2023, 1/31/2023, 2/1/2023, 2/2/2023, 2/3/2023, 2/4/2023 and 2/5/2023. The comprehensive care plan for R6 documented in part, "The resident is frequently incontinent of bladder and bowels and is not a candidate for a toileting program due to: dementia. Created on: 11/04/2022. Revision on: 11/30/2022." Under "Interventions" it documented in part, "...Check and change briefs frequently as needed. Created on: 11/04/2022. Provide toileting hygiene with brief changes. Created on: 11/30/2022..." On 2/6/2023 at 5:36 p.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated that incontinence care rounds should be made every two hours. On 2/7/2023 at 11:06 a.m., an interview was conducted with CNA #1. CNA #1 stated the CNAs document ADL care in the computer system and then on flowsheets if the computer system is not available. CNA #1 stated blank spaces on the ADL records meant that the resident had not been documented on and that it was said that if it was not documented, it was not done. CNA #1 stated that they could not say that it was not done but there was nothing to justify or evidence that it was being done because they could not physically see that the care was being done on that particular day or shift.	F 677		

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F 677	Continued From page 112 On 2/8/2023 at 11:23 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit. 3. For Resident #114 (R114), the facility staff failed to provide personal hygiene during the day shift on 6/15/22 and during the evening shifts on 6/19/22 and 6/24/22. A review of R114's ADL (activities of daily living) records for June 2022 revealed blank spaces for personal hygiene (combing hair, brushing teeth, shaving, washing/drying face and hands) for the day shift on 6/15/22 and for the evening shift on 6/19/22 and 6/24/22. R114's baseline care plan dated 6/21/22 documented, "ADL Self care deficit related to physical limitations. Assist with daily hygiene, grooming, dressing, oral care and eating as needed..." On 2/7/23 at 11:06 a.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated the CNAs document ADL care in the computer system and then on flowsheets if the computer system is not available. CNA #1 stated blank spaces on the ADL records means, "They haven't been documented on. They say if it wasn't documented, it wasn't done. I'm not saying it wasn't done but there is nothing to justify or evidence it's been done. They can't physically see that you took care of that client that particular day or shift."	F 677		

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F 677	Continued From page 113 On 2/7/23 at 5:02 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Shift Responsibilities for CNA" documented, "4. Perform shift responsibilities/assignments that promote quality of care; make rounds, identify and address any immediate patient needs, promptly respond to call lights and notify the licensed nurse of any pertinent patient findings (reddened skin, etc.)." 4. For Resident #128 (R128), the facility staff failed to assist in dressing in street clothes rather than a hospital gown on 2/5/23, 2/6/23, and 2/7/23. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/22/23, R128 was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). The resident was coded as requiring the extensive assistance of staff for personal hygiene, grooming, and dressing. On each of the following dates and times, R128 was dressed in a hospital gown, and was in a location visible to visitors and staff: 2/5/23 at 3:18 p.m., 3:40 p.m., and 5:12 p.m.; 2/6/23 at 8:16 a.m., 9:40 a.m., 2:56 p.m.; 2/7/23 at 12:10 p.m. On 2/6/23 at 2:56 p.m., LPN (licensed practical nurse) #2 and LPN #11 were asked what types of services a resident should receive with morning ADL (activities of daily living) care each day. LPN #2 stated morning care includes washing a resident's face and hands, changing incontinence	F 677		

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F 677	Continued From page 114 briefs/assisting with toileting, repositioning a resident up in a chair, and getting a resident dressed for the day. When asked if it is acceptable care for a resident to be dressed all day in a hospital gown, she stated: "No, it is not." LPNs #11 and #2 observed R128 sitting up in the bed, still dressed in a hospital gown. LPN #11 stated: "This is not acceptable. Not at all. I will get [R128] changed." On 2/7/23 at 5:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. On 2/8/23 at 10:18 a.m., CNA (certified nursing assistant) #5 was interviewed. He stated morning ADL resident care consists of getting a resident up, washing their face, brushing their teeth combing their hair, and getting them dressed in regular clothes. No further information was provided prior to exit. 5. For R113, the facility staff failed to provide bathing for four days between 9/15/2022 through 10/10/2022. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 9/18/2022, the resident scored an 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired for making daily decisions. In Section G - Functional Status, R113 was coded as being dependent of one or more staff members for dressing and bathing. It was coded the resident required extensive assistance of one staff member for personal	F 677		

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F 677	Continued From page 115 hygiene. Review of the CNA (certified nursing assistant) documentation for September 2022 documented R113 was to receive a shower on the day shift on Mondays and Thursdays and as needed. It was documented R113 received a shower on 9/26/2022. On 9/22/2022 and 9/29/2022, it was documented the resident received bed baths rather than a shower. Under the heading, ADL (activities of daily living) bed bath, for September 2022, it was documented the resident received a bed bath every day except for 9/18/2022, 9/19/2022 and 9/20/2022. There was nothing documented for any type of bathing for those days. The October 2022 CNA documentation revealed R113 was to receive a shower/bed bath on Mondays and Thursdays. On 10/6/2022 and 10/10/2022, it was documented the resident received a bed bath, however there was nothing documented for 10/3/2022. On 2/7/23 at 11:06 a.m., an interview was conducted with CNA #1. CNA #1 stated the CNAs document ADL care in the computer system and then on flowsheets if the computer system is not available. CNA #1 stated blank spaces on the ADL records means, "They haven't been documented on. They say if it wasn't documented, it wasn't done. I'm not saying it wasn't done but there is nothing to justify or evidence it's been done. They can't physically see that you took care of that client that particular day or shift."	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25	F 684		3/21/23

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F 684	Continued From page 116 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide care and services to maintain residents' highest level of well-being for four of 58 residents in the survey sample, Residents #114, #22, #77 and #116. The findings include: 1. For Resident #114 (R114), the facility staff failed to administer multiple physician ordered medications in June 2022. These medications were available in the facility over-the-counter medication supply. A review of R114's clinical record revealed the following physician's orders: -6/9/22- omeprazole (1) 20 mg (milligrams)- 1 capsule by mouth one time a day for gastroesophageal reflux disease. -6/21/22-calcium with vitamin D 600 mg/200 units- 1 tablet by mouth one time a day for COVID. -6/21/22-melatonin 3 mg- 1 tablet by mouth at bedtime for COVID. -6/21/22-vitamin C 500 mg by mouth one time a day for COVID.	F 684	F684 Quality of care- Meds not administered as ordered 1-Residents #114, #22, and #116 were discharged. Resident #77 is receiving Gabapentin as ordered. 2-All current residents have the potential to be affected. The DON, or designee will audit current residents for medication availability, by completing a MAR to medication cart verification audit, check to ensure that wound treatment orders are in place as ordered and Neuro assessments are completed as required. 3-The ADON, or designee will educate all licensed nurses notify MD when Meds not available, the process for refilling or obtaining medications, and awareness of OTC medications available in the center; obtaining orders for wound care; completion of Neurological assessment requirements. 4-The Unit Managers will complete a weekly audit x 8 weeks and monthly x 2 to ensure the following: Medications are available for administration, MAR to medication cart audits to verify medications are available, wound care	

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F 684	Continued From page 117 A review of R114's June 2022 MAR (medication administration record) failed to reveal evidence that omeprazole 20 mg was administered on 6/10/22, and calcium with vitamin D 600 mg/200 units, melatonin 3 mg and vitamin C 500 mg were administered on 6/21/22 (as evidenced by blank spaces on the MAR). A review of the in-house over-the-counter medication supply list revealed these medications were available in the facility. On 2/7/23 at 12:00 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated when nurses receive a physician's order, they should put the order into the computer system for the pharmacy and pull the medication from the facility supply of immediate medications if the medication is due for administration and has not arrived from the pharmacy. On 2/8/23 at 8:31 a.m., an interview was conducted with LPN #2. LPN #2 stated nurses evidence medication administration by signing off on the MAR. LPN #2 stated if a medication has not been documented as being given or signed off on then you can say the medication hasn't been given. On 2/8/23 at 9:50 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. Reference: (1) Omeprazole decreases the amount of acid in the stomach. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a617014.html	F 684	orders are in place for wounds; Neurological assessments are completed as required. 5 Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

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F 684	Continued From page 118 2. For Resident #22 (R22), the facility staff failed to evidence neurological assessment following a fall on 2/3/23. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/23, R22 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). A review of R22's progress notes revealed the following: "Effective Date: 2/3/2023 21:58 (9:58 p.m.) Type: Fall Note...Resident had no injuries from fall, but complaints of pain 10/10 in the neck and the head...Resident was assisted off the floor by nurse and nurse aide. VS (vital signs), neurological assessment assessed. Therapeutic care and medication administered for pain." This note was written by LPN (licensed practical nurse) #10. "Effective Date: 2/4/2023 08:02 (8:02 a.m.) Type: Change of Condition Note Text Writer notes upon entering resident room, writer notes resident vomiting and in severe pain, resident reported he had a fall from previous shift, resident reported pain in neck, head, and left arm, writer notes limited ROM (range of motion) in upper extremities...MD notified and requested resident to be sent to Er (emergency room) for further evaluation and requested CT (computed tomography) scan. POA (power of attorney) has been notified of current events." Further review of R22's clinical record revealed no evidence of a neurological assessment	F 684		

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F 684	Continued From page 119 documenting details of what was assessed or what the resident's assessment responses were following the fall on 2/3/23. On 2/6/22 at 4:28 p.m., LPN #10 was interviewed. She stated a CNA (certified nursing assistant) had discovered R22 on the floor after the resident rang the call bell. She stated R22 could move his arms and legs, and was alert and oriented to person, place, time, and situation. She stated she spoke with ASM (administrative staff member) #2, the director of nursing to let ASM #2 know the resident had sustained a fall. LPN #10 stated that, at this time, the resident told her that they had hit their head when they fell. She stated she took vital signs and did a neurological assessment. When asked what exactly she assessed neurologically, she stated she could not remember. When asked where she documented her assessment findings, she stated she was a nurse from a contract agency, and she did not know how to use the facility's electronic medical record. She added: "I did have another family and another resident that wanted to be sent out that shift. There was a lot going on." She stated: "I did everything I knew to do." On 2/6/22 at 5:42 p.m., ASM #5, the on-call physician on 2/3/22, was interviewed. ASM #5 stated LPN #10 never told him the resident had hit their head and was having severe head and neck pain. He stated LPN #10 reported that the resident's blood pressure was elevated, and he gave an order for her to give an additional dose of blood pressure medication. However, he stated if he had been told the resident had hit their head and was having such severe head and neck pain, he would have instructed the nurse to send the resident to the ER immediately.	F 684		

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F 684	Continued From page 120 On 2/7/23 at 1:54 p.m., ASM #1, the administrator, ASM #2, and ASM #3, the regional director of clinical services, were informed of these concerns. On 2/7/23 at 3:35 p.m., RN (registered nurse) #3, the night shift supervisor, was interviewed. She stated R22's fall happened before she arrived at the facility for her shift. She stated the resident's nurse never told her that the resident had hit their head when they fell. She stated if she had known R22 had hit their head, she would have done a full neurological assessment, gotten vital signs, called the doctor, and sent the resident to the ER. On 2/7/23 at 4:00 p.m., LPN #8 was interviewed. She stated she arrived at 11:15 p.m. on 2/3/23, and was assigned to R22. She stated when LPN #10 gave her report, LPN #10 did not tell her that the resident had hit their head during a fall. She stated she has frequently taken care of R22, and the resident slept all night. She stated she had no indication that the resident needed a neurological assessment done on her shift. A review of the facility policy, "Falls Management Program," revealed, in part: "Fall Occurrence Immediate Responsibilities...Evaluate, monitor, and document patient response for the first 24 hours (3 consecutive shifts) post fall, include a neurological assessment if the fall was unwitnessed and/or the patient hit his/her head." No further information was provided prior to exit. 3. For Resident #77 (R77), the facility staff failed to ensure that Gabapentin (1) was administered as ordered.	F 684		

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F 684	Continued From page 121 On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/24/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section J documented R77 receiving scheduled pain medications and not having any pain during the assessment period. On 2/5/2023 at 4:13 p.m., an interview was conducted with R77 in their room. R77 stated that there were times when they did not receive their scheduled Gabapentin because the facility ran out and that the nurses would tell them that they had run out and the pharmacy had not delivered the medication. R77 stated that they took the Gabapentin for neuropathy and had pain in their hands often, that they needed their Gabapentin three times a day, and the facility should have something in place to not run out of medications. R77 stated that they normally had to wait until the next day to get the medication from pharmacy. The physician orders for R77 documented in part, "Gabapentin capsule 100 mg (milligram), give 1 capsule by mouth two times a day for neuropathic pain. Order Date: 08/11/2022. Start Date: 08/11/2022..." The orders further documented, "Gabapentin capsule 100 mg, give 3 capsule by mouth at bedtime for neuropathic pain. Order Date: 08/11/2022. Start Date: 08/11/2022..." Review of the eMAR (electronic medication administration record) for R77 for 1/1/2023-1/31/2023 and 2/1/2023-2/28/2023 failed to evidence administration of the Gabapentin on 1/4/2023 at 5:00 p.m. The area	F 684		

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F 684	Continued From page 122 for administration of Gabapentin 100mg on 1/4/2023 at 5:00 p.m. was observed to be blank. The progress notes failed to evidence a reason that the Gabapentin was not administered on 1/4/2023. The comprehensive care plan for R77 documented in part, "Pain related to disease process Morbid Obesity, Anemia, Depression, generalized discomfort. Created on: 10/29/2021. Revision on: 11/08/2021." Under "Interventions" it documented in part, "Administered [sic] pain medication per physician orders. Created on: 10/29/2021..." On 2/7/2023 at 12:30 p.m., a review of the facility provided document listing the available medications in the facility Omnicell (automated dispensing system) documented in part, "Gabapentin 100mg capsule; PAR 10...Gabapentin 300mg capsule; PAR 10..." On 2/8/2023 at 8:17 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that medications were evidenced as administered by documenting them on the eMAR. LPN #2 stated that if the medications were not signed off on the eMAR they could not evidence that they were given. LPN #2 stated that if it was not documented it was not done. LPN #2 stated that if medications were not available on the medication cart the nurse had access to the Omnicell to get some medications, that every staff nurse had access to the Omnicell, and all agency nurses were granted temporary access. LPN #2 stated that there was no reason why a resident should not get their medication. LPN #2 stated that they had recently switched to	F 684		

