STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495079	A. BUILDING _____ B. WING _____	C 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE CENTER LUCY CORR	6800 LUCY CORR BLVD CHESTERFIELD, VA 23832

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/31/23 through 2/7/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/31/2023-2/7/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. VA00052553-Substantiated with deficiency. VA00051861-Substantiated with deficiency. The census in this 216 certified bed facility was 183 at the time of the survey. The survey sample consisted of 73 resident reviews.	F 000		
F 565 SS=E	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	F 565		3/27/23

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

Electronically Signed | 02/22/2023

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F 565	Continued From page 1 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. (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 Resident interviews, facility staff interviews and facility documentation review, the facility staff failed to permit the Resident Council to meet without a staff member being present which had the potential to affect Residents who attend resident council. The findings included: The facility staff attended Resident Council meetings without the approval of the group. On 1/31/23, Surveyor D met with the Resident Council President obtained permission to review	F 565	F 565 Corrective Action(s): The elected President of the Resident Council and Activity Director were educated by the Administrator that Resident Council is permitted to meet without a staff member present. The facility has completed a Risk Management Incident and Accident form for this incident to include the Medical Director□s notification.	

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F 565	Continued From page 2 the Resident Council meeting minutes. On 2/2/23 at 10:30 AM, the facility Administrator provided Surveyor D the Resident Council meeting minutes which were reviewed. This review revealed that during each meeting held, facility staff were in attendance. The minutes from the September 30, 2022, meeting read, "...Questions asked about follow up of a secretary position [Resident # name redacted] asked if she could hold two positions...". During the meeting held October 20, 2022, the following notation was made in the minutes, "[Activities Director name redacted] followed up about the conversation from last meeting about secretary position. [Activities Director name redacted] explained that we only need a President and Vice President position since we have staff member appointed to assist with Resident Council Meetings...". On 2/2/23 at 11 AM, Surveyor D met with the Resident Council, 14 Residents were in attendance. During the meeting, the Residents expressed that they were not permitted to meet without facility staff being present. Multiple Residents verbalized this was a concern. When asked if any of them had approved for the facility staff to attend the meeting they responded "no". On 2/2/23 at 2:50 PM, an interview was conducted with Employee F, the Activities Director. When asked if she always attends the Resident Council Meetings, Employee F said, "Yes". When asked, do they have right to meet without staff present? Employee F said, "Yes".	F 565	Identification of Deficient Practice & Corrective Action(s): The facility has determined that all residents have the potential to be affected. Systemic Change(s): The facility Policies and Procedures have been reviewed. No revisions are warranted at this time. The Administrator, or designee, will conduct in-service education for the Activity staff and Resident Council members regarding the Resident Council policy and procedures. Monitoring: The Administrator is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The Administrator or designee will monitor the provision of residents to meet as a council without the presence of staff members. Resident Council minutes will be reviewed monthly for three (3) months to ensure Resident council meetings are being conducted per policy. Any/all negative findings will be corrected at the time of discovery and communicated to the Administrator.	

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F 565	Continued From page 3 When asked if she was aware that the Resident Council didn't want her present she said, "Not from a group consensus, No". Review of the facility policy titled; "Resident Council Meetings" was conducted. This policy read, "... 5. The Activity Director shall be designated, if approved by the group, to serve as a liaison between the group and the facility's administration and any other staff members. a. If the Activity Director is not approved by the group, the group's designee shall serve as the liaison, and documentation shall be maintained to reflect the group's designation. b. The designated liaison shall be responsible for providing assistance with facilitating successful group meetings and responding to written requests from the group meetings. 6. The group may appoint a resident to take notes/maintain meeting minutes or may elect that the Activity Director/designated liaison to take notes/maintain minutes. Meeting minutes may include, but are not limited to: a. Names of the residents in attendance. b. Follow up from previous meetings. c. Issues discussed. d. Recommendations from the group to facility staff. e. Names of staff members, speakers, and other guests present in the meeting (as invited by the group to attend) ...". On 2/2/23, during the afternoon, during an end of day meeting, the facility Administrator confirmed that Resident Council has the right to meet without staff being present. The Administrator was made aware that the Residents desire to hold meetings without staff being present.	F 565	Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 27, 2023	

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F 565	Continued From page 4 No further information was provided.	F 565		
F 575 SS=C	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interviews, staff interview, and facility documentation review, the facility staff failed to have posted the list of names, addresses and telephone number of all pertinent State agencies and advocacy groups affecting Residents on all 5 nursing units. The findings included:	F 575	F 575 Corrective Action(s): The facility has posted in a manner accessible to residents the list of names, addresses and telephone numbers of all pertinent State Agencies and advocacy groups. The facility has completed a Risk	3/27/23

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F 575	Continued From page 5 For Residents residing on all 5 nursing units, the facility failed to post in a manner accessible to Residents, a list of names, addresses, and telephone numbers of all pertinent State Agencies and advocacy groups. On 2/2/23 at 11 AM, during a Resident Council meeting, the 13 of the 14 Residents verbalized they did not know where the posting of required agencies was located. Several Residents who resided on the 2nd floor of the facility reported that it was not posted on their floor. On 2/2/23 at approximately 12:30 PM, Surveyor D toured the entire facility to include the upstairs 400 and 500 units, to include the activities room, dining rooms, communication boards and hallways. It was noted that there were no posting of state agencies and advocacy groups. The tour continued downstairs on the ground level, which included but was not limited to the facility lobby, outside of the elevator used by Residents and visitors, the auditorium, dining rooms, 3 Resident units to include common areas and communication boards. The only posting noted on the ground level was on a wall prior to entering the rehabilitation gym and hall entering the secure memory care unit. On 2/2/23, during the afternoon an interview was conducted with Employee G the social worker. Employee G reported that the posting of state survey agency and advocacy groups was located on each unit. Employee G and Surveyor D walked to the 100 and 300 units and noted no such posting. Employee G also indicated that she had this posting in her office, and it was available to Residents upon request.	F 575	Management Incident and Accident form for this incident to include the Medical Director□s and Resident Council President□s notification. Identification of Deficient Practice & Corrective Action(s): The facility has determined that all residents have the potential to be affected. Systemic Change(s): The facility Policies and Procedures have been reviewed. The policy was revised to meet the required regulation. The Administrator, or designee, will conduct in-service education for the all staff regarding the facility required postings policy and procedures. Monitoring: The Administrator is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The Administrator or designee will monitor the postings assessible in the facility weekly for twelve (12) weeks to ensure compliance. Any/all negative findings will be corrected at the time of discovery and communicated to the Administrator.	

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F 575	Continued From page 6 On 2/2/23, during the end of day meeting, the facility Administrator was made aware of the above findings. The Administrator stated that it was posted outside of the elevator on the second floor. Following the meeting, the facility Administrator and Surveyor D toured the second floor finding no posting of the state survey agency and advocacy groups contact information. The Administrator commented that they had done some painting and it must have been removed during that process. The tour with the Administrator and Surveyor D continued downstairs on the ground level. The Administrator confirmed that there was no such posting in the lobby or other common areas accessible to all Residents and families. The facility policy regarding Resident Rights was requested. The facility provided a document titled, "Exhibit B, Resident Rights Policy & Notice". The Administrator reported that this document was an attachment to their admissions agreement. The policy/notice did provide the state survey agency and advocacy groups contact information within the document but made no reference of the posting of this information within the facility. On 2/6/23 at 2:40 PM, a facility policy titled, "Resident Right- ROP" was received. This document was reviewed and it read, "...8. A posting of names, addresses and phone numbers of all pertinent state client advocacy groups will be available in the facility...". No further information was provided.	F 575	Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 27, 2023	
F 578	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F 578		3/27/23

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F 578 SS=D	Continued From page 7 CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.	F 578		

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F 578	Continued From page 8 Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one Resident (R)141 out of one reviewed for advanced directives was provided written information of the right to accept or refuse medical or surgical treatment and formulate an advance directive. Findings include: On 02/02/23 at 3:30 PM the facility's policy and procedure was requested regarding Advanced Directives. None was provided by the time of the exit. Review of R141's admission "Minimum Data Set (MDS)" located in the resident's EMR under the "RAI" tab with an Assessment Reference Date (ARD) of 01/12/23, revealed the facility assessed the resident to have a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated R141 was cognitively intact. Review of R141's clinical record showed no documentation that the facility provided written information to the resident regarding the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. During an interview with R141 on 02/02/23 at 11:00 AM the resident stated that she was never provided information regarding advanced directives and what treatment, or life sustaining treatment options (such as tube feedings, intravenous fluids, comfort care, etc.) were	F 578	F 578 Corrective Action(s): Written information of the right to accept and refuse medical or surgical treatment was provided to Resident #141. The Advance Directive was formulated for Resident #141 according to her wishes. The facility has completed a Risk Management Incident and Accident form for this incident to include Physician and Resident's Responsible party notification. Identification of Deficient Practice & Corrective Action(s): The facility has determined that all residents have the potential to be affected. A 100% audit of all residents medical records for Advance Directives. Residents and/or responsible parties will be interviewed to ensure that they have been provided with written information of the right to accept or refuse treatment and ensure that an Advance directive has been formulated based on the resident's choice. Any/all negative findings will be corrected at the time of discovery and communicated to the Administrator and Director of Nursing.	

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F 578	Continued From page 9 available for her to choose. She stated that she was just given a piece of paper and she had to decide if she wanted CPR or be a DNR, in the event of a cardiac arrest. During an interview on 02/03/23 at 4:23 PM, with the Social Services Director, Staff D confirmed no information regarding Advanced Directives were provided or discussed with the resident.	F 578	Systemic Change(s): The facility Policies and Procedures have been reviewed. A policy was revised to meet the required regulation. The Director of Nursing, or designee, will conduct in-service education for all Social Service staff and all Licensed Nursing staff regarding the required Advanced Directive written information to be provided including the right to accept or refuse treatment and to confirm the Advance Directive has been formulated based on the resident□s choice. Monitoring: The Director of Nursing is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The Director of Nursing or designee will monitor the completion of Advanced Directives formulated based on the resident□s choice. All Admission records will be reviewed weekly for twelve (12) weeks to ensure Advanced directives are completed per policy. Any/all negative findings will be corrected at the time of discovery and communicated to the Administrator and Director of Nursing. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and	

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F 578	Continued From page 10	F 578	recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 27, 2023	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other	F 582		3/27/23