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F 684	Continued From page 123 a new pharmacy and had the Omnicell in place for about 2 months now, and prior to that they had some emergency medications in a box but mostly had to wait for pharmacy to bring the medications in. On 2/8/2023 at 9:20 a.m., an interview was conducted with LPN #1. LPN #1 stated that if there were no medications for a resident they would check the medication cart first and other carts, the check the Omnicell to see if available. LPN #1 stated that they would call the pharmacy and notify the physician and the resident and/or the responsible party and document that the medication was not available. On 2/8/2023 at 11:23 a.m., ASM (administrative staff member) #3, the regional director of clinical services stated that they had transitioned to the current pharmacy on 12/15/2022. On 2/8/2023 at approximately 11:30 a.m., ASM #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit. Reference: (1) Gabapentin Gabapentin capsules, tablets, and oral solution are used along with other medications to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles). Gabapentin extended-release tablets (Horizant) are used to	F 684		

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F 684	Continued From page 124 treat restless legs syndrome (RLS; a condition that causes discomfort in the legs and a strong urge to move the legs, especially at night and when sitting or lying down). Gabapentin is in a class of medications called anticonvulsants. Gabapentin treats seizures by decreasing abnormal excitement in the brain. Gabapentin relieves the pain of PHN by changing the way the body senses pain. It is not known exactly how Gabapentin works to treat restless legs syndrome. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694007.html 4. For Resident #116 (R116), the facility staff failed to assess and put treatments in place for a necrotic arterial wound. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 3/26/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact for making daily decisions. In Section M - Skin Conditions, R116 was not coded as having any type of wound. The hospital discharge instructions, dated, 3/22/2022, documented in part, "Discharge Diagnoses: Right bimalleolar fracture, PAD (peripheral arterial disease) with vascular wound - foot - Wound care following...Continue Betadine paint to dry gangrenous areas twice daily.... Additional Recommendation: Wound care: na (not applicable)." The Admission Assessment dated 3/22/2022 at 2:48 p.m. documented in part, "Identification of	F 684		

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F 684	Continued From page 125 Skin Conditions - 7. Is there any current skin breakdown or skin conditions present? Yes. Identify location of skin conditions and describe appearance including measurements, if applicable. Abdomen - peritoneal dialysis site. Right lower leg (front) - Fx (fracture) cast intact. Other - left upper arm multiple bruises." The Resident Evaluation dated 3/22/2022 at 2:48 p.m. documented in part, "Skin evaluation reveals current skin breakdown/skin conditions; refer to the completed evaluation and physician's orders for type and location.... Cardiovascular: Right pedal pulses palpable, no edema noted to right foot or ankle...Braden Scale Score: 15.0 = low risk." The comprehensive care plan dated, 3/23/2022, documented in part, "Focus: Actual skin breakdown related to gangrenous 2nd toe." The "Interventions" documented, "Administer treatment per physician order. Report evidence of infection such as purulent drainage, swelling, localized heat, increased pain, etc. Notify physician PRN (as needed)." The nurse's note dated, 3/24/2022 at 1:47 a.m. documented in part, "Skin intact." The nurse practitioner note dated, 3/24/2022 at 11:33 a.m. documented in part, "Initial visit summary...Hospital diagnoses: Right bimalleolar fracture. PAD with vascular wound...Hospital Course: Right bimalleolar fracture. Continue multimodal pain control to work with physical therapy. PAD with vascular wound...Continue Betadine paint to dry gangrenous areas.... ROS (Review of systems)..Skin: warm, right lower leg wrapped, toes war(sic). Right 2nd toe non-healing	F 684		

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F 684	Continued From page 126 ulcer...A/P (Approach/Plan) ...PAD with vascular wound foot...Continue Betadine paint to dry gangrenous areas." The nurse's note dated, 3/24/2022 at 12:32 p.m. documented in part, "Cast intact to Rt lower leg. Pulse positive in RT foot and resident able to wiggle toes." The physical medicine physician note dated 3/24/2022 at 8:07 p.m. documented in part, "CC (chief complaint): Right foot 2nd toe gangrene, repeated falls and difficulty walking. S/P (status post) right ankle bimalleolar fracture...Patient also has a right foot with 2nd toe chronic wound, treated by podiatrist for the past few months, nonhealing and with clinical signs of black 2nd toe with drainage.....Pt in room to start treatment, patient reporting she is not feeling pain in the right ankle at the fracture site, she has little information about her treatment at the hospital. She reports she has had her right foot non healing wound at least 4 - months, receiving wound care by "foot doctor" and reporting her wound continues to worsen and now before her fall her 2nd toe was turning black, reporting decreased sensation on all right foot digit toes, especially on the 2nd toe but denies any tingling, numbness, or neuropathic pain. Denies feeling any pressure due to posterior splint, denies any pain on the right knee or hip. She states she would like to have her 2nd to amputated to prevent further complications...Inspections. Skin: Inspection of all 4 extremities negative for rashes. Right foot 2nd toe with gangrenous changes, black in color and atrophic toenail and skin...RLE (right lower extremity) with decreased sensation to superficial touch and vibration on exposed toes and distal midfoot."	F 684		

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F 684	Continued From page 127 Review of the clinical record failed to evidence any treatment orders for the right foot 2nd toe. The Wound Care Specialist note dated 3/25/2022 at 8:41 a.m. documented in part, "Wound status: present on admission. Etiology: Arterial. % (percentage) slough/eschar - 100.00%. Dressing: Skin prep." The physician order dated 3/25/2022, documented, "Skin prep right second toe every shift." The March TAR (treatment administration record) documented the above order. It was documented as administered on 3/25/2022 on the evening and night shift. It was documented as administered on 3/26/2022 on the day shift. The nurses who cared for R116 during their stay at the facility were no longer employed at the facility and unavailable for interview. An interview was conducted with RN (registered nurse) #2, on 2/7/2023 at approximately 10:30 a.m. When asked if there is a skin concern, such as necrosis, noted on the admission of a resident, where is that documented, RN #2 stated it would be on the admission assessment and in a nurse's note. The nurse should make the doctor or nurse practitioner aware of the area so that treatment orders can be put in place. Also notify the wound care nurse as they see all residents with wounds. When asked if a nurse sees a resident with a necrotic area, what is expected of the nurse to do, RN #2 stated the same thing, document it in the nurse's notes, notify the doctor or nurse practitioner, notify the wound nurse, and get	F 684		

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F 684	Continued From page 128 treatment orders in place. An interview was conducted with LPN (licensed practical nurse) #3 on 2/7/2023 at 11:50 a.m. When asked if there is a skin concern, such as necrosis, noted on the admission of a resident, where is that documented, LPN #3 stated, is should be documented on the admission skin assessment and a progress note. When asked if a nurse sees a resident with a necrotic area, what is expected of the nurse to do, LPN #3 stated, "I would do the best I can to take care of it. What we have available to put on it. I would do what is in my scope of practice." When asked if there were any standard wound care orders, LPN #3 stated she was not aware of any. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above findings on 2/7/2023 at 5:20 p.m. No further information was provided prior to exit.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		3/21/23

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F 686	Continued From page 129 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide care and services to promote healing for two of 58 residents in the survey sample, Residents #113 and #93. The findings include: 1. For Resident #113 (R113), the facility staff failed to administer treatments for a pressure injury per the physician orders. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 9/18/2022, the resident scored an 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired for making daily decisions. In Section M - Skin Conditions, the resident was coded as having a stage four pressure injury. (1) The physician order dated, 9/15/2022, documented, "Dakin's (1/4 strength) Solution 0.125% (Sodium Hypochloride) Apply to right hip topically every day and evening shift for apply for wet to dry dressing on wound." The September 2022 TAR (treatment administration record) documented the above order. The box to indicate the treatment was administered was blank for all of 9/16/2022.	F 686	F686 Treatment/Services to prevent/Heal pressure Ulcers Quality of care- 1-Resident #113 was discharged. Resident #93 is receiving proper Incontinence care and the wound care treatments are being completed as ordered. 2-Current residents have the potential to be affected. The DON, or designee will review the Treatment administration record for residents with wounds to ensure the treatments are being completed as ordered and will check residents with wound to ensure that the wound dressings are in place and incontinence care is provided appropriately. 3-The Staff Development Coordinator will educate all licensed nurses on following MD orders for wound care treatment orders and documentation requirements for providing wound care in the clinical record, and provisions for providing Incontinence care. The CNA□s will be educated on notifying Nurses if a wound dressing is not in place and the provisions for proper incontinence care. 4-The Unit Manager, or designee will complete weekly audits x 8 weeks and then monthly x 2 to review completion of documentation of wound care in the clinical record, wound care orders are in place for the wounds, wound care dressings are in place as ordered and that	

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F 686	Continued From page 130 The physician order dated, 9/17/2022, documented, "Wound care: clean right hip pressure ulcer stage four with wound cleanser, apply collagen, pack with silver alginate and cover with ABD (abdominal) pad daily every day shift for wound care." The September 2022 TAR (treatment administration record) documented the above order. The box to indicate the treatment was administered was blank on 9/18/2022 and 9/19/2022. The physician order dated, 9/21/2022, documented, "Wound care: Clean right hip pressure ulcer stage four with wound cleanser, apply collagen, pack with silver alginate and cover with ABD pad daily every day shift for wound care." The September 2022 TAR (treatment administration record) documented the above order. The box to indicate the treatment was administered was blank on 9/24/2022 and 9/25/2022. The comprehensive care dated 9/20/2022 failed to evidence documentation related to skin related concerns or a pressure injury. An interview was conducted with RN (registered nurse) #2, on 2/7/2023 at approximately 10:30 a.m. When asked what a blank on the TAR indicated, RN #2 stated, if it's not documented it's not done. The nurse could have forgotten to sign it off. An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on	F 686	proper incontinence care is provided. 5 Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

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F 686	Continued From page 131 2/7/2023 at 11:50 a.m. When asked what a blank on the TAR indicates, LPN #3 stated she was not sure. The facility policy, "General Wound Care/Dressing Changes" documented in part, "POLICY: A licensed nurse will provide wound care/dressing change(s) as ordered by physician...PROCEDURE...3. Provide treatments as ordered." ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above findings on 2/7/2023 at 5:20 p.m. No further information was provided prior to exit. (1) Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. This	F 686		

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F 686	Continued From page 132 information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf 2. For Resident #93 (R93), the facility staff failed to provide care and services to promote healing of a pressure ulcer (1). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/2023, the resident was assessed as being independent in making daily decisions. Section G documented R93 requiring extensive assistance from one staff member for toileting. Section M documented R93 having four stage 3 pressure ulcers with three of them present on admission to the facility. On 2/6/2023 at 8:26 a.m., an interview was conducted with R93 in their room. R93 stated that they had requested incontinence care before 7:00 a.m. and was still waiting for staff to come to provide the care at 8:26 a.m. R93 stated that the last time they had been provided incontinence care was around 4:00 a.m. On 2/06/2023 at 10:16 a.m., CNA (certified nursing assistant) #2 was observed providing incontinence care to R93. R93's brief was observed to be heavily saturated with a strong urine odor that was present through this observer's N95 mask. R93's pressure ulcer to the left ischium was observed to be uncovered with no dressing present to the area. The physician orders for R93 documented in part, "Left ischium- cleanse with NS (normal saline) pat dry, apply collagen particles, pack with silver alginate secure with bordered gauze every	F 686		

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F 686	Continued From page 133 evening shift. Order Date: 01/19/2023." The orders further documented, "Left ischium-cleanse with NS pat dry, apply collagen particles, pack with silver alginate secure with bordered gauze as needed. Order Date: 01/19/2023." Review of the eTAR (electronic treatment administration record) for R93 dated 12/1/2022-12/31/2022, 1/1/2023-1/31/2023 and 2/1/2023-2/28/2023 failed to evidence treatment completed to the left ischium pressure ulcer on 12/4/2022, 12/5/2022, 12/7/2022, 12/8/2022, 12/26/2022, 1/3/2023, 1/14/2023, 1/16/2023 and 1/28/2023. The dates listed were observed to be blank. The comprehensive care plan for R93 dated 10/22/2022 documented in part, "[R93] was admitted to this SNF (skilled nursing facility) with with 3 Stage 3 pressure ulcers, a surgical wound and other wounds. She is at risk for further alterations in her skin integrity related to impaired mobility, incontinence, diabetes and circulation problems. Created on: 09/29/2022. Revision on: 01/10/2023." Under "Interventions" it documented in part, "...Keep skin clean and dry as possible. Created on: 09/29/2022...Treatments to skin as ordered. Created on: 10/22/2022. Wound care consults and treatment as ordered. Created on: 10/23/2022." The Wound evaluation dated 2/1/2023 for R93 documented in part, "...Left ischium length 0.86 cm (centimeter) Width 0.76 cm...Depth (cm) 2.50...Wound status Improving...Dressing change frequency Daily..." On 2/06/2023 at 10:17 a.m., an interview was	F 686		

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F 686	Continued From page 134 conducted with CNA (certified nursing assistant) #2. CNA #2 stated that they worked the 7:00 a.m. to 3:00 p.m. shift and was assigned to R93. CNA #2 stated that the incontinence care provided to R93 at 10:16 a.m. was the first care they had provided to them that morning. CNA #2 stated that they felt that they were able to meet the needs of the residents with the assignment they were given. On 2/08/2023 at 8:17 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that wound care was evidenced as completed by signing off on the eTAR. LPN #2 stated that they had a wound nurse during the week who completed the treatments and signed them off and when they were not there the nurses were responsible and were to sign them off. LPN #2 stated that the wound nurse was focused only on the wounds and the nurse had to go back and complete any additional treatments on the eTAR. LPN #2 stated that they had agency nurses who did not look at the eTARs when they had a wound nurse and things looked as if they were not done when they were not signed off. LPN #2 stated that they could not evidence that the wound care was done if there were blanks on the eTAR. LPN #2 stated that if it was not documented it was not done. On 2/8/2023 at approximately 11:30 a.m., ASM #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit. Reference: 1. Pressure Ulcer	F 686		

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F 686	Continued From page 135 A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm.	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 staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide an environment free of hazards for two out of 58 residents in the survey sample, Residents #48 and #96.	F 689	F689 Free of Accident Hazards/supervision devices 1-Resident #48 and #96 have been re-educated on the safety measures for the use of smoking materials.	3/21/23

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F 689	Continued From page 136 The findings include: 1. The facility staff failed to ensure Resident #48's smoking paraphernalia was secured when not in use. Resident #48 was admitted to the facility on 4/13/20 with diagnosis that included but were not limited to: diabetes mellitus, atrial fibrillation and depression. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/6/22, 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. A review of the comprehensive care plan dated 5/17/22 and revised 1/2/23, which revealed, "FOCUS: Resident chooses to smoke -will smoke off facility grounds. Understands smokefree facility, declines smoking cessation and independent smoker. The resident prefers to smoke. INTERVENTIONS: Educate to interventions and center smoking policy and procedures, smoke free facility, smoke off facility grounds. Flag placed on wheelchair while off facility grounds to help with physical safety for easier identification to drivers. Offer/encourage smoking cessation (i.e., nicotine patch, medications, etc.). Smoking assessment as needed. Educate on facility smoking policy." A review of the facility's "Safe Smoking Evaluation" dated 8/2/21, revealed "Independent Smoker: Capable and independent, requires no	F 689	2-All current residents have the potential to be affected. All residents who smoke will be re-educated on the safety measures for the use of smoking materials by the Administrator, or designee. 3-The Administrator, or designee will educate all staff on the facility smoking policy and handling of smoking material. 4-The DON or designee will complete weekly audits x 8 weeks and then monthly x2 to ensure that the residents are following the safety measures for smoking materials. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