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F 582	Continued From page 11 items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to ensure written acknowledgement of the Notice of Medicare Non Coverage for two Residents (Resident # 81 and # 123) in a survey sample of 3 Residents reviewed for Beneficiary Notices. The findings included: 1. For Resident # 81, the facility staff failed to have the NOMNC (Notice of Medicare Non Coverage) form signed by the Resident and/or the Resident Representative. A copy of the form was not acknowledged by the beneficiary or beneficiary's representative.	F 582	F 582 Corrective Action(s): Resident #81 and responsible party was informed of payment status as of their last covered day and the signature of notification was obtained. Resident #123 has been discharged. The facility has completed a Risk Management Incident and Accident form for this incident to include Physician and Resident□s Responsible party notification. Identification of Deficient Practice &	

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F 582	Continued From page 12 Review of the clinical record was conducted on 2/3/2023 and 2/6/2023. Review of the Beneficiary notices revealed the notice stated Skilled Nursing Services would end on 1/16/2023. The form was not signed by Resident or representative. There was documentation in the "Additional information" section of "verbal notification" to the beneficiary representative on 1/13/2023 at 4:50 p.m. The bottom of the notice form was not signed or dated in the section that had the statement: "Please sign below that you received and understood this notice. I have been notified that the coverage if not services will end on the effective date indicated and I may appeal this decision by contacting my QIO." The signature line and date line were blank. On 2/6/2023 at 12:51 p.m., an interview was conducted with the Social Worker (Employee G) who stated Beneficiary notices should be given to Residents or the Resident Representative by the Social Worker. Employee G stated verbal notices were given if the resident or representative were not available to sign. On 2/7/2023 during the end of day debriefing, the Administrator and Director of Nursing were informed of the findings. The Administrator stated the expectation was that the beneficiary notices would be signed by the Resident or Resident Representative. The Administrator stated that if the Social Worker gave verbal notification, there should have been follow up with attempts to notify the Resident and/or Representative in writing such as a Certified letter.	F 582	Corrective Action(s): The facility has determined that residents with a qualifying hospital stay and Medicare Part A benefit days available have the potential to be affected. An audit was conducted on current residents who were admitted in the past three (3) months, and corrective actions were completed. Systemic Change(s): The facility Policies and Procedures have been reviewed. No revisions are warranted at this time. The Administrator, or designee, will conduct in-service education for the following personnel on the facility□s Notice of Medicare Non- Coverage (NOMNC) and Advance Beneficiary Notices policy: Business Office Manager, Social Services Director and Assistant, MDS Coordinator, Director of Nursing, Rehabilitation Program Manager, and Unit Managers. Monitoring: The Administrator is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. For three (3) months, the Administrator or designee will conduct a medical record	

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	495079	A. BUILDING _____ B. WING _____	C 02/07/2023

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F 582	Continued From page 13 No further information was provided. 2. For Resident # 123, the facility staff failed to have the NOMNC (Notice of Medicare Non Coverage) form signed by the Resident and/or the Resident Representative. A copy of the form was not acknowledged by the beneficiary or beneficiary's representative. Review of the clinical record was conducted on 2/3/2023 and 2/6/2023. Review of the Beneficiary notices revealed the notice stated Skilled Nursing Services would end on 1/19/2023. The form was not signed by Resident or representative. There was documentation in the "Additional information" section of verbal notification to the beneficiary representative on 1/13/2023 at 1:15 p.m.. The bottom of the notice form was not signed or dated in the section that had the statement: "Please sign below that you received and understood this notice. I have been notified that the coverage if not services will end on the effective date indicated and I may appeal this decision by contacting my QIO." The signature line and date line were blank. On 2/6/2023 at 12:51 p.m., an interview was conducted with the Social Worker (Employee G) who stated Beneficiary notices should be given to Residents or the Resident Representative by the Social Worker. Employee G stated verbal notices were given if the resident or representative were not available to sign.	F 582	audit of all residents who required a Notice of Medicare Non-Coverage (NOMNC) to ensure that written acknowledgement was obtained Any/all negative findings will be corrected at the time of discovery and communicated to the Administrator and Director of Nursing. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 27, 2023	

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F 582	Continued From page 14 On 2/7/2023 during the end of day debriefing, the Administrator and Director of Nursing were informed of the findings. The Administrator stated the expectation was that the beneficiary notices would be signed by the Resident or Resident Representative. The Administrator stated that if the Social Worker gave verbal notification, there should have been follow up with attempts to notify the Resident and/or Representative in writing such as a Certified letter. No further information was provided.	F 582		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including	F 622		3/27/23

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F 622	Continued From page 15	F 622		

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

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

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F 622	Continued From page 16 (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to provide ensure that the appropriate information regarding a transfer was communicated to the receiving health care institution or provider for one Resident (Resident # 8) in a survey sample of 73 Residents. The findings included: For Resident # 8, the facility staff failed to document that the reason for the transfer to the hospital was communicated with the hospital staff. Review of the clinical record was conducted	F 622	F 622 Corrective Action(s): Resident # 8 record was reviewed for documentation for the reason for transfer. The facility has completed a Risk Management Incident and Accident form. Identification of Deficient Practice & Corrective Action(s): The facility has determined that all residents have the potential to be affected.	

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F 622	Continued From page 17 2/3/2023 and 2/6/2023. Review of the Progress Notes revealed Resident # 8 was sent to the hospital on 3/16/2022 due to a change in condition related to involuntary muscle movement and confusion. Review revealed no documentation of the information provided to the receiving hospital. On 2/6/2023 at 12:24 p.m., an interview was conducted with LPN (Licensed Practical Nurse) H, the Unit Manager, who stated "when a resident is transferred to the hospital, we print a facesheet, transfer sheet, x-rays, labs, medication list and bed hold to send." When asked where the nurses document the information, the LPN H stated "it should be in PCC (Point Click Care-the electronic medical record)." Review of the electronic Clinical record revealed no documentation of any information reviewed with the resident and/or the family representative. LPN H stated some documents might be in the hard chart. A copy of the documents sent with Resident #8 to the hospital was requested. The Administrator presented scanned copies of documents that were sent with Resident # 8 during the transfer to the hospital. Review of the scanned documents revealed no evidence of communication with the hospital of the reason for the transfer. On 2/7/2023 during the end of day debriefing, the Administrator and Director of Nursing were informed of the findings The Administrator stated	F 622	Systemic Change(s): The facility Policies and Procedures have been reviewed. No revisions are warranted at this time. The Director of Nursing, or designee, will in-service all Licensed Nursing staff on the requirements of documentation at discharge including the reason for the transfer to the hospital and documentation it was communicated to the hospital staff. Monitoring: The Director of Nursing is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. For three (3) months, the Director of Nursing or designee will conduct a medical record audit of all residents who have been discharged from the facility to ensure that the record includes the reason for the transfer to the hospital and documentation it was communicated to the hospital staff. Any/all negative findings will be communicated to the Administrator and Director of Nursing for corrective action. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility	

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F 622	Continued From page 18 the expectation was that the reason for the transfer to the hospital should be communicated to the hospital and documented. No further information was provided.	F 622	policy, procedure, and/or practice. Completion Date: March 27, 2023	
F 623 SS=D	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 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	F 623		3/27/23

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F 623	Continued From page 19	F 623		

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;
(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

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F 623	Continued From page 20 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 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 documentation review and clinical record review, the facility staff failed to provide Notice to the Ombudsman of discharge for one Resident (Resident # 8) in a survey sample of 73 Residents. The findings included: For Resident # 8, the facility staff failed to notify the ombudsman of transfer to the hospital. Resident # 8 was sent to the hospital on 3/16/2022 due to a change in condition related to involuntary muscle movement and confusion.	F 623	F 623 Corrective Action(s): The State Long-Term Care Ombudsman was notified of Resident #8 discharge 3/16/2022. The facility has completed a Risk Management Incident and Accident form. Identification of Deficient Practice & Corrective Action(s):	

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F 623	Continued From page 21 Resident # 8 was readmitted to the facility on 3/25/2022. On 2/6/2023 at 12:51 p.m., an interview was conducted with the Social Worker (Employee G) who stated she did not notify the Ombudsman. Employee G stated she was unsure of who notified the Ombudsman. On 2/6/2023 at 12:53 p.m., an interview was conducted with the Business Office Manager (Employee K) who stated she did not notify the Ombudsman of the transfer to the hospital. Employee K stated she would check to see if she could find out who would notify the Ombudsman. During the end of day debriefing on 2/6/2023, the Administrator and Director of Nursing were informed of the findings. The Administrator stated the Ombudsman should have been notified. The Administrator stated "the Unit Secretary used to do it." The Administrator stated normally, the list of discharges would be printed from PCC (Point Click Care) and faxed to the Ombudsman. No further information was provided.	F 623	The facility has determined that all residents who have been transferred or discharged have the potential to be affected. Systemic Change(s): The facility Policies and Procedures have been reviewed. No revisions are warranted at this time. The Director of Nursing, or designee, will in-service all Social Services staff addressing circumstances regarding required notices for residents upon transfer and discharge from the facility. Monitoring: The Director of Nursing is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The Director of Nursing, or designee, will conduct an audit weekly for twelve (12) weeks for the notification of transferred or discharged resident list sent to the State Ombudsman Office with proof of delivery. Any/all negative findings will be communicated to the Administrator and Director of Nursing for corrective action. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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F 623	Continued From page 22	F 623	Completion Date: March 27, 2023	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to provide the bed hold policy to the resident and resident representative for one	F 625	F 625 Corrective Action(s):	3/27/23

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F 625	Continued From page 23 Resident (Resident # 8) in a survey sample of 73 Residents. The findings included: For Resident # 8, the facility staff failed to provide the resident and/or resident representative with the bed hold policy at the time of transfer to the hospital. Resident # 8 was sent to the hospital on 3/16/2022 due to a change in condition related to involuntary muscle movement and confusion. Resident # 8 was readmitted to the facility on 3/25/2022. Review of the clinical record was conducted 2/3/2023 and 2/6/2023. Review of the Nursing Notes, Social Services Notes, and Physician Progress notes revealed no evidence that Resident # 8 or the resident representative was made aware of the facility's bed hold policy. On 2/6/2023 at 12:24 p.m., an interview was conducted with LPN (Licensed Practical Nurse) H, the Unit Manager, who stated "when a resident is transferred to the hospital, we print a facesheet, transfer sheet, x-rays, labs, medication list and bed hold to send." The unit manager stated the nurses should document what was reviewed with the resident and family. When asked where the nurses document the information, the unit manager stated "it should be in PCC (Point Click Care-the electronic medical record)."	F 625	Resident # 8 record was reviewed for notification of Bed Hold. The resident and/or legal representative was immediately notified of the facility□s bed hold policy. The facility has completed a Risk Management Incident and Accident form. Identification of Deficient Practice & Corrective Action(s): The facility has determined that all residents have the potential to be affected. Systemic Change(s): The facility Policies and Procedures have been reviewed. No revisions are warranted at this time. The Director of Nursing, or designee, will in-service all Licensed Nursing staff addressing the facilities□ notification of bed hold policy. Monitoring: The Director of Nursing is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. For three (3) months, the Director of Nursing or designee will conduct a medical record audit of all residents who have been discharged from the facility to ensure that the record includes proper notification of bed hold was provided to	