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F 689	Continued From page 137 supervision to smoke." On 2/6/23 at 2:50 PM, Resident #48 was observed smoking on the far side of the white fence at the corner of the entrance to the facility parking lot and the road leading into the shopping center. When asked how often he comes out to smoke, Resident #48 stated three to four times per day. When asks the process for him to smoke, Resident #48 stated, I sign out and in, there is a book at the reception desk. I come out and smoke and then go back to my room after I sign in. When asked if he keeps his cigarettes and lighter, Resident #48 stated, yes, at one point the staff had them, but they could not keep up with them and gave them back to us. On 2/7/23 at 11:00 AM, an interview was conducted with Resident #48 in his room. When asked if he would show me where he stores his cigarettes and lighter, Resident #48 stated, no, there is no one but me who knows where they are and I am going to keep it that way. On 2/7/23 at approximately 12:30 PM, during the review of a facility event synopsis, evidence of staff education on the smoking policy dated 12/31/22 and 1/2/23 was provided. The learning objectives for 12/31/22 were revealed to be, "All smoking paraphernalia has to be taken from all residents, packaged and placed in medication room. Staff is to give smoking materials to residents per request, staff must take smoking supplies back from resident and lock supplies up". An interview was conducted on 2/8/23 8:00 AM with LPN (licensed practical nurse) #6. When asked actions are implemented when a resident	F 689		

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F 689	Continued From page 138 is identified as a smoker, LPN #6 stated, there is a smoking assessment done to if they are an independent smoker or if they need supervision. If they are independent, there is an orange flag that is attached to their wheelchair, so they will be more visible to the traffic. When asked who keeps the smoking implements when they are in the facility, LPN #6 stated, they give us their smoking implements. An interview was conducted on 2/8/23 at 8:30 AM with LPN #5, the MDS (minimum data set) coordinator. When asked who keeps the smoking implements for the residents, LPN #5 stated, we are utilizing the smoking policy. I believe the front desk takes their materials when the residents come back in from smoking. On 2/8/23 at 9:35 AM, a resident was observed entering the building after smoking. The resident signed himself in and did not give any smoking implements to the receptionist. An interview was conducted on 2/8/23 at 9:50 AM, with OSM (other staff member) #9, the front desk receptionist. When asked if the residents give their cigarettes and lighters to the receptionist when they enter the facility, OSM #9 stated, no, the residents keep their cigarettes and lighters with them. On 2/7/23 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the findings. On 2/8/23 at approximately 11:00 AM, ASM #1, provided the facility's "Patient Smoking Agreement" with a date of 1/16/23.	F 689		

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F 689	Continued From page 139 A review of the facilities "Smoke/Tobacco/Vapor Free Environment" policy dated 1/23/20 revealed, "Facility promote a smoke/tobacco/vapor free environment. Use of tobacco products and other electronic smoking paraphernalia is not permitted within the facility." No further information was provided prior to exit. 2. For Resident #96 (R96), the facility staff failed to evidence that they smoking paraphernalia was secured when not in use. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/20/2022, (R96) scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. The facility's "Smoking-Safety Screen" for (R96) dated 12/20/2022 documented in part, "1. Dose the resident smoke? Yes." Under "F. INTERVIEW" it documented in part, "10. Patient understands that smoking accessories (cigarettes, cigar, pipes, electronic delivery systems (electronic cigarettes, vape pen) lighters, matches, etc.) must be returned to and kept under control of the center staff when not in use: Yes." On 02/05/2023 at approximately 1:30 p.m., (R96) was observed outside of the facility smoking. On 02/06/2023 at approximately 3:10 p.m., (R96) was observed outside of the facility smoking. On 02/07/2023 at approximately 9:17 a.m., during	F 689		

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F 689	Continued From page 140 an interview with (R96), an observation of their wheelchair revealed two packs of cigarettes laying on the seat. When asked where they keep their cigarettes (R96) stated that they take out two or three cigarettes from a pack and give the rest to the person at the front desk when they come back into the facility from smoking. When asked about a lighter (R96) stated that they keep the lighter with them all the time. On 2/8/2023 at approximately 8:00 a.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked what actions are implemented when a resident is identified as a smoker, LPN #6 stated, there is a smoking assessment done to determine if they are an independent smoker or if they need supervision. If they are independent, there is an orange flag that is attached to their wheelchair, so they will be more visible to the traffic. When asked who keeps the smoking implements when they are in the facility, LPN #6 stated, they give us their smoking implements. On 2/8/2023 at approximately 8:30 a.m., an interview was conducted with LPN #5, the MDS (minimum data set) coordinator. When asked who keeps the smoking implements for the residents, LPN #5 stated, we are utilizing the smoking policy. I believe the front desk takes their materials when the residents come back in from smoking. On 2/8/2023 at approximately 9:50 a.m., an interview was conducted, with OSM (other staff member) #9, the front desk receptionist. When asked if the residents give their cigarettes and lighters to the receptionist when they enter the facility, OSM #9 stated, no and that the residents	F 689		

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F 689	Continued From page 141 keep their cigarettes and lighters with them. On 02/08/2023 at approximately 10:30 a.m., ASM (administrative staff member) #1, administrator, was made aware of the above findings. No further information was provided prior to exit.	F 689		
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. 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 provide care and services for a colostomy for one of 58 residents in the survey sample, Resident #117. The findings include: The facility staff failed to evidence the colostomy bag was cared for and emptied for Resident #117 (R117). On the most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 1/29/2022, the resident scored a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for	F 691	F691 Colostomy, Urostomy, or Ileostomy Care - 1-Resident # 117 was discharged. 2-All current residents receiving Colostomy care have the potential to be affected. The Unit Manager, or designee will audit residents with colostomies to ensure that the Colostomy care is being documented in the ADL portion of the clinical record and that the care for the colostomy is reflected on the care plan. 3-The ADON, or designee will educate all certified nursing aides and licensed nurses on the process for documentation of colostomy care provided and inclusion of the colostomy care on the care plan. 4-The Unit Manager, or designee will complete weekly audits x 8 weeks and	3/21/23

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F 691	Continued From page 142 making daily decisions. In Section G - Functional Status, R117 was coded as requiring extensive assistance of one staff member for most of their ADLs (activities of daily living) except eating in which they only required supervision after set up assistance provided. In Section H - Bladder and Bowel, the resident was coded as having a colostomy. There was no care plan for the care of a colostomy. The physician order dated, 1/26/2022 read, "Colostomy: change bag and care as indicated. Ostomy supplies as indicated, odor eliminator spray, adhesive remove wipes, ostomy paste, skin barrier powder, ostomy tape, as needed for bowel elimination management." The ADL (activities of daily living) documentation for January 2022 was reviewed. There was no documentation to indicate that colostomy care/emptying of the colostomy bag was provided. Under "Bowel Movements," the following was documented: 1/26/2022 - 7:00 p.m. to 3:00 p.m. (7-3) - 97 documented for all categories, according to the legend at the bottom of the documentation, a 97 indicates "not applicable." 1/27/2022 - 7-3 - 97 - not applicable 1/27/2022 - 3-11 (3 p.m.-11 p.m.) - 97 - not applicable 1/28/2022 - 11-7 (11 p.m.-7 a.m.)- 97 - not applicable 1/28/2022 - 7-3 - blank, no documentation An interview was conducted with LPN (licensed practical nurse) #1 on 2/8/2023 at 9:18 a.m.	F 691	then monthly x2 to ensure that colostomy care is documented in the ADL portion of the clinical record and included in the care plan. 5 Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

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F 691	Continued From page 143 When asked who is responsible for emptying an ostomy bag, LPN #1 stated the nurse and the CNAs (certified nursing assistants) can empty it. The nurse normally deals with the seal and replacing the bags. The output is documented in the CNA documentation. When asked if, "not applicable" should be documented on the ADL documentation under bowel movement, LPN #1 stated, no. An interview was conducted with CNA # 5 on 2/8/2023 at 10:17 a.m. When asked who empties a colostomy bag, CNA #5 stated the CNA did. When asked how often a colostomy bag is checked, CNA #5 stated they check residents with colostomies every one to two and a half hours. When asked where the documentation of the emptying of the colostomy is, CNA #5 stated in (name of computer program). The above ADL documentation was reviewed with CNA #5. When asked if it should be documented as not applicable, CNA #5 stated, no, there is a spot for colostomy. After reviewing the ADL document with the above information, CNA #5 was asked if they could tell if the colostomy bag was emptied, CNA #5 stated no and concurred it was not correct documentation for a resident with a colostomy. The facility policy, "Colostomy Care," documented in part, "POLICY: Colostomy stoma/wafer/pouch will be applied/changed by a licensed nurse as ordered by physician. CNAs are allowed to empty/clean colostomy appliances. However, CNAs may not manipulate a colostomy wafer under any circumstances." ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of	F 691		

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F 691	Continued From page 144 nursing, and ASM #3, the regional director of clinical services, were made aware of the above findings on 2/8/2023 at 11:26 a.m. No further information was provided prior to exit.	F 691		
F 694 SS=E	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services for maintenance of a central venous access device for two of 58 residents in the survey sample, Residents #112 and #365. The findings include: 1. For Resident #112 (R112), the facility staff failed to evidence maintenance care for a PICC (peripherally inserted central catheter) (1), from the date of admission, 1/12/23, until 2/2/23. On R112's admission assessment dated 1/12/23, the resident was assessed to be cognitively intact, and oriented to person, place, time, and situation. On 2/5/23 at 2:54 p.m., R112 was observed to have a double lumen (two lines) PICC line inserted in the right arm. When asked about the	F 694	F694 Parenteral/IV fluids 1-Resdients #112 and #365 were discharged. 2-All current residents receiving IV fluids have the potential to be affected. The DON, or designee will complete audits of residents with IV access to ensure that the care of the PICC or IV access is reflected in the Orders and on the care plan and followed appropriately. 3-The Staff Development Coordinator or designee will educate all licensed nurses on obtaining orders for the care of IV access/PICC line and following the plan of care provisions for the IV access/PICC line. 4-The Unit Manager, or designee will complete weekly audits x 8 weeks, then monthly x2 to ensure that IV access/PICC line care orders are in place, reflected on the care plan and the care is implemented appropriately.	3/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495391		C 02/08/2023

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F 694	Continued From page 145 care the staff gave the PICC line, R112 stated the staff did not always have the supplies to flush the line, and had only started putting heparin in the line recently. A review of R112's progress note revealed, in part: "2/1/2023 22:14 (10:14 p.m.) Orders - Administration Note Text: Ceftriaxone Sodium Solution (antibiotic administered intravenously)...Use 2 gram intravenously every 24 hours for infection for 25 Days. Picc line clogged." "2/2/2023 02:20 (2:20 a.m.) Orders - Administration Note Text: primary nurse...reported patient's PICC Line was occluded. RN Supervisor came to bedside to assess PICC Line using 0.9% NACL (normal saline) flush. RN supervisor was successful. Updated orders include Heparin Flush and 0.9% NACL flush Q (each) Shift. Will continue to monitor patient status." A review of R112's physician orders revealed the following order dated 2/2/23: "PICC line - flush with 10ml (milliliters) NS (normal saline), then 5ml 10 units/ml heparin (non-valved)." Further review of R112's medical record, including the January and February 2023 MARs (medication administration records) revealed no evidence of PICC line flushing prior to 2/2/23, however the physician's order had been followed since 2/2/23. On 2/7/23 at 11:13 a.m., ASM (administrative staff member) #4, the nurse practitioner (NP) for R112's attending physician, was interviewed. When asked what orders needed to be written	F 694	5 Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

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F 694	Continued From page 146 and implemented for a resident who has a PICC line, she stated: "You have to flush it. I think they have a protocol. You flush it with normal saline." She stated the frequency of flushing depended on how often the line was used to administer medications to the resident. She stated: "I would assume it would need to be flushed daily with normal saline. I don't know that we use heparin here." On 2/7/23 at 5:05 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. On 2/8/23 at 8:18 a.m., LPN (licensed practical nurse) #2 was interviewed. When asked about PICC line care, she stated: "You have to go by whatever the order is." She stated PICC lines needed regular flushing, and needed to have dressing changes. A review of the facility document, "Infusion Intravenous (IV) Access Line Maintenance Protocol," revealed, in part: "Flush Protocols...Intermittent nonvalved...10ml NS (normal saline)...Medication...10ml NS...3ml 10 units/ml Heparin." No further information was provided prior to exit. (1) "A device used to draw blood and give treatments, including intravenous fluids, drugs, or blood transfusions. A thin, flexible tube is inserted into a vein in the upper arm and guided (threaded) into a large vein above the right side of the heart called the superior vena cava. A needle is inserted into a port outside the body to draw blood or give fluids. A PICC may stay in place for	F 694		

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F 694	Continued From page 147 weeks or months and helps avoid the need for repeated needle sticks. Also called peripherally inserted central catheter." This information is taken from the website https://www.cancer.gov/publications/dictionaries/cancer-terms/def/picc. 2. For Resident #365 (R365), the facility staff failed to evidence maintenance care for a PICC (peripherally inserted central catheter) (1) from the date of admission, 1/31/23 through the resident's discharge on 2/7/23. On 2/6/23 at 8:29 a.m., R365 stated they did not remember the staff flushing the PICC line "unless there was some kind of problem." A review of R365's clinical record revealed no evidence that PICC line flushes had been scheduled or completed for R365 since admission to the facility. On 2/7/23 at 11:13 a.m., ASM (administrative staff member) #4, the nurse practitioner (NP) for R112's attending physician, was interviewed. When asked what orders needed to be written and implemented for a resident who has a PICC line, she stated: "You have to flush it. I think they have a protocol. You flush it with normal saline." She stated the frequency of flushing depended on how often the line was used to administer medications to the resident. She stated: "I would assume it would need to be flushed daily with normal saline. I don't know that we use heparin here." On 2/7/23 at 5:05 p.m., ASM #1, the administrator, ASM #2, the director of nursing,	F 694		