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F 625	Continued From page 24 Review of the electronic Clinical record revealed no documentation of any information reviewed with the resident and/or the family representative. LPN H stated some documents might be in the hard chart. A copy of the documents sent with Resident #8 to the hospital was requested. Review of the scanned documents from the hard chart presented by the Administrator revealed a Bed Hold Agreement form that was incomplete. The form had Resident # 8's name written in the section that stated "I DO wish to hold the bed for _____ [Resident # 8's name was written on that line], Beginning date 3/16/22 " The space for "Ending date" was blank. There was no amount written in the section to denote the cost of each day. The rest of the form was blank. There was no signature nor any documentation that the information on the form was discussed with Resident # 8 and/or the family representative. On 2/7/2023 during the end of day debriefing, the Administrator and Director of Nursing were informed of the findings that there was no evidence to indicate the facility did communicate with Resident # 8 or Resident # 8's representative about the facility bed hold policy at the time of discharge. The Administrator stated the expectation was that the bed hold policy would explained and signed by the Resident or Resident Representative. No further information was provided.	F 625	the resident and/or legal representative and documented as such. Any/all negative findings will be communicated to the Administrator and Director of Nursing for corrective action. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 27, 2023	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		3/27/23

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F 656	Continued From page 25	F 656		

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the 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

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F 656	Continued From page 26 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 staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure care plan measures were developed and implemented to prevent skin injury during care for one Resident (Resident #222) in a survey sample of 73 Residents. The findings included: For Resident #222, the facility staff failed to develop a care plan for effective measures to prevent and intervene in skin injuries. Resident #222 had an admission minimum data set assessment dated 4-7-21 which coded the Resident with a Brief Interview of Mental Status score of 1 indicating severe cognitive impairment. Progress notes, skin evaluation sheets, physician's orders, and Treatment Administration Records (TAR) were reviewed and revealed the following chronology of events; 3-31-21 - On admission Left elbow & Left posterior knee skin tears treated and healed 4-5-23. No further skin tears nor skin problems were documented as having occurred in the clinical records until a room change on 4-21-21 at 2:52 P.m..	F 656	F 656 Corrective Action(s): Resident #222 has been discharged from the facility. The facility has completed a Risk Management Incident and Accident form. Identification of Deficient Practice & Corrective Action(s): The facility has determined that all residents have the potential to be affected. Systemic Change(s): The facility Policy and Procedure has been reviewed and revised. All disciplinary care plan team members responsible for writing care plans will be re-educated on the facility□s policy and procedure for developing Comprehensive Care plans including measures to prevent and intervene in skin injuries. Monitoring:	

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F 656	Continued From page 27 4-21-21 - 8:50 p.m., Skin tears Left lower leg, & Left outer fore arm. 4-23-21 - Skin tears Right lower leg, Left anterior fore arm, & Right fore arm 4-26-21m - Geri legs & sleeves protection begun on evening shift, and not documented as applied on 4-27-21 during the day shift. 4-30-21 - Skin tears Right shin & Left upper leg. Resident #222's care plan was reviewed and revealed that the Resident was to have daily skin inspections, and baths 2 times per week, and as needed or requested. The "Skin Tears" care plan was initiated on 4-26-21 after 5 days of known skin tears. On 2-3-23, the DON stated that skin checks were completed during hygiene care. The Administrator was asked for any investigations involving this Resident's skin injuries, and she stated "we don't have any." No investigation was conducted to ascertain why so many skin injuries occurred in such a short time for this Resident, and after none had occurred until the transfer to a new room in the facility. The Resident incurred 8 skin injuries in 9 days. The Administrator and Director of Nursing (DON) were notified at the end of day meeting on 2-3-23. No further information was provided by the facility.	F 656	The Director of Nursing is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator. All care plans will be updated as indicated. The Director of Nursing or designee will complete ten (10) random weekly audits of care plans for three (3) months. Random audits will be completed to ensure that comprehensive care plans are developed for residents that include measures to prevent and intervene in skin injuries. Any/all negative findings will be communicated to the Administrator and Director of Nursing for corrective action. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 27, 2023	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary	F 661		3/27/23

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F 661	Continued From page 28 When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a discharge summary was written for one Residents (# 171) in a survey sample of 73 Residents. The findings included: 1. For Resident # 171, the facility staff failed to document a Discharge Summary.	F 661	F 661 Corrective Action(s): Resident # 171 record was reviewed for documentation of discharge summary. Resident #171 was discharged from the facility. The facility has completed a Risk Management Incident and Accident form.	