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F 694	Continued From page 148 and ASM #3, the regional director of clinical services, were informed of these concerns. On 2/8/23 at 8:18 a.m., LPN (licensed practical nurse) #2 was interviewed. When asked about PICC line care, she stated: "You have to go by whatever the order is." She stated PICC lines needed regular flushing, and needed to have dressing changes. No further information was provided prior to exit.	F 694		
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 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, the facility staff failed to provide respiratory equipment per plan of care; and failed to store respiratory equipment in a sanitary manner for one of 58 residents in the survey sample, Resident #95. The findings include: The facility staff failed to ensure an ambu bag, tracheostomy (trach) care kits and an inner cannula were at the bedside of Resident #95 per	F 695	F695 Respiratory/Tracheostomy Care and Suctioning □ 1-Resident #95 has the necessary trach and respiratory equipment available and the respiratory equipment is stored in a sanitary manner. 2-All current residents receiving and/or performing self-Tracheostomy Care and that have respiratory equipment have the potential to be affected. The DON, or designee will complete an audit of residents requiring trach care to ensure the necessary supplies are available and	3/21/23

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F 695	Continued From page 149 the resident's care plan; and failed to store the resident's trach collar mask, used for nebulizer treatments, in a sanitary manner. Resident #95 was admitted to the facility on 9/20/22 with diagnoses that included but were not limited to: trach, malignant neoplasm of pharynx, dysphagia and anemia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/28/22, 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. A review of the comprehensive care plan dated 10/22/22 documented in part, "the resident is at risk for complications secondary to a tracheostomy secondary to history of cancer. INTERVENTIONS: Administer nebulizers as ordered. Ambu (bag/valve/mask) bag and trach collar at bedside. Change inner cannula daily as ordered. Observe for signs and symptoms of respiratory complications including infection and or respiratory blockage or mucous plug and notify MD as indicated. Refer to pulmonologist as needed. Resident may provide his own trach care as he feels able. Suction as needed. Tracheostomy care per order. Tracheostomy tie change per order." A review of the physician orders dated 10/7/22, revealed "Ambu-bag and trach collar to be kept at bedside. Change trach ties every week and as needed if soiled or wet. every day shift every Wednesday. Trach Inner cannula to be kept at bedside 6.5mm I.D. (inner diameter) 9.4mm O.D.	F 695	that respiratory equipment in use by residents is stored appropriately. 3-The ADON, or designee will educate all licensed nurses on the process for ensuring Trach care supplies are at the bedside and storage of respiratory equipment. 4-The Unit Managers, or designee will conduct weekly audits x 8 weeks and monthly x2 of residents receiving Trach care to verify supplies are at the bedside and that respiratory equipment is stored in a sanitary manner. 5 Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

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F 695	Continued From page 150 (outer diameter) 62mm length. Resident may provide his own trach care as he feels able." An interview was conducted on 2/5/23 at 5:04 PM with Resident #95. When asked who cares for his trach, Resident #95 stated, "I take care of my trach." When asked if he has the supplies he needs, Resident #95 stated "No, I do not have supplies. I would like to talk with you about this more, but I am trying to get my laundry together. Can we talk in the morning?" An interview was conducted on 2/06/23 at 8:06 AM with Resident #95. When asked about his trach care supplies, Resident #95 stated, there is not an inner cannula, I would like to have one. I clean my trach every morning when I get up. I use the water from the tap in the bathroom sink. I do not have a brush to clean the cannula with. I would like one of those also. There were no trach care kits, inner cannula or ambu bag in Resident #95's room. On 2/6/23 at 10:00 AM, an inventory of trach supplies in the clean supply room on Resident #95's unit revealed 15 trach care kits but no inner cannulas. An ambu bag was on the code cart. On 2/6/23 at 11:10 AM an inventory was conducted in the clean supply room on the other unit in the facility. LPN #3, the unit manager assisted. When asked about trach care supplies, LPN #3 stated, we do not keep trach care kits on this side because they usually go to the other unit. If they were coming to this unit, I would get the kits from upstairs. When asked if they have inner cannulas, LPN #3 stated, no, we have to order them from our supplier. When asked if there are ambu bags in the building, LPN #3	F 695		

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F 695	Continued From page 151 stated yes, additional bags are stored upstairs. On 2/7/23 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the findings. A review of the facility's "Respiratory Equipment" policy dated 11/1/19 revealed, "Place trach mask/collar over patient's stoma/trach. Store mask/collar in storage bag when not in use." A review of the facility's "Tracheostomy Care" policy dated 11/1/19 revealed, "Tracheostomy care will be provided by licensed nurses in accordance with the physician's order. PROCEDURE: If inner cannula is non-disposable: a. Remove inner cannula from trach tube. b. Immerse in sterile normal saline. c. Use a pipe cleaner/brush to clean inside the inner cannula and remove all secretions. d. Rinse the inside and outside of the inner cannula with sterile normal saline. Shake cannula to remove any excess sterile saline. e. Reinsert inner cannula, secure into place." No further information was provided prior to exit.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 697		3/21/23

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F 697	Continued From page 152 by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement a pain management program for one of 58 residents in the survey sample, Resident #22. The findings include: For Resident #22 (R22), the facility staff failed to administer pain medication according to the physician orders and applicable pain scale, and failed to intervene after a pain reassessment on 2/3/23. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/23, R22 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). A review of R22's progress notes revealed the following: "Effective Date: 2/3/2023 21:58 (9:58 p.m.) Type: Fall Note...Resident had no injuries from fall, but complaints of pain 10/10 in the neck and the head...Resident was assisted off the floor by nurse and nurse aide. VS (vital signs), neurological assessment assessed. Therapeutic care and medication administered for pain." This note was written by LPN (licensed practical nurse) #10. "Effective Date: 2/4/2023 08:02 (8:02 a.m.) Type: Change of Condition Note Text Writer notes upon entering resident room, writer notes resident vomiting and in severe pain, resident reported he had a fall from previous shift, resident reported	F 697	F697 Pain Management 1-Resident #22 is discharged. 2-All current residents have the potential to be affected. The DON, or designee will audit current residents to ensure that pain is appropriately managed. 3-The DON or designee will educate all licensed nurses on assessing and evaluating residents in pain and notifying the MD when the pain is not adequately managed. 4-The Unit Managers, or designee will conduct weekly audits x 8 weeks and monthly x2 to ensure that residents with complaints of pain are having their pain managed effectively. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

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F 697	Continued From page 153 pain in neck, head, and left arm, writer notes limited ROM (range of motion) in upper extremities...MD notified and requested resident to be sent to Er (emergency room) for further evaluation and requested CT (computed tomography) scan. POA (power of attorney) has been notified of current events." A review of R22's physician orders revealed the following order, dated 8/31/22: "Acetaminophen (Tylenol) 500 mg (milligrams) Give 2 tablets by mouth every 4 hours as needed for Mild Pain." This review also revealed the following order dated 1/29/23: "Tramadol Tablet 50 mg Give 1 tablet by mouth every 6 hours as needed for moderate and severe pain." A review of R22's February 2023 MAR (medication administration record) revealed R22 received 1000 mg of Tylenol at 7:14 p.m. on 2/3/23. Further review of R22's clinical record revealed the resident's pain was reassessed at 11:23 p.m. by LPN #10, and the resident reported pain was 6 out of 10. There is no evidence in the clinical record that LPN #10 offered additional pain relief options to R22 or contacted the physician to update him regarding the resident's pain level. At the next pain assessment for R22 at 4:37 a.m., R22's pain was rated at zero out of 10. On 2/6/22 at 4:28 p.m., LPN #10 was interviewed. She stated she spoke with the on-call physician, who told her to "give the Tylenol." She added: "I did have another family and another resident that wanted to be sent out that shift. There was a lot going on." She stated: "I did everything I knew to do."	F 697		

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F 697	Continued From page 154 On 2/7/23 at 1:54 p.m., ASM #1, the administrator, ASM #2, and ASM #3, the regional director of clinical services, were informed of these concerns. On 2/8/23 at 8:18 a.m., LPN #2 was interviewed. When asked if she would consider 10 out of 10 to pain to be mild, moderate, or severe, she stated: "It is severe." When asked if she had orders for both Tramadol and Tylenol as need, which of these medications she would choose to give a resident reporting 10 out of 10 pain, she stated: "I would definitely give the Tramadol." When asked what she would do if the same patient reported six out of 10 pain on the next assessment, she stated: "I would call the doctor and ask for direction." A review of the facility policy, "Pain Management," revealed, in part: "If pain is not relieved, notify physician. Any unusual findings and follow-up interventions are to be documented on the Progress Notes including notification of physician and responsible party." No further information was provided prior to exit.	F 697		
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:	F 698		3/21/23

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F 698	Continued From page 155 Based on staff interview, resident interview, clinical record review and facility document review, it was determined the facility staff failed to ensure ongoing communication with the dialysis facility for two of 58 residents in the survey sample, Resident #463 and #127. The findings include: 1. For Resident #463, the facility failed to ensure there was ongoing communication with the dialysis facility for 2 out of 4 visits in January-February 2023, on the dates of 1/30/23 and 2/6/23. Resident #463 was admitted to the facility on 1/28/23 with diagnoses that included but were not limited to: ESRD (end stage renal disease). The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 1/30/23, 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. A review of Section O-Special Procedures coded dialysis-yes. A review of the comprehensive care plan dated 1/30/23, revealed, "FOCUS: the resident is at increased risk for complications secondary to requiring hemodialysis due to ESRD. INTERVENTIONS: Dialysis Vascular Access. Hold Medications on dialysis days if ordered by physician. Labs and Diagnostics as ordered. Observe for signs and symptoms of bleeding or bruising related to anticoagulation use during dialysis. Observe for signs and symptoms of complications related to ESRD including but not	F 698	F698 Dialysis 1-Residents #463 and #127 were discharged. 2-All current residents receiving dialysis treatments have the potential to be affected. The DON, or designee will review current residents receiving Dialysis treatment to ensure that the Dialyis communication form is being utilized. 3-The ADON or designee will educate all licensed nurses on the process for Dialysis communication forms. 4-The Unit Managers or designee will conduct weekly audits x 8 weeks, monthly x2 to verify residents receiving dialysis treatments have a completed Dialysis communication log is sent and brought back with each Dialysis treatment. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

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GLENBURNIE REHAB & NURSING CENTER	1901 LIBBIE AVE RICHMOND, VA 23226

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F 698	Continued From page 156 limited to fluid overload, hemorrhage, infection to the access site, hypotension, respiratory and/ or cardiac distress and notify MD as indicated. Pack lunch or snacks to be sent with the resident to dialysis as needed. Therapeutic diet as ordered." A review of the physician order dated 1/28/23 and revised 2/7/23 revealed, "Hemodialysis Diagnosis: ESRD Dialysis Days and Time: MWF Pick up time: Dialysis Center: (Name). An interview was conducted on 2/5/23 at 5:15 PM with Resident #463. When asked if she takes a communication book with her to dialysis, Resident #463 stated, "Yes, there is a book that goes with me." A review of Resident #463's dialysis book on 2/5/23, evidenced a sheet missing on 1/30/23. A request for the dialysis communication sheets for Resident #463 was made on 2/7/23 at approximately 2:30 PM. On 2/7/23 at 4:49 PM, the dialysis facility faxed to the facility, their dialysis sheets related to the treatments for 1/30/23, 2/1/23, 2/3/23 and 2/6/23. An interview was conducted on 2/8/23 at 8:15 AM with LPN (licensed practical nurse) #7. When asked the purpose of the dialysis communication sheets, LPN #7, they are forms to communicate the resident's current vital signs and any other pertinent information to the dialysis facility and then they are to complete the bottom portion for us to have when the resident returns. When asked to validate the dialysis sheets in the book, LPN #7 stated, there are sheets done on 2/1/23 and 2/3/23. The dialysis treatments were ordered	F 698		

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F 698	Continued From page 157 for 1/30/23, 2/1/23, 2/3/23 and 2/6/23. When LPN #7 was asked if all the communication sheets were present, she stated, no they are not. Two are missing. On 2/7/23 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the findings. A review of the facility's dialysis contract with the facility which revealed, "Collaboration of Care: both parties shall ensure that there is documented evidence of collaboration of care and communication between the nursing facility and ESRD dialysis unit. Documentation shall include, but not be limited to, participation in care conferences, and care plan." A review of the facility's "Hemodialysis" policy dated 11/1/19, revealed, "The Dialysis Communication Form will be initiated prior to sending patient for dialysis." No further information was provided prior to exit. 2. For Resident #127, the facility failed to ensure there was ongoing communication with the dialysis facility for 3 out of 9 visits in January-February 2023, on the dates of 1/24/23, 2/2/23 and 2/7/23. Resident #127 was admitted to the facility on 1/18/23 with diagnoses that included but were not limited to: ESRD (end stage renal disease). The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 1/30/23,	F 698		

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F 698	Continued From page 158 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. A review of Section O-Special Procedures coded dialysis-yes. A review of the comprehensive care plan dated 1/18/23, revealed, "FOCUS: the resident is at increased risk for complications secondary to requiring hemodialysis due to ESRD. INTERVENTIONS: Assess Bruit and Thrill every shift. DIALYSIS DAYS: (SPECIFY DAYS). DIALYSIS CENTER: (SPECIFY CENTER NAME). Dialysis Vascular Access (Specify fistula, graft or central venous catheter and location). Do not use (SPECIFY SIDE) arm for vitals. Hold Medications on dialysis days if ordered by physician. Labs and Diagnostics as ordered. Observe for signs and symptoms of bleeding or bruising related to anticoagulation use during dialysis. Observe for signs and symptoms of complications related to ESRD including but not limited to fluid overload, hemorrhage, infection to the access site, hypotension, respiratory and/ or cardiac distress and notify MD as indicated. Pack lunch or snacks to be sent with the resident to dialysis as needed. Therapeutic diet as ordered treatment as ordered to fistula site." A review of the physician order dated 1/20/23 revealed, "Hemodialysis Diagnosis: ESRD Dialysis Days and Time: Tues, Thurs, Saturday Pick up time:10 am Dialysis Center: (Name)." An interview was conducted on 2/5/23 at 5:00 PM with Resident #127. When asked if she takes a communication book with her to dialysis, Resident #127 stated, "Yes, a book goes with me. I believe it is at the nurse's station."	F 698		

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F 698	Continued From page 159 A review of Resident #127's dialysis book on 2/5/23, evidenced sheets missing on 1/24/23 and 2/2/23. A request for the dialysis communication sheets for Resident #127 was made on 2/7/23 at approximately 2:30 PM. On 2/7/23 the facility was faxed at 3:21 PM dialysis communication sheets for 1/24/23 and 2/2/23. On 2/7/23 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the findings. When asked who faxed the forms, ASM #2, the director, stated, they came from the dialysis center. When asked why these two forms would have been removed from the communication book, ASM #2 stated, sometimes the dialysis center just does that. An interview was conducted on 2/8/23 at 8:15 AM with LPN (licensed practical nurse) #7. When asked the purpose of the dialysis communication sheets, LPN #7, they are forms to communicate the resident's current vital signs and any other pertinent information to the dialysis facility and then they are to complete the bottom portion for us to have when the resident returns. When asked to validate the dialysis sheets in the book, LPN #7 stated, there are sheets done on 1/19/23, 1/21/23, 1/26/23, 1/28/23, 1/31/23 and 2/4/23. The dialysis treatments were ordered for 1/19/23, 1/21/23, 1/24/23, 1/26/23, 1/28/23, 1/31/23, 2/2/23, 2/4/23 and 2/7/23. When LPN #7 was asked if all the communication sheets were present, she stated, no they are not. Three are	F 698		

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F 698	Continued From page 160 missing for the dates of 1/24/23, 2/2/23 and 2/7/23. The faxed sheets for dates 1/24/23 and 2/2/23 were not in the communication book. A review of the facility's dialysis contract with the facility which revealed, "Collaboration of Care: both parties shall ensure that there is documented evidence of collaboration of care and communication between the nursing facility and ESRD dialysis unit. Documentation shall include, but not be limited to, participation in care conferences, and care plan." A review of the facility's "Hemodialysis" policy dated 11/1/19, revealed, "The Dialysis Communication Form will be initiated prior to sending patient for dialysis." No further information was provided prior to exit.	F 698		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 700		3/21/23

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F 700	Continued From page 161 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to implement side rail safety procedures for one of 58 residents in the survey sample, Resident #363. The findings include: For Resident #363 (R363), the facility staff to assess a resident for the use of side rails, educate the resident regarding the risks and benefits of using side rails, and obtain consent from the resident for the use of side rails. On 2/5/23 at 3:14 p.m. and 2/6/23 at 8:12 a.m., R363 was sitting up in bed with eyes closed. Quarter side rails were up on both sides of the resident's bed. A review of R363's admission assessment dated 2/2/23 revealed, in part: "Does the resident need bed rails for positioning and/or rising from supine to sitting/standing position as mobility enabler? No. Bed rails are: Not indicated as a mobility enabler at this time. Are bed rails a resident/resident representative preference? No." Further review of R363's clinical record failed to reveal any additional information regarding the resident's use of side rails, including informed consent.	F 700	F700 Bed Rails- 1-The bed rail assessment and consent for resident #363 was completed. 2-All current residents with side rails have the potential to be affected. The DON, or designee will audit residents with bed rails in place to ensure that the bed rail assessment was completed. 3-The ADON, or designee will educate all licensed nurses on the process for assessing the need for bed rails and providing the documented assessment and obtaining consent for the use of side rails as needed. 4-The Unit Managers or designee will conduct weekly audits x 8 weeks, monthly x2 of residents with bed rails to verify proper assessment and that consent is obtained and documented. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

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F 700	Continued From page 162 On 2/8/23 at 8:18 a.m., LPN (licensed practical nurse) #2 was interviewed. She stated for a resident to use side rails, it is the staff's responsibility to make sure they are needed for positioning and mobility. She stated the admitting nurse does an assessment as a part of the admission process. If the admitting nurse determines that the resident needs the side rails, or if the resident or family members ask for side rails, the admitting nurse sends a recommendation to the physical therapists, who complete a recommendation separately. She stated if physical therapy signs off on the use of side rails, the nurse responsible for the resident that day contacts maintenance and asks them to install side rails. She stated a resident must be educated on the risks and benefits of the side rails, and must sign an informed consent prior to the side rails being placed on the bed for the resident to use. On 2/7/23 at 5:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. A review of the facility policy, "Device Assessment/Bed Safety," revealed, in part: "The Device Assessment will be completed to provide documentation of the needs, and risk factors involved in the use of a restraint or device by the patient." No further information was provided prior to exit.	F 700		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2)	F 710		3/21/23

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F 710	Continued From page 163 §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation, and clinical record review, the facility physician failed to initiate orders for a medication in a timely manner for one of six residents in the medication administration observation, Resident #416. The findings include: For Resident #416, the facility physician failed to order Pancreaze (1) until 2/3/23. The resident was admitted to the facility on 1/31/23. On R416's admission assessment dated 1/31/23, the resident was assessed to be cognitively intact, and oriented to person, place, time, and situation. A review of R416's diagnoses revealed the resident had part of the pancreas surgically	F 710	F710 Resident Care Supervised by a Physician 1-Resident #416 was discharged. 2-All current residents have the potential to be affected. The DON, or designee will review newly admitted residents to ensure that medications are ordered timely and available for administration. 3-The DON or designee will educate all licensed nurses on the process for ordering medications timely and the process for obtaining medications for administration. 4-The Unit Managers or designee will conduct weekly audits x 8 weeks, then monthly x2 to verify medications are available for administration and ordered timely.	

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F 710	Continued From page 164 removed prior to admission to the facility. On 2/4/23 at 9:02 a.m. during the medication administration observation, LPN (licensed practical nurse) #11 was observed preparing medications to administer to R416. LPN #11 stated: "His Pancreaze is not in the cart." She stated she had been told there was a problem with the resident's insurance coverage, and the pharmacy would not send the medication to the facility without verification of payment. At 9:16 a.m., ASM (administrative staff member) #6, who was R416's attending physician, approached LPN #11. LPN #11 told ASM #6 that R416 had not received any of the Pancreaze because of insurance coverage issues. ASM #6 stated: "That is his lifesaving medication. He cannot digest his food without it." On 2/7/23 at 3:15 p.m., R416 was sitting up in bed. He stated that day (2/7/23) he had received his first dose of Pancreaze since arriving at the facility. He stated: "At lunchtime, the nurse came in and showed me the bottle. She said the pharmacy just delivered it." When asked what happens without the Pancreaze, he stated he has orange, oily, strong, and foul-smelling stools. He stated: "My body can't digest the food." A review of R416's physician's orders revealed the following order dated 2/3/23: "Pancreaze Oral Capsule Delayed Release Particles...4200 - 14200 UNIT...Give 1 capsule by mouth with meals for pancreatic insufficiency." A review of pharmacy receipts for R416 revealed the medication was not delivered to the facility from the pharmacy until 2/7/23.	F 710	5- Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

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F 710	Continued From page 165 On 2/8/23 at 8:07 a.m., ASM #6 was interviewed. When asked if he was aware R416 had not received Pancreaze until lunchtime on 2/7/23, he stated: "The nurse called me. They could not understand the order." He added: "This resident has a history of [name of a surgical procedure to remove part of the pancreas]." When asked the process he follows for ordering medications for residents, he stated: "The nurses are the ones who review the medications. If they have a question, they will call me." When asked if he received a phone call regarding R416's Pancreaze, he stated: "I don't remember whether they called me or not." On 2/8/23 at 11:24 a.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. A review of the facility policy, "History and Physical," revealed, in part: "A Physician's Admission Medical Care Plan (History and Physical) must be provided at the time of admission, or within 48 hours after admission. The admission medical plan of care is to be prescribed and signed by the attending physician...The complete medical plan of care is to include at a minimum: 1) Primary diagnosis; 2) Identification of patient problems; 3) Medical history and physical exam; 4) Orders for medications." No further information was provided prior to exit. (1) Pancrelipase delayed-release capsules (Creon, Pancreaze, Pertzye, Ultresa, Zenpep) are used to improve digestion of food in children and	F 710		

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F 710	Continued From page 166 adults who do not have enough pancreatic enzymes (substances needed to break down food so it can be digested) because they have a condition that affects the pancreas (a gland that produces several important substances including enzymes needed to digest food)...Pancrelipase delayed-release capsules (Creon) are also used to improve digestion in people who have had surgery to remove all or part of the pancreas or stomach." This information was taken from the website https://medlineplus.gov/druginfo/meds/a604035.html.	F 710		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by:	F 712		3/21/23

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F 712	Continued From page 167 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure timely physician visits for one of 58 residents in the survey sample; Resident #67. The findings include: For Resident #67, there were no physician visits for 125 days. A review of the clinical record for physicians visits for the last 6 months revealed physician visits dated 8/3/22, 8/5/22, 8/25/22 and 10/6/22. Up to the survey review on 2/7/23, there had been no further physicians visits identified in the clinical record, for a total of 125 days without a physician's visit. On 2/7/23 at 5:00 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator ASM #2 the interim Director of Nursing, and ASM #3 the Regional Director of Clinical Services, were made aware of the findings and it was requested to see if there were any visit notes located anywhere else that had not been added to the electronic health record. On 2/8/23 at 9:20 AM an interview was conducted with ASM #4, the Nurse Practitioner. She stated that Resident #67 was on the list to be seen again on 2/9/23. She stated that she is provided a list on who needs to be seen. She stated she was not sure where the list comes from; just that she goes by the list and sends it to the physician. She stated that the physician / nurse practitioner documents in the facility's electronic health record system and does not use a separate system, so there would not be any other notes anywhere	F 712	F712 Physician Visits-Frequency/Timeliness/Alternate NPPs 1- Resident #67 was seen by the Provider as required. 2-All current residents have the potential to be affected. The Medical Records director, or designee will complete an audit to ensure residents have been seen by the Provider, as required. 3-The Administrator, or designee will educate the medical staff on the requirements for resident visits. 4-The Medical Records staff will conduct weekly monthly audits x2 to verify all residents receive a therapeutic visit from their physician as required. 5 Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495391		C 02/08/2023

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F 712	Continued From page 168 else. When asked how often a resident is to be seen, she said every 90 days. She stated that it is believed the resident was missed being added to the list for the previous required visit, which she believed was to be January 2023 for a 90 day visit. The resident should have been seen approximately December 6, 2022, as the requirement was for every 60 days. On 2/8/23 at 10:30 AM an interview was conducted with RN #1 (Registered Nurse), the Assistant Director of Nursing. When asked who tracks physicians visits to ensure they are timely, she stated that the physicians print their own lists and track who they need to see, themselves. She stated that the physicians see residents according to if there is a new admission, a recertification, or a change of condition. She stated that the facility does not know who the physicians are seeing unless there is a change of condition or a new admission. When asked how often are residents to be seen, she stated it is at the discretion of the provider. When asked if the residents are to be seen every 60 days, is there no one tracking that, she stated the providers track it themselves. A review was conducted of the facility policy "Physician Documentation" policy #2304 dated 11/1/19, "1. Physician visits with a corresponding progress note must be complete at least monthly for the first 90 days of the patient stay and every 60 days thereafter. 2. After the initial physician visit, a qualified nurse practitioner or physician assistant may make every other required visit in accordance with state law." On 2/8/23 at 11:30 AM, ASM #1, ASM #2, and ASM #3 were made aware of the findings. No	F 712		

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F 712	Continued From page 169 further information was provided by the end of the survey.	F 712		
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 an RN (registered nurse) was on duty on one of 31 days reviewed. The findings include: The facility staff failed to ensure an RN was on duty at least eight consecutive hours on 01/05/2023. On 02/07/2023 at approximately 3:25 p.m., a review of the facility's "As worked schedule" dated 01/01/2023 through 01/31/2023 was conducted with CNA (certified nursing assistant) #4, staffing coordinator. The review revealed that on 01/05/2023, the facility failed to maintain	F 727	F727 RN 8 hrs./7days week Full time DON 1-The facility is ensuring that RN hour coverage is being provided as required. 2-The DON, or designee will review the current schedule to ensure that RN coverage is being provided as required. 3-The DON or designee will educate the staffing coordinator and Nursing Leadership team on the process for having an RN in the building 7 days a week 8 hours a day. 4-The DON/Administrator or designee will conduct weekly audits x 8 weeks, then monthly x2 to verify that adequate RN coverage is provided 5- Results of the audits will be presented	3/21/23

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F 727	Continued From page 170 registered nurse coverage for a 24-hour period. When asked about the lack of eight hours of RN coverage on 01/05/2023, CNA #4 stated it was an oversight in scheduling. On 02/08/2023 at approximately 10:30 a.m., ASM (administrative staff member) #1, administrator, was made aware of the above findings. No further information was provided prior to exit.	F 727	to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and employee record review it was determined that the facility staff failed to ensure CNAs (certified nursing assistants) received annual performance reviews for five of five CNA records reviewed. The findings include: On 02/07/2023 a record review was conducted of the annual performance reviews of five CNAs. This review failed to evidence annual performance reviews for the following CNAs: 1. CNA #1 - hire date 01/01/2020, no evidence of performance review between 01/01/2021 and 01/01/2022.	F 730	F730 Nurse Aide Perform review 1-Staff members #1, #6. #8. #9 and #10 have a Performance evaluation completed. 2--All CNA team members have the potential to be affected. An audit will be completed, by HR to ensure annual performance evaluations have been completed. 3-The Administrator or designee will provide in-service education to Administrative Nurses on the requirement for timely Performacny evaluations. 4-The Human Resources staff member or designee will conduct weekly audits x 8 weeks, then monthly x2 to ensure team	3/21/23

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F 730	Continued From page 171 2. CNA #6 - hire date 01/01/2020, no evidence of performance review between 01/01/2021 and 01/01/2022. 3. CNA #8- hire date 01/01/2020, no evidence of performance review between 01/01/2021 and 01/01/2022. 4. CNA #9- hire date 01/01/2020, no evidence of performance review between 01/01/2021 and 01/01/2022. 5. CNA #10- hire date 01/20/2020, no evidence of performance review between 01/20/2021 and 01/20/2022. On 02/08/2023 at approximately 4:10 p.m. an interview was conducted with OSM (other staff member) #10, human resource director. When asked for the competency reviews for the CNAs listed above OSM #10 stated that they did not have the competency reviews and where unable to locate them. When asked to describe the procedure for the competency reviews OSM #10 stated that the reviews are conducted by the unit managers with the CNA's hire date as the anniversary date for completing the competency reviews then are sent to human resource office to be filed. The facility's policy "Performance Appraisal" documented in part, "Generally, all employees will receive a performance appraisal around ninety (90) days of employment and annually thereafter. This includes Full-time, Part-time, Casual, and PRN." On 02/08/2023 at approximately 10:30 a.m., ASM (administrative staff member) #1, administrator, was made aware of the above findings. No further information was provided prior to exit.	F 730	members receive performance evaluations timely. 5 Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Completion date 3/21/23	

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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 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 732		3/21/23