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F 661	Continued From page 29 Resident # 171 discharged on 12/12/2022 to an Independent Living apartment on the facility's campus . Review of the clinical record was conducted on 2/6/2023. An interview was conducted on 02/6/2023 at 12:24 p.m. with LPN (Licensed Practical Nurse) H who stated notes should be written in PCC (Point Click Care) in the Progress Notes about discharges. LPN H reviewed the Progress Notes and stated she did not see the information about Resident # 171. On 2/6/2023 at 12:51 p.m., an interview was conducted with the Social Worker (Employee G) who stated she did remember the resident but could not find the information in the clinical record. Employee G stated Resident # 171 chose to move back to the Independent Living apartment on the facility's campus. Employee G stated she would check with the Business Office about dates of the stay. On 2/6/2023 at 12:53 p.m., an interview was conducted with the Business Office Manager (Employee K) who stated Resident # 171 had been in the facility for 4 days from 12/8/2022 until 12/12/2022. Employee K explained how to find the information for Resident # 171 in the electronic clinical record. She stated that since Resident # 171 was still on the campus but in Independent Living, the system had the documentation in a different place. Review of the electronic clinical record revealed no Discharge Summary was written for Resident	F 661	Identification of Deficient Practice & Corrective Action(s): The facility has determined that all residents have the potential to be affected. Systemic Change(s): The facility Policies and Procedures have been reviewed. No revisions are warranted at this time. The Director of Nursing, or designee, will in-service all Licensed Nursing staff, all Social Service staff and all Medical Records staff on the requirements of documentation at discharge including the following; a recapitulation of stay, final summary, reconciliation of medications and post discharge plan of care. Monitoring: The Director of Nursing is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. For three (3) months, the Director of Nursing or designee will conduct a medical record audit of all residents who have been discharged from the facility to ensure that the record includes the discharge summary.	

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F 661	Continued From page 30 # 171 upon discharge to the Independent Living apartment. Review of a Social Worker Progress Note revealed the following : 12/12/2022 16:38 "Administrator, PT(Physical Therapy) and OT (Occupational Therapy) met with (Resident # 171's name redacted), her son, and her SIL (Son in law) this afternoon. Reviewed ADL (Activity of Daily Living) status and progress. Discussed home health vs. outpatient therapy follow up." The note further stated that Per Resident # 171's and family choice, the resident "returned to her (name of facility) apartment this afternoon, with therapy follow up from (name of facility redacted) in-house therapy department. The note was electronically signed by the Social Worker (Employee G). On 2/7/2023 during the end of day debriefing, the Administrator and Director of Nursing were informed of the findings of no recapitulation of the stay at the facility. The Administrator stated the expectation was that the Discharge Summary would be completed after discharge. The Administrator stated that a Discharge Summary should have been documented even though the resident was only in the facility for a few days before returning to the previous living arrangement of an apartment on the facility's campus. No further information was provided.	F 661	Any/all negative findings will be communicated to the Administrator and Director of Nursing for corrective action. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 27, 2023	
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 out activities of daily living receives the necessary	F 677		3/27/23

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F 677	Continued From page 31 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on Resident Interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide services to maintain personal hygiene for 2 Residents (#222, and #375) in a survey sample of 73 Residents. The Findings included: 1. For Resident #222, the bed ridden and incontinent Resident did not receive bathing nor personal hygiene care on multiple days. Resident #222 had an admission minimum data set assessment dated 4-7-21 which coded the Resident with a Brief Interview of Mental Status score of 1 indicating severe cognitive impairment. The Resident was incontinent of bladder and bowel, and was totally dependent on staff for transferring, toileting, hygiene and bathing. The Resident's closed record "ADL Care sheets" documented by certified nursing assistants (CNA's) for Activities of Daily Living care were reviewed on 2-2-23. No ADL (activities of daily living) hygiene care was documented as being provided for the Resident on the following days and shifts. 7a.m. to 3p.m. shift - 4-3-21, 4-4-21, 4-13-21, 4-14-21, 4-15-21, 4-16-21, 4-17-21, 4-18-21, 4-19-21, 4-20-21, 4-23-21, 4-24-21, 4-25-21, 4-26-21, 4-27-21, 4-28-21, 4-30-21. The Resident was only documented as receiving hygiene care 13 times in 30 shifts.	F 677	F 677 Corrective Action(s): Resident #222 and Resident #375 have been discharged from the facility. The facility has completed a Risk Management Incident and Accident form for both incidents. Identification of Deficient Practice & Corrective Action(s): The facility has determined that all residents have the potential to be affected. A 100% audit of all resident□s personal hygiene condition will be conducted. Any/all negative findings will be communicated to the Administrator and Director of Nursing for corrective action. The facility has determined that all residents requiring assistance with facial hair shaving have the potential to be affected. Systemic Change(s): The facility Policy and Procedure has been reviewed and revised. The Director of Nursing or designee will in-service all	

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F 677	Continued From page 32 3p.m. to 11p.m. shift - 4-1-21, 4-2-21, 4-4-21, 4-5-21, 4-6-21, 4-7-21, 4-9-21, 4-12-21, 4-13-21, 4-14-21, 4-15-21, 4-16-21, 4-17-21, 4-18-21, 4-21-21, 4-22-21, 4-24-21, 4-25-21, 4-26-21, 4-27-21, 4-28-21, 4-29-21, 4-30-21. The Resident was only documented as receiving hygiene care 7 times in 30 shifts. 11p.m. to 7a.m. shift - none was documented as being given during this shift. A tub bath or shower was documented as given only once during the Resident's 32 day stay, on 4-23-21. The ADL care policy was reviewed and under "hygiene" read "Scheduled showers or baths with assistance are provided." Resident #222's care plan was reviewed and revealed that the Resident was incontinent of bladder and bowel. On 2-3-23 The Director of Nursing and Administrator were asked if the ADL documents should be signed correctly indicating care was given, and they stated "if it's not documented, it's not done." The DON stated that the facility policy is to provide incontinence care hygiene per policy. They were asked what the expectation was for numbers of baths or showers per week and they stated 2 per week with daily hygiene as needed. The Administrator and Director of Nursing (DON) were notified of the missing documentation and the complaint allegation, at the end of day meeting on 2-3-23. No further information was provided by the facility.	F 677	direct care staff addressing the personal hygiene, bathing and facial hair shaving including resident preferences and high-risk conditions. The Director of Nursing, or designee, will in-service all direct care staff on providing timely assistance with ADL□s (Activities of Daily Living), providing care in accordance to the plan of care and documentation of assistance given. Monitoring: The Director of Nursing is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The Director of Nursing, or designee, will conduct random audit of personal hygiene and bathing three (3) times a week for three (3) months to monitor compliance. The Director of Nursing, or designee, will conduct random observations of resident facial hair shaving three (3) times a week for the next three (3) months to monitor compliance. Any/all negative findings will be communicated to the Administrator and DON for corrective action. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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F 677	Continued From page 33	F 677	Completion Date: March 27, 2023	