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F 732	Continued From page 173 by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to display the daily nurse staffing information on one of four days. The findings include: The facility staff failed to display the nurse staffing on 02/05/2023 and failed to display the nurse staffing on 02/06/2023 prior to the beginning of the shift. On 02/05/2023 at 1:30 p.m., observation of the facility's lobby area, Linden Unit nurse's station and immediate surrounding area, and the Bradford Unit and immediate surrounding area, failed to evidence the facility's staff posting. On 02/05/2023 at 5:30 p.m., observation of the facility's lobby area, Linden Unit nurse's station and immediate surrounding area, and the Bradford Unit and immediate surrounding area, failed to evidence the facility's staff posting. On 02/06/2023 at 8:30 a.m., observation of the facility's lobby area, Linden Unit nurse's station and immediate surrounding area, and the Bradford Unit and immediate surrounding area, failed to evidence the facility's staff posting. On 02/07/2023 at approximately 3:30 p.m., an interview was conducted with CNA #4, staffing coordinator. When asked about the procedure for posting the daily nurse staffing information CNA #4 stated they place the staffing sheet in a frame on the facility's receptionist desk in the front lobby of the facility each morning by 8:00 a.m. Monday through Friday. When asked who	F 732	F732 Posted Nurse Staffing Daily staffing not posted on entrance (weekend) 1-Nursing Staffing hours are now being posted daily as required. 2-The Administrative Nurses or designee will educate the staff coordinator and Department Heads on the importance of posting the staffing schedule daily to include weekends. 3-The MOD will ensure that the staff posting is current on each weekend day. 4-The ADON or designee will conduct daily audits on weekdays X 4 weeks, weekly X 4 weeks and daily X 1 month for verification of the staffing schedule posting. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation he Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6-Date of Compliance: 3/21/23	

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F 732	Continued From page 174 was responsible for displaying the staff posting on Saturdays and Sundays CNA #4 stated it is put out by the receptionist and added that the facility did not have a permanent receptionist. When informed of the observations stated above CNA #4 stated that the receptionist probably did not know they were supposed to display the staff posting on Sunday and that they didn't get the staff posting displayed until 11:00 a.m. on Monday. When asked what time the staff posting should be displayed CNA #4 stated that it should be displayed at the beginning of the shift. The facility's policy "Daily Nurse Staffing Report Summary" documented in part, "The MFA Daily Nurse Staffing Summary must be initiated each morning. 2. The Center name, current date and the first shift census and staffing information should be completed posted at the beginning of each shift. The staffing data must reflect those nursing individuals who are directly responsible for patient care during the shift i.e., registered nurses, licensed practical nurses and certified nurse aids. Identify the total number of staff working per category per shift and the actual number of hours worked per category per shift." On 02/08/2023 at approximately 10:30 a.m., ASM (administrative staff member) #1, administrator, was made aware of the above findings. No further information was provided prior to exit.	F 732		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		3/21/23

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F 755	Continued From page 175 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, responsible party interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure that medications were available for administration for six of 58 residents in the survey sample, Residents #6, #77, #114, #112, #118, #365 and for one of six residents in the medication administration observation, Resident	F 755	F755 Pharmacy Services/Procedures/Pharmacist/Records □ 1-Residents #6, #114, #112, #118, #416 and #365 were discharged. Resident #77 has medications available for administration. 2-All current residents have the potential to be affected. The medication carts will	

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F 755	Continued From page 176 #416. The findings include: 1. For Resident #6, (R6), the facility staff failed to ensure Piperacillin-Tazobactam, an antibiotic, was acquired from the pharmacy for administration in a timely manner. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/11/2022, the resident scored one out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. On 2/5/2023 at 4:38 p.m., an interview was conducted with R6's responsible party (RP). The RP voiced concerns regarding the lack of consistent communication with facility staff regarding R6's care. R6's RP stated that the resident had missed multiple doses of their antibiotic that was ordered in January of 2023. The physician orders for R6 documented in part, - "Piperacillin-Tazobactam (antibiotic) in Dex (dextrose) Solution 2-0.25 GM (gram)/50ML (milliliter). Use 2.25 gram intravenously every 8 hours for infection for 7 days start PIV (peripheral intravenous access). Order Date: 01/20/2023. Start Date: 01/20/2023. End Date: 01/25/2023." The progress notes for R6 documented in part, - "1/20/2023 22:23 (10:23 p.m.) Piperacillin-Tazobactam in Dex Solution 2-0.25 GM/50ML, Use 2.25 gram intravenously every 8 hours for infection for 7 Days start PIV. Awaiting arrival from pharmacy."	F 755	be audited by the Unit Manager or designee to verify that all ordered medications are available for administration. 3-The ADON or designee will educate all licensed nurses on the process for obtaining meds and completing refills for medications, notifying the MD if a medication is not available and documentation of medication administration in the clinical record. 4-The Unit Managers or designee will conduct weekly audits x 8 weeks, then monthly x 2 to ensure residents rare receiving their medications as ordered. Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5-Date of Compliance: 3/21/23	

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F 755	Continued From page 177 - "1/21/2023 06:34 (6:34 a.m.) Piperacillin-Tazobactam in Dex Solution 2-0.25 GM/50ML, Use 2.25 gram intravenously every 8 hours for infection for 7 Days start PIV. On order." Review of the eMAR (electronic medication administration record) for R6 dated 1/1/2023-1/31/2023 documented in part, "Piperacillin-Tazobactam in Dex Solution 2-0.25 GM/50ML, Use 2.25 gram intravenously every 8 hours for infection for 7 Days start PIV. Order Date: 01/20/2023 1404 (2:04 p.m.) D/C (discontinue) date: 01/25/2023 1500 (3:00 p.m.)." The eMAR documented the first dose of the antibiotic administered on 1/21/2023 at 2:00 p.m. On 2/7/2023 at 12:30 p.m., the facility provided a document listing the available medications in the facility Omnicell (automated dispensing system) which failed to evidence stock of the ordered Piperacillin-Tazobactam. On 2/8/2023 at 8:17 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that when they get an order for medications they entered it into the computer and it went directly to the pharmacy to be processed. LPN #2 stated that it depended on the time that it was ordered as to when it would be filled because the pharmacy had a window. LPN #2 stated that they thought that if a medication was ordered prior to 3:00 p.m. it would come on the 9:00 p.m. pharmacy delivery. LPN #2 stated that the medication did not always come when they were supposed to and the nursing staff have to call the pharmacy often. LPN #2 reviewed R6's eMAR dated 1/1/2023-1/31/2023 which documented the 1/20/2023 10:00 p.m. and 1/21/2023 6:00 a.m.	F 755		

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F 755	Continued From page 178 doses not administered due to the medication not being available from pharmacy and stated that they understood that R6 missed multiple doses of their antibiotic due to pharmacy and IV access issues and saw the concern. On 2/8/2023 at 9:20 a.m., an interview was conducted with LPN #1. LPN #1 stated that if there were no medications for a resident they would check the medication cart first and other carts, the check the Omnicell to see if available. LPN #1 stated that they would call the pharmacy and notify the physician and the resident and/or the responsible party and document that the medication was not available. On 2/8/2023 at approximately 11:30 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit. 2. For Resident #77 (R77), the facility staff failed to ensure that Gabapentin (1) was available for administration as ordered. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/24/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section J documented R77 receiving scheduled pain medications and not having any pain during the assessment period. On 2/5/2023 at 4:13 p.m., an interview was	F 755		

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F 755	Continued From page 179 conducted with R77 in their room. R77 stated that there were times when they did not receive their scheduled Gabapentin because the facility ran out. R77 stated that the nurses would tell them that they had run out and the pharmacy had not delivered the medication. R77 stated that they took the Gabapentin for neuropathy and had pain in their hands often. R77 stated that they needed their Gabapentin three times a day and the facility should have something in place to not run out of medications. R77 stated that they normally had to wait until the next day to get the medication from pharmacy. The physician orders for R77 documented in part, "Gabapentin capsule 100 mg (milligram), give 1 capsule by mouth two times a day for neuropathic pain. Order Date: 08/11/2022. Start Date: 08/11/2022..." The orders further documented, "Gabapentin capsule 100 mg, give 3 capsule by mouth at bedtime for neuropathic pain. Order Date: 08/11/2022. Start Date: 08/11/2022..." Review of the eMAR (electronic medication administration record) for R77 for 11/1/2022-11/30/2022 and 12/1/2022-12/31/2022 failed to evidence administration of the Gabapentin on 11/3/2022 at 9:00 p.m., 11/5/2022 at 9:00 a.m., 11/23/2022 at 5:00 p.m., 11/28/2022 at 9:00 p.m., and 12/11/2022 at 9:00 a.m. and 5:00 p.m. The progress notes for R77 documented in part, - "11/5/2022 09:47 (9:47 a.m.) Note Text: Gabapentin Capsule 100 MG Give 1 capsule by mouth two times a day for neuropathic pain. on order." - "11/28/2022 22:54 (10:54 p.m.) Note Text: Gabapentin Capsule 100 MG Give 3 capsule by	F 755		

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F 755	Continued From page 180 mouth at bedtime for neuropathic pain. Only two capsule in supply 2 given." - "12/11/2022 08:03 (8:03 a.m.) Note Text: Gabapentin Capsule 100 MG Give 1 capsule by mouth two times a day for neuropathic pain. Awaiting delivery from pharmacy." - "12/11/2022 21:04 (9:04 p.m.) Note Text: Gabapentin Capsule 100 MG Give 1 capsule by mouth two times a day for neuropathic pain. On way from pharmacy." On 2/8/2023 at 8:17 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that when they get an order for medications they entered it into the computer and it went directly to the pharmacy to be processed. LPN #2 stated that it depended on the time that it was ordered as to when it would be filled because the pharmacy had a window. LPN #2 stated that they thought that if a medication was ordered prior to 3:00 p.m. it would come on the 9:00 p.m. pharmacy delivery. LPN #2 stated that the medication do not always come when they were supposed to and the nursing staff have to call the pharmacy often. LPN #2 stated that they had recently switched to a new pharmacy and had the Omnicell (automated medication dispensing system) in place for about 2 months now. LPN #2 stated that prior to that they had some emergency medications in a box but mostly had to wait for pharmacy to bring the medications in. On 2/8/2023 at 9:20 a.m., an interview was conducted with LPN #1. LPN #1 stated that if there were no medications for a resident they would check the medication cart first and other carts, the check the Omnicell to see if available. LPN #1 stated that they would call the pharmacy and notify the physician and the resident and/or	F 755		

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F 755	Continued From page 181 the responsible party and document that the medication was not available. On 2/8/2023 at 11:23 a.m., ASM (administrative staff member) #3, the regional director of clinical services stated they had contracted with another pharmacy until 12/15/2022 and then switched to the current pharmacy. ASM #3 provided a partial list of medications of in-house medication available prior to 12/15/2022 and stated that was all they were able to provide. Review of the list provided failed to evidence Gabapentin 100mg. On 2/8/2023 at approximately 11:30 a.m., ASM #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit. Reference: (1) Gabapentin Gabapentin capsules, tablets, and oral solution are used along with other medications to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles). Gabapentin extended-release tablets (Horizant) are used to treat restless legs syndrome (RLS; a condition that causes discomfort in the legs and a strong urge to move the legs, especially at night and when sitting or lying down). Gabapentin is in a class of medications called anticonvulsants. Gabapentin treats seizures by decreasing abnormal excitement in the brain. Gabapentin relieves the pain of PHN by changing the way the	F 755		

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F 755	Continued From page 182 body senses pain. It is not known exactly how Gabapentin works to treat restless legs syndrome. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694007.html 3. For Resident #114 (R114), the facility staff failed to administer the physician ordered medication mupirocin ointment (1) on 6/15/22 and the physician ordered medication zinc on 6/21/22. A review of R114's clinical record revealed the following physician's orders: -6/10/22-mupirocin ointment 2%- apply to sacrum/buttocks rash two times a day for ten days (scheduled at 9:00 a.m. and 9:00 p.m.) -6/21/22 (12:32 a.m.)-zinc sulfate 220 mg (milligrams)- 1 capsule by mouth one time a day for 14 days for COVID (scheduled at 9:00 a.m.) A review of R114's June 2022 MAR (medication administration record) and June 2022 TAR (treatment administration record) failed to reveal evidence that mupirocin was administered on 6/15/22 at 9:00 p.m. and zinc sulfate was administered on 6/21/22 at 9:00 a.m. (as evidenced by blank spaces on the MAR and TAR). On 2/7/23 at 12:00 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated when nurses receive a physician's order, they should put the order into the computer system for the pharmacy, wait a little bit for the pharmacy to see the order then contact the pharmacy to send the medication STAT (immediately) if the medication cannot be pulled from the Omnicell (a general supply of	F 755		

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F 755	Continued From page 183 medications in the facility that can be used if needed). On 2/8/23 at 8:31 a.m., an interview was conducted with LPN #2. LPN #2 stated nurses evidence medication administration by signing off on the MAR. LPN #2 stated if a medication has not been documented as being given or signed off on then you can say the medication hasn't been given. On 2/8/23 at 9:50 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility contracted with a different pharmacy in June 2022 and did not use an Omnicell. ASM #1 and ASM #2 could not provide a list for the STAT box (another general supply of medications) used during that time period. Reference: (1) Mupirocin ointment is an antibiotic used to treat skin infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a688004.html 4. For Resident #112 (R112), the facility staff failed to obtain and administer the physician ordered antibiotic, ceftriaxone sodium (1), on 1/26/23. A review of R112's clinical record revealed a physician's order dated 1/12/23 for ceftriaxone sodium solution reconstituted 2 grams intravenously every 24 hours for infection for 25 Days. A review of R112's January 2023 MAR (medication administration record) failed to reveal	F 755		

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F 755	Continued From page 184 evidence that ceftriaxone sodium was administered to the resident on 1/26/23. A nurse's note dated 1/26/23 documented, "On order." Further review of R112's clinical record (including progress notes and the January 2023 MAR) failed to reveal the scheduled dose was given. (Ceftriaxone sodium 2 grams dose was not available in the Omnicell [a general supply of medications in the facility that can be used if needed]). On 2/7/23 at 12:00 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated nurses should contact the pharmacy to send a medication STAT (immediately) if the medication cannot be pulled from the Omnicell. LPN #3 stated if nurses document they are waiting for a medication from the pharmacy, then the nurses should document if the medication is received and administered. On 2/7/23 at 5:02 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. Reference: (1) Ceftriaxone sodium is used to treat infection. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a685032.html 5. For Resident #118 (R118), the facility staff failed to administer the physician ordered medication gabapentin (1) on 11/5/21. A review of R118's clinical record revealed a physician's order dated 11/5/21 (2:42 p.m.) for gabapentin 100 mg (milligrams)- 1 capsule by	F 755		

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F 755	Continued From page 185 mouth three times a day for right hip osteoarthritis. The medication was scheduled at 6:00 a.m., 2:00 p.m. and 10:00 p.m. A review of R118's November 2021 MAR (medication administration record) failed to reveal the medication was administered on 11/5/21 at 10:00 p.m. A nurse's note dated 11/5/21 documented, "Awaiting order from pharmacy." Further review of R118's clinical record (including progress notes and the November 2021 MAR) failed to reveal the scheduled dose was given. On 2/7/23 at 12:00 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated when nurses receive a physician's order, they should put the order into the computer system for the pharmacy, wait a little bit for the pharmacy to see the order then contact the pharmacy to send the medication STAT (immediately) if the medication cannot be pulled from the Omnicell (a general supply of medications in the facility that can be used if needed). On 2/7/23 at 5:02 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility contracted with a different pharmacy in 2021 and did not use an Omnicell. ASM #1 and ASM #2 could not provide a list for the STAT box (another general supply of medications) used during that time period. Reference: (1) Gabapentin is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694007.html 5. For Resident #365 (R365), the facility staff	F 755		

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F 755	Continued From page 186 failed to ensure Doxycycline (an antibiotic), Mycophenolate Mofetil (an anti-rejection medication for organ transplant), Pramipexole (medication for restless legs), Tacrolimus (an anti-rejection medication for organ transplant), and Cefepime (an intravenous antibiotic) were available for administration. On R365's admission assessment dated 1/31/23, the resident was assessed to be cognitively intact, and oriented to person, place, time, and situation. On 2/6/23 at 8:29 a.m., R365 expressed disappointment in what the facility promised prior to admission, and what the facility actually delivered regarding medication. The resident stated: "I have just received a brand new kidney, and I have a terrible infection in a wound in my belly." The resident expressed fear that the infection would increase the chance that their body would reject the kidney. The resident stated before admission, the admission coordinator "promised me" that the facility would have all the anti-rejection drugs needed by the time the resident arrived at the facility. R365 stated: "This turned out to not be true at all." R365 stated it took "a day or two" for the anti-rejection medications to arrive. R365 stated: "I think the antibiotics were slow to come, too." A review of R365's progress notes revealed, in part: "1/31/2023 22:01 (10:01 p.m.) Orders - Administration Note Text: Doxycycline Hyclate Oral Tablet 100 MG (milligrams) Give 1 tablet by mouth two times a day for infection for 10 Days Take with at least 8 ounces of water, do not lie down for 30 minutes after. Awaiting on	F 755		

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F 755	Continued From page 187 medication." "1/31/2023 22:02 (10:02 p.m.) Orders - Administration Note Text: Mycophenolate Mofetil Oral Capsule 250 MG Give 3 tablet by mouth two times a day for Kidney Disorders. Awaiting on medication." "1/31/2023 22:03 (10:03 p.m.) Orders - Administration Note Text: Pramipexole Dihydrochloride Oral Tablet 0.5 MG Give 1 tablet by mouth every 8 hours for Restless legs. Awaiting on medication." "1/31/2023 22:03 (10:03 p.m.) Orders - Administration Note Text: Tacrolimus Oral Capsule Give 1 capsule by mouth two times a day for Infection. Awaiting on medication." "2/2/2023 06:48 (6:48 a.m.) Orders - Administration Note Text: Cefepime HCl Solution 2 GM/100ML (grams per 100 milliliter) Use 2 gram intravenously every 8 hours for pseudomonas infection until 02/05/2023 23:59 (11:59 p.m.) Called pharmacy spoke with [name of pharmacy employee) will called (sic) local pharmacy for delivery." On 2/7/23 at 5:05 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. On 2/8/23 at 8:18 a.m., LPN (licensed practical nurse) #2, a unit manager, was interviewed. She stated it can be difficult to get all the medications a newly admitted resident needs from the pharmacy. She stated: "Sometimes you just have to get on the phone. Sometimes they have to	F 755		

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F 755	Continued From page 188 make a separate pharmacy run, or you have to get the medicine from a local pharmacy." She stated residents should be given medications prescribed for them when they are due. 6. For #416 (R416), the facility staff failed to ensure Pancreaze (1) was available for administration from 2/3/23 through 2/6/23. On R416's admission assessment dated 1/31/23, the resident was assessed to be cognitively intact, and oriented to person, place, time, and situation. A review of R416's diagnoses revealed the resident had part of the pancreas surgically removed prior to admission to the facility. On 2/4/23 at 9:02 a.m. during the medication administration observation, LPN (licensed practical nurse) #11 was observed preparing medications to administer to R416. LPN #11 stated: "His Pancreaze is not in the cart." She stated she had been told there was a problem with the resident's insurance coverage, and the pharmacy would not send the medication to the facility without verification of payment. At 9:16 a.m., ASM (administrative staff member) #6, who was R416's attending physician), approached LPN #11. LPN #11 told ASM #6 that R416 had not received any of the Pancreaze because of insurance issues. ASM #6 stated: "That is his lifesaving medication. He cannot digest his food without it." LPN #11 stated she would see what needed to be done to get the medication in the building for the resident. On 2/7/23 at 3:15 p.m., R416 was sitting up in bed. He stated that day (2/7/23) he had received his first dose of Pancreaze since arriving at the facility. He stated: "At lunchtime, the nurse came	F 755		

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F 755	Continued From page 189 in and showed me the bottle. She said the pharmacy just delivered it." When asked what happens without the Pancreaze, he stated he has orange, oily, strong, and foul-smelling stools. He stated: "My body can't digest the food." A review of R416's physician's orders revealed the following order dated 2/3/23: "Pancreaze Oral Capsule Delayed Release Particles...4200 - 14200 UNIT...Give 1 capsule by mouth with meals for pancreatic insufficiency." A review of R416's February 2023 MAR (medication administration record) revealed the medication was signed off as given on 2/4/23 (all three doses), 2/5/34 at 5:00 p.m., and 2/6/23 (5:00 p.m.). The medication was documented as not given on 2/5/23 at 8:00 a.m., and 12:00 p.m., and 2/6/23 at 8:00 a.m. and 12:00 noon. A review of pharmacy receipts for R416 revealed the medication was not delivered to the facility from the pharmacy until 2/7/23. On 2/7/23 at 5:05 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. On 2/8/23 at 10:52 a.m., ASM #3 stated she had just spoken to the pharmacy. She stated the pharmacy was taking responsibility for not getting the Pancreaze to R416 in a timely manner. She stated: "The delay in getting the medication was an error on their part." No further information was provided prior to exit. (1) Pancrelipase delayed-release capsules	F 755		

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F 755	Continued From page 190 (Creon, Pancreaze, Pertzye, Ultresa, Zenpep) are used to improve digestion of food in children and adults who do not have enough pancreatic enzymes (substances needed to break down food so it can be digested) because they have a condition that affects the pancreas (a gland that produces several important substances including enzymes needed to digest food)...Pancrelipase delayed-release capsules (Creon) are also used to improve digestion in people who have had surgery to remove all or part of the pancreas or stomach." This information was taken from the website https://medlineplus.gov/druginfo/meds/a604035.html.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		3/21/23

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GLENBURNIE REHAB & NURSING CENTER	1901 LIBBIE AVE RICHMOND, VA 23226

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F 756	Continued From page 191 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. 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 evidence monthly drug regimen reviews were conducted by the pharmacist for one of 58 residents in the survey sample, Resident #42. The findings include: Resident #42 was admitted to the facility on 1/20/17. Resident #42's diagnoses included but were not limited to Hepatitis A, high blood pressure, heart failure, depression, PTSD (post-traumatic stress disorder) and OCD (obsessive compulsive disorder). A review of the comprehensive care plan dated 2/2/17, revealed, "FOCUS: At risk for adverse effects related to use of anti-depression	F 756	F756 Drug Regimen Review, Report Irregular, Act On 1-The MMR was completed and reviewed by the Physician for Resident #42. 2-All current residents have the potential to be affected. The DON, or designee will obtain the MMR completed for current residents and ensure that the MMR□s are addressed appropriately. 3-The RDCS will educate all DON and Nursing Administrative Team on the process for obtaining pharmacy regimen review and ensuring that they MMR□s are addressed appropriately and timely. 4-The DON, or designee will conduct weekly audits x 8 weeks, then monthly x2 to ensure that the MMR□s completed area addressed appropriately. 5- Results of the audits will be presented to the QAPI Committee for review and	

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F 756	Continued From page 192 medication/depression/PTSD, anti-anxiety. Use of antipsychotic medication. INTERVENTIONS: Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs. Notify physician of decline in ADL ability or mood/behavior related to a dosage change. Provide patient education to risks and benefits of medications as needed. Psychiatrist consult and follow-up as needed. Reduce environmental noise/distractions to facilitate sleep. Report to physician signs of adverse reaction such as decline in mental status decline in positioning/ambulation ability, lethargy, complaints of dizziness and tremors." On 2/7/23 at 12:39 PM, during Resident #42's medication review, it was revealed that the monthly medication regimen reviews (MRR) were missing from the documentation for 2/22, 3/22, 8/22 and 9/22. On 2/08/23 the administrator provided the 3/22 and 8/22 medication regimen reviews. On 2/8/23 at 1:00 PM, ASM #1, the administrator verified there were no additional MRRs for Resident #42. On 2/7/23 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the findings. A review of the facility's "Medication Management/Medication Unavailability" policy, dated 4/21/22 which revealed, "The consultant pharmacist will provide MRR reports addressed to the Medical Director, Director of Nursing and attending physician within three (3) days of	F 756	recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6- Date of completion 3/21/23.	

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F 756	Continued From page 193 completion via secure email or hard copy." A review of the facility's "Consultant Pharmacist Services Provider Requirements" policy, dated 8/20 revealed, "Reviewing the medication regiment review (MRR) of each resident at least monthly, or more frequently under certain conditions and documenting the review and findings in the medical record or in a readily retrievable format if using electronic documentation." No further information was provided prior to exit.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to administer medications in a manner free of medication errors less than five percent to two of six residents in the medication administration observation, Residents #56 and #416. There were two errors out of 33 opportunities, resulting in a medication error rate of 6.06%. The findings include: 1. The facility staff failed to instruct Resident #56 (R56) to rinse their mouth after the administration	F 759	F759 Free of Medication error rate set 5% or More 1-Resident #416 was discharged. Resident #56 is receiving medications as ordered. LPN #11 was re-educated on proper administration of medication. 2-All current residents receiving medications have the potential to be affected by deficient practice in handwashing or medication administration. 3-The ADON,or designee will educate all licensed nurses on the process of Hand washing and education on Medication administration with inhaler use.	3/21/23

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F 759	Continued From page 194 of Breo Ellipta dry powder inhaler (1). On 2/06/23 at 8:48 a.m., LPN (licensed practical nurse) #1 prepared medications to be administered to R56. LPN #11 took the Breo Ellipta powder inhaler to R56, prepared the correct amount of medication to be delivered by the inhaler, and had the resident inhale one puff of the medication. LPN #11 took the inhaler back from the resident, and returned to the medication cart without instructing the resident to rinse their mouth with water and spit the water out. R56 did not rinse their mouth on their own. A review of R56's physician's orders revealed an order dated 9/23/22: "Breo Ellipta 100-25 MCG/INH (microgram/inhalation) Aerosol Powder, breath activated Give 1 puff by mouth one time a day for COPD (chronic obstructive pulmonary disease)." On 2/8/23 at 8:18 a.m., LPN (licensed practical nurse) #2 was interviewed. When asked what action a nurse should take after administering medication from a dry powder inhaler to a resident, she stated: "The resident has to rinse their mouth out." When asked why this is necessary, she stated: "A resident needs to have a clean mouth. They can get thrush in there." On 2/8/23 at 11:24 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. A review of the facility's medication reference book, Mosby's 2023 Nursing Drug Reference, revealed the following information under the	F 759	4-The Unit Managers or designee will conduct weekly audits of Nurses during Medication Administration to ensure that handwashing is completed as required and inhalers are administered properly. Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5- Date of completion 3/21/23.	

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F 759	Continued From page 195 heading, "Breo Ellipta: Patient should rinse mouth with water after inhalation and expectorate rinse solution." No further information was provided prior to exit. (1) "The combination of fluticasone and vilanterol is used to control wheezing, shortness of breath, coughing, and chest tightness caused by asthma and chronic obstructive pulmonary (COPD; a group of diseases that affect the lungs and airways, that includes chronic bronchitis and emphysema). Fluticasone is in a class of medications called steroids. It works by reducing swelling in the airways. Vilanterol is in a class of medications called long-acting beta-agonists (LABAs). It works by relaxing and opening air passages in the lungs, making it easier to breathe." This information is taken from the website https://medlineplus.gov/druginfo/meds/a613037.html 2. For Resident #416, the facility staff failed to administer Pancreaze (2) as ordered by the physician. On R416's admission assessment dated 1/31/23, the resident was assessed to be cognitively intact, and oriented to person, place, time, and situation. A review of R416's diagnoses revealed the resident had part of the pancreas surgically removed prior to admission to the facility. On 2/4/23 at 9:02 a.m. during the medication administration observation, LPN (licensed practical nurse) #11 was observed preparing medications to administer to R416. LPN #11	F 759		

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F 759	Continued From page 196 stated: "His Pancreaze is not in the cart." She stated she had been told there was a problem with the resident's insurance coverage, and the pharmacy would not send the medication to the facility without verification of payment. At 9:16 a.m., ASM (administrative staff member) #6, who was R416's attending physician), approached LPN #11. LPN #11 told ASM #6 that R416 had not received any of the Pancreaze because of insurance issues. ASM #6 stated: "That is his lifesaving medication. He cannot digest his food without it." LPN #11 stated she would see what needed to be done to get the medication in the building for the resident. On 2/7/23 at 3:15 p.m., R416 was sitting up in bed. He stated that day (2/7/23) he had received his first dose of Pancreaze since arriving at the facility. He stated: "At lunchtime, the nurse came in and showed me the bottle. She said the pharmacy just delivered it." When asked what happens without the Pancreaze, he stated he has orange, oily, strong, and foul-smelling stools. He stated: "My body can't digest the food." A review of R416's physician's orders revealed the following order dated 2/3/23: "Pancreaze Oral Capsule Delayed Release Particles...4200 - 14200 UNIT...Give 1 capsule by mouth with meals for pancreatic insufficiency." On 2/7/23 at 5:05 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. A review of the facility policy, "Medication Management," revealed, in part: "Nursing staff members are to reference the established	F 759		

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F 759	Continued From page 197 contracted provider's Pharmacy Services and Procedures Manual regarding medication orders, delivery, monitoring and other related processes for promoting efficiency and consistency in medication administration and standards of best practice." No further information was provided prior to exit. (2) Pancrelipase delayed-release capsules (Creon, Pancreaze, Pertzye, Ultresa, Zenpep) are used to improve digestion of food in children and adults who do not have enough pancreatic enzymes (substances needed to break down food so it can be digested) because they have a condition that affects the pancreas (a gland that produces several important substances including enzymes needed to digest food)...Pancrelipase delayed-release capsules (Creon) are also used to improve digestion in people who have had surgery to remove all or part of the pancreas or stomach." This information was taken from the website https://medlineplus.gov/druginfo/meds/a604035.html.	F 759		
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 observation, resident interview, staff interview, facility documentation, and clinical record review, the facility staff failed to prevent a significant medication error for one of six residents in the medication administration	F 760	F760 Residents are free of significant med errors. □ 1-Residents # 416 was discharged. 2-All current residents have the potential to be affected. The medication carts will	3/21/23

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F 760	Continued From page 198 observation, Resident #416. The findings include: For Resident #416, the facility staff failed to administer Pancreaze (1) during the medication administration observation on 2/4/23. On R416's admission assessment dated 1/31/23, the resident was assessed to be cognitively intact, and oriented to person, place, time, and situation. A review of R416's diagnoses revealed the resident had part of the pancreas surgically removed prior to admission to the facility. On 2/4/23 at 9:02 a.m. during the medication administration observation, LPN (licensed practical nurse) #11 was observed preparing medications to administer to R416. LPN #11 stated: "His Pancreaze is not in the cart." She stated she had been told there was a problem with the resident's insurance coverage, and the pharmacy would not send the medication to the facility without verification of payment. At 9:16 a.m., ASM (administrative staff member) #6, who was R416's attending physician), approached LPN #11. LPN #11 told ASM #6 that R416 had not received any of the Pancreaze because of insurance issues. ASM #6 stated: "That is his lifesaving medication. He cannot digest his food without it." LPN #11 stated she would see what needed to be done to get the medication in the building for the resident. On 2/7/23 at 3:15 p.m., R416 was sitting up in bed. He stated that day (2/7/23) he had received his first dose of Pancreaze since arriving at the facility. He stated: "At lunchtime, the nurse came in and showed me the bottle. She said the	F 760	be audited by the Unit Manager or designee to verify that all ordered medications are available for administration. 3-The ADON, or designee will educate all licensed nurses on the process for obtaining unavailable medication to administer per physician order, documentation requirements of medication administration. The physician and responsible party (RP) notified of weekly medication not given and/or any new orders per physician with documentation. 4-The Unit Managers or designee will conduct weekly audits x 8 weeks, then monthly x2 to verify residents have medications as ordered by MD , the MD is notified of medications not available and that medications are documented as administered. 5 Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6- Date of completion 3/21/23.	