2. For Resident #375, the facility staff failed to provide personal hygiene, namely shaving.

On 02/03/2023 at 3:00 P.M., Resident #375 was observed sleeping in his bed wearing a white T-shirt and covered with a blanket. It appeared Resident #375's face had not been shaved for several days.

On 02/06/2023 at 12:15 P.M., Resident #375 was observed sleeping in his bed wearing a white T-shirt and covered with a blanket. It appeared Resident #375's face had not been shaved for several days. Resident #375's sister was visiting. When asked about Resident #375's preference, the family member stated [Resident #375] would prefer to be clean shaven.

According to the nursing admission assessment dated 01/26/2023 in Section M entitled "ADL's/Functional Devices" and subpart (1)(h) entitled, "Personal Hygiene" it was documented that [Resident #375] requires assistance of staff with personal hygiene.

According to Resident #375's baseline care plan, Resident #375 needed the assistance of staff with grooming and hygiene.

A review of Resident #375's Activities of Daily Living flowsheet for January and February 2023 were reviewed. According to the flowsheets, Resident #375 received personal hygiene (which includes shaving) on 01/26/2023, 01/28/2023,

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F 677	Continued From page 34 01/29/2023, 01/30/2023, and 02/02/2023 - 02/06/2023. However, observations on 02/03/2023 and 02/06 2023 clearly showed that the resident was not clean shaven. On 02/06/2023 at approximately 4:10 P.M., the Administrator and Director of Nursing were notified of findings. The facility staff provided a copy of their policy entitled, "Activities of Daily Living (ADL)." Under the header "Policy" in Sections 1 and 2 it was documented, "The capability of each resident to meet the demands of daily living is assessed by a licensed nurse. Assistance and instruction in ADL skills is provided to residents as designated by the individual care plan."	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff	F 686	F 686	3/27/23

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F 686	Continued From page 35 failed to prevent, and treat timely, a stage 2 pressure ulcer prior to development for one Resident (Resident #222) in a survey sample of 73 residents. The findings included: For Resident #222, the facility staff failed to identify (prior to the development of a stage 2) a pressure ulcer, and failed to treat for 5 further days after identification was documented in the care plan. Resident #222 had a minimum data set assessment dated 4-7-21 which coded the Resident with a Brief Interview of Mental Status score of 1 indicating severe cognitive impairment. The Resident was incontinent of bladder and bowel. Resident #222's care plan was reviewed and revealed that the Resident was incontinent of bladder and bowel and wore incontinence disposable briefs. The Resident could not feed herself, nor turn and reposition without extensive help from staff. The Resident was to have daily skin inspections, and baths 2 times per week, and as needed or requested. The care plan review also revealed an entry on 4-19-21 indicating the Resident had a stage 2 pressure ulcer on the right buttock which was the first pressure ulcer care plan documented for the Resident. The care plan entry on 4-19-21 was the only documentation of the pressure ulcer until 4-23-21 when it was documented in a progress note, and on a skin sheet document. On 4-24-21 a	F 686	Resident #222 has been discharged. The facility has completed a Risk Management Incident and Accident form. Identification of Deficient Practice & Corrective Action(s): The facility has determined that all residents have the potential to be affected. A 100% audit of all residents with orders for prevention of pressure ulcers will be completed to identify resident as risk. Any/all negative findings will be communicated to the Administrator and DON for corrective action. Skin assessments were completed for all residents. For those residents at risk, care plans were reviewed to ensure appropriate interventions. The Nurse Mangers reviewed the revised care plans with staff involved in the care of at risk residents. Systemic Change(s): The facility Policies and Procedures have been reviewed. No revisions are warranted at this time. The Director of Nursing, or designee, will conduct in-service education for all Licensed Nursing staff regarding following physician□s orders. The facility policy regarding Pressure Injury Prevention and Management was reviewed. No revisions are warranted at this time. The all nursing staff was	