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F 760	Continued From page 199 pharmacy just delivered it." When asked what happens without the Pancreaze, he stated he has orange, oily, strong, and foul-smelling stools. He stated: "My body can't digest the food." A review of R416's physician's orders revealed the following order dated 2/3/23: "Pancreaze Oral Capsule Delayed Release Particles...4200 - 14200 UNIT...Give 1 capsule by mouth with meals for pancreatic insufficiency." A review of R416's February 2023 MAR (medication administration record) revealed the medication was signed off as given on 2/4/23 (all three doses), 2/5/34 at 5:00 p.m., and 2/6/23 (5:00 p.m.). The medication was documented as not given on 2/5/23 at 8:00 a.m., and 12:00 p.m., and 2/6/23 at 8:00 a.m. and 12:00 noon. A review of pharmacy receipts for R416 revealed the medication was not delivered to the facility from the pharmacy until 2/7/23. On 2/7/23 at 5:05 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. A review of the facility policy, "Medication Management," revealed, in part: "Nursing staff members are to reference the established contracted provider's Pharmacy Services and Procedures Manual regarding medication orders, delivery, monitoring and other related processes for promoting efficiency and consistency in medication administration and standards of best practice." No further information was provided prior to exit.	F 760		

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F 760	Continued From page 200 (1) Pancrelipase delayed-release capsules (Creon, Pancreaze, Pertzye, Ultresa, Zenpep) are used to improve digestion of food in children and adults who do not have enough pancreatic enzymes (substances needed to break down food so it can be digested) because they have a condition that affects the pancreas (a gland that produces several important substances including enzymes needed to digest food)...Pancrelipase delayed-release capsules (Creon) are also used to improve digestion in people who have had surgery to remove all or part of the pancreas or stomach." This information was taken from the website https://medlineplus.gov/druginfo/meds/a604035.html.	F 760		
F 840 SS=D	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility;	F 840		3/21/23

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F 840	Continued From page 201 and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to have a written agreement for one of six contracted dialysis centers. The findings include: The facility failed to evidence a written agreement with one dialysis center where Resident #127 received dialysis services. During the entrance conference to the facility on 2/5/23, a request was made for the dialysis contracts or agreements to be provided. On 2/6/23, a review of the dialysis contracts evidenced no contract for the one dialysis company. On 2/6/23 at approximately 3:45 PM, ASM (administrative staff member) #1, the administrator stated, "There are more contracts I am going through to get you that contract." On 2/7/23 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the findings. ASM #1 stated, "It is in a pile of contracts I have." On 2/8/23 at approximately 1:00 PM, ASM #1 stated, there is no contract for this dialysis center. No further information was provided prior to exit.	F 840	F840 Use of Outside resources □ 1-The Dialysis contract was obtained. 2-The Administrator will complete an audit to ensure that written agreements are in place with all contracted services. 3-The Vice President of Operations will educate Administrator or designee on how to obtain the contracts needed for all outside services 4-The Administrator or designee will conduct monthly audits x x2 to verify contracts are active. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6- Date of completion 3/21/23.	

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F 842	Continued From page 202	F 842		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (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,	F 842		3/21/23

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F 842	Continued From page 203 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain an accurate clinical record for one of 58 residents in the survey sample, Resident #117 (R117). The findings include: For R117, the facility staff failed to accurately	F 842	F842 Resident Records 1--Residents # 117 was discharged. 2-All current residents with a colostomy have the potential to be affected. The Unit Manager, or designee will audit the ADL clinical record to ensure there is a place to document colostomy care. 3-The ADON nurse or designee will educate all licensed nurses and CNA□s	

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F 842	Continued From page 204 document the care for a colostomy. On the most recent MDS (minimum data set) assessment, a Medicare five-day assessment, with an assessment reference date of 1/29/2022, the resident was coded in Section H - Bladder and Bowel, as having a colostomy. The ADL (activities of daily living) documentation for January 2022, documented the bowel movements of a resident. Under "Bowel Movements," the following was documented: 1/25/2022 - 3:00 p.m. to 11:00 p.m. shift (3-11)- M (medium), 1 - incontinent, 4 - total dependence on staff, 2 - one-person physical assist 1/26/2022 - 11:00 p.m. to 7:00 a.m. (11-7)- M, 3 -Continence not rated due to Ostomy, 2 - limited assistance, 2 - one-person physical assist 1/26/2022 - 7:00 p.m. to 3:00 p.m. (7-3) - 97 documented for all categories, according to the legend at the bottom of the documentation, a 97 indicates "not applicable." 1/26/2022 - 3-11 - L (large), 0 - continent, 4 - total dependence on staff, 2 - one-person physical assist. 1/27/2022 - 11-7, M - 1 - Incontinent, 2 - limited assistance, 2 - one-person physical assist. 1/27/2022 - 7-3 - 97 - not applicable 1/27/2022 - 3-11 - 97 - not applicable 1/28/2022 - 11-7 - 97 - not applicable 1/28/2022 - 7-3 - blank, no documentation 1/28/2022 - 3-11 - M - 1 - incontinent, 4 - total dependence on staff, 2- one-person physical assist. 1/29/2022 - 11-7 - M - 1 - incontinent, 4 - total dependence on staff, 2- one-person physical assist. An interview was conducted with LPN (licensed	F 842	on the requirement for the documentation of colostomy care in resident record. 4-The Unit Manager or designee will complete weekly audits x 8 weeks, then monthly x2 to of residents with a colostomy to ensure that the colostomy care is documented in the clinical record. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6- Date of completion 3/21/23.	

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F 842	Continued From page 205 practical nurse) #1 on 2/8/2023 at 9:18 a.m. When asked where is the output from a colostomy bag documented, LPN #1 stated under output in the CNA (certified nursing assistant) documentation. When asked if it's acceptable to document, "not applicable" on the ADL documentation under bowel movement, LPN #1 stated, no. An interview was conducted with CNA #5 on 2/8/2023 at 10:17 a.m. When asked who empties a colostomy bag, CNA #5 stated the CNA did. When asked how often a colostomy bag is checked, CNA #5 stated they check residents with colostomies every one to two and a half hours. When asked where the documentation of the emptying of the colostomy is, CNA #5 stated in (name of computer program). The above ADL documentation was reviewed with CNA #5. When asked if it should be documented as not applicable, CNA #5 stated, no, there is a spot for colostomy. After reviewing the ADL document with the above information, CNA #5 was asked if they could tell if the colostomy bag was emptied, CNA #5 stated no and concurred it was not correct documentation for a resident with a colostomy. The facility policy, "Nursing Documentation" documented in part, "POLICY: Licensed Nurses and CNAs will document all pertinent nursing assessments, care interventions, and follow up actions in the medical record." ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above findings on 2/8/2023 at 11:26 a.m.	F 842		

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F 842	Continued From page 206	F 842		
	No further information was provided prior to exit.			
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: (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;	F 880		3/21/23

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F 880	Continued From page 207 (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: Based on observations, staff interview, resident interview, clinical record review and facility document review, it was determined the facility staff failed to maintain effective infection control practices for two of 58 residents in the survey sample, Resident #4 and #95.	F 880	F880 Infection Control and Prevention 1-Residents #4 is receiving medications in a sanitary manner and Resident #95 are receiving care has the respiratory equipment stored appropriately. LPN #2 was re-educated on proper handwashing. 2-All current residents with respiratory	

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F 880	Continued From page 208 The findings include: 1. For Resident #4 (R4), the facility staff failed to wash or sanitize hands before administering medications to the resident. On 2/05/23 at 4:34 p.m., RN (registered nurse) #5 was observed as she came out of a resident's room after administering medications. RN #5 was wearing gloves. RN #5 approached the medication cart, removed the gloves, put on another pair of gloves, and prepared medications to be administered to R4. RN #5 delivered the medications to the resident, and the resident took the medications as instructed by RN #5. RN #5 did not wash or sanitize her hands after removing the old gloves or putting on new gloves just prior to preparing R4's medications. On 2/8/23 at 8:18 a.m., LPN (licensed practical nurse) #2 was interviewed. When asked what a nurse should do after administering medications to one resident and before administering other medications to a new resident, she stated: "The nurse should either wash their hands or sanitize them with hand sanitizer." When asked why this is important, LPN #2 stated: "Infection control. To prevent the spread of germs." On 2/8/23 at 11:24 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. A review of the facility Infection Prevention and Control Policy, "Handwashing Requirements," revealed, in part: "Employees will wash hands at appropriate times to reduce the risk of	F 880	equipment and receiving medications have the potential to be affected by deficient practice with handwashing by staff during medication administration. The Unit Manager or designee will audit residents with respiratory equipment to ensure that it is stored correctly when not in use and that nursing staff are using proper handwashing procedures when administering medications 3-The ADON, or designee will educate all Licensed Nursing staff on proper handwashing during care and storage of respiratory equipment when not in use. 4-The Unit Manager or designee will conduct observations of Nurses during medication administration to ensure that proper handwashing is provided and ensure that respiratory equipment is stored appropriately when not in use weekly x 8 weeks, then monthly x2. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6- Date of completion 3/21/23.	

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F 880	Continued From page 209 transmission and acquisition of infections...Hand hygiene can consist of handwashing with soap and water, or use of an alcohol based hand rub...The following is a list of some situations that require hand hygiene...After removing gloves or aprons." No further information was provided prior to exit. 2. Resident #95's tracheostomy collar mask, used for nebulizer treatments, was attached to the bedrail and uncovered 2/5/23 through 2/7/23. Resident #95 was admitted to the facility on 9/20/22 with diagnoses that included but were not limited to: trach (tracheostomy). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/28/22, 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. A review of the comprehensive care plan dated 10/22/22 documented in part, "the resident is at risk for complications secondary to a tracheostomy secondary to history of cancer. INTERVENTIONS: Administer nebulizers as ordered...Observe for signs and symptoms of respiratory complications including infection and or respiratory blockage or mucous plug and notify MD as indicated..." An interview was conducted on 2/5/23 at 5:04 PM with Resident #95. When asked what the trach collar (mask) is used for, Resident #95 stated, "It is for the nebulizer to help me with secretions."	F 880		

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F 880	Continued From page 210 When asked if the trach collar is covered in a bag when not in use, Resident #95 stated, no, it is just hanging on the bedrail. On 2/6/23 at 10:00 AM, the trach collar mask was observed not in use, hanging on the bed rail, and uncovered. On 2/6/23 at 10:15 AM, LPN (licensed practical nurse) #1 was asked to come to Resident #95's room. When asked how the trach collar mask should be cared for when not in use, LPN #1 stated, it should be covered. On 2/7/23 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the findings. A review of the facility's "Respiratory Equipment" policy dated 11/1/19 revealed, "Place trach mask/collar over patient's stoma/trach. Store mask/collar in storage bag when not in use." No further information was provided prior to exit.	F 880		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training.	F 947		3/21/23

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F 947	Continued From page 211 §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and employee record review it was determined that the facility staff failed to ensure CNAs (certified nursing assistants) received annual retraining in the areas of dementia and abuse for four of five CNA records reviewed (CNAs #1, #6, #9, and #10). The findings include: On 02/07/2023 an employee record review was conducted for five CNAs. This review failed to evidence the annual required training for the following CNAs: 1. CNA #1 - hire date 01/01/2020, no evidence of dementia and abuse training between 01/01/2021 and 01/01/2022. 2. CNA #6 - hire date 01/01/2020, no evidence of abuse training between 01/01/2021 and 01/01/2022. 3. CNA #9- hire date 01/01/2020, no evidence of dementia and abuse training between 01/01/2021 and 01/01/2022. 4. CNA #10- hire date 01/20/2020, no evidence of dementia and abuse training between 01/20/2021 and 01/20/2022.	F 947	F947 Required in service training for Nurse Aides 1-CNA staff have now been identified for completion of their required training. 2-All CNA staff have the potential to be affected by this practice. An audit has been completed on the required training for CNAs to ensure the required training has been completed. 3-The DON or designee will provide in-service education to the ADON and HR on the monitoring of staff training to ensure requirements are met. 4-An audit will be completed by the ADON or designee monthly X 3 months to ensure that required in-service education is completed. Any variances will be corrected with additional training and/or corrective action. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6- Date of completion 3/21/23	

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F 947	Continued From page 212 On 02/07/2023 at approximately 4:10 p.m. an interview was conducted with OSM (other staff member) #10, human resource director. When asked for the evidence of dementia and abuse training for the CNAs listed above OSM #10 stated that they did not have them and were unable to locate them. On 02/08/2023 at approximately 10:30 a.m., ASM (administrative staff member) #1, administrator, was made aware of the above findings. No further information was provided prior to exit.	F 947		