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F 686	Continued From page 36 treatment was ordered for the pressure sore 5 days after the care plan denoted the wound. The Resident was assessed upon admission as "at risk for developing pressure sores." Progress notes, skin evaluation sheets, physician's orders, and Treatment Administration Records (TAR) were reviewed and revealed the following chronology of events; 3-31-21 - On admission Left elbow & Left posterior knee skin tears treated and healed 4-5-23. No further skin tears nor skin problems were documented as having occurred in the clinical records until a room change on 4-21-21 at 2:52 P.M. 4-21-21 - 8:50 p.m., Skin tears Left lower leg, & Left outer fore arm. 4-23-21 - Skin tears Right lower leg, Left anterior fore arm, & Right fore arm 4-24-21 - Stage 2 pressure sore right inner buttock On 2-3-23, The DON stated that skin checks were completed during that care. The Administrator and Director of Nursing (DON) were notified at the end of day meeting on 2-3-23. No further information was provided by the facility.	F 686	in-serviced by the Director of Nursing, or designee on the revised facility policy for Pressure Injury Prevention and prevention interventions. Monitoring: The Director of Nursing is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The Director of Nursing, or designee, will review pressure injury risk assessments, interventions and care plans on all new admissions, re-admissions on-going. The Director of Nursing, or designee, will audit the care for a random sample of residents who require interventions to prevent pressure ulcers weekly for twelve (12) weeks to ensure proper care to prevent pressure ulcers and promote healing of existing pressure ulcers. Any/all negative findings will be corrected at the time of discovery and communicated to the Administrator and Director of Nursing. The Director of Nursing, or designee, will complete random skin assessments on five (5) residents per unit (25 total residents) weekly for twelve (12) weeks. Any/all negative findings will be corrected at the time of discovery and communicated to the Administrator and Director of Nursing. Aggregate findings of these audits will be provided to the Quality Assurance	

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F 686	Continued From page 37	F 686	Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 27, 2023	
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 by: Based on observation, Resident interviews, staff interviews, clinical record reviews, and facility documentation review, the facility staff failed to provide timely pain management measures for 2 Residents (Resident #144, Resident #376) in a sample size of 73 Residents. The findings included: 1) For Resident #144, the facility staff delayed assessment and treatment of Resident #144's left leg pain on 02/01/2023. On 02/01/2023 at 10:10 A.M., Resident #144 was observed in her bed. Resident #144 was grimacing, signing, and restless. When asked about this, Resident #144 stated that her entire left leg was having muscle spasms. When asked to rate the severity of the muscle spasms [0=no pain to 10=worst pain], Resident #144 stated the pain severity was "9." When asked if the nurse	F 697	F 697 Corrective Action(s): Resident # 144 and 376 were assessed for pain; appropriate interventions were implemented. The facility has completed a Risk Management Incident and Accident forms to include notification to the physicians and responsible parties. Identification of Deficient Practice & Corrective Action(s): All residents have the potential to be affected. 100% Pain Assessments will be completed and interventions currently in place will be reviewed and revised as	3/27/23

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F 697	Continued From page 38 was aware, Resident #144 stated she did tell the nurse but didn't know her name because she was new. Resident #144 stated that, many times, she receives her medications late, not as scheduled. On 02/01/2023 at 10:30 A.M., Licensed Practical Nurse E (LPN E) was interviewed. LPN E verified she was Resident #144's nurse and this was her first time working with Resident #144. When asked to share what she knew about Resident #144, LPN E referred to her notes and stated that Resident #144 needed to have her medications crushed. LPN E also stated that she knew Resident #144 was in pain. When asked about this, LPN E stated that Resident #144 told her she was in pain around 9:00 A.M. When asked where Resident #144's pain was located, LPN E stated that Resident #144 couldn't say where the pain was. When asked what happened next, LPN E stated she brought Resident #144 some water and told her she would be back later to assess. This surveyor and LPN E then entered Resident #144's room. LPN E asked Resident #144 if she was in pain. Resident #144 stated her entire left leg was having muscle spasms. LPN E asked Resident #144 to rate the pain severity and Resident #144 stated "9." Upon exiting the room, LPN E stated that Resident #144 has not received her scheduled medications yet and will be given now. LPN E administered the medications that were scheduled for 8:00 A.M. and 9:00 A.M. at 10:39 A.M. which included Robaxin (a muscle relaxer). On 02/01/2023, the facility staff provided a copy of Resident #144's Medication Administration Record (MAR) for January and February 2023 with the exact medication times included as requested. A review of the January 2023 MAR	F 697	indicated. Systemic Change(s): The facility Policies and Procedures have been reviewed and revised. The Director of Nursing, or designee, will in-service all Licensed Nursing staff and all direct care staff on the facility□s Pain Management policy and procedures. Monitoring: The Director of Nursing is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The Director of Nursing, or designee, will complete ten (10) random pain assessment audits to ensure completion with interventions weekly for twelve (12) consecutive weeks. The Director of Nursing, or designee, will conduct ten (10) random interviews weekly for residents who have pain medication ordered regarding the effectiveness of their pain management plan of care for twelve (12) consecutive weeks. Any/all negative findings will be communicated to the Administrator and Director of Nursing for corrective action. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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revealed that Robaxin was scheduled to be given at 8:00 A.M., 4:00 P.M., and 12:00 A.M. For the 8:00 A.M. scheduled administration of Robaxin, it was administered late at the following times:
01/01/2023 at 11:23 A.M.
01/02/2023 at 9:33 A.M.
01/04/2023 at 9:45 A.M.
01/06/2023 at 9:46 A.M.
01/07/2023 at 10:26 A.M.
01/08/2023 at 3:20 P.M.
01/14/2023 at 11:20 A.M.
01/15/2023 at 11:59 A.M.
01/21/2023 at 11:36 A.M.
01/22/2023 at 11:23 A.M.
01/25/2023 at 12:55 P.M.
01/28/2023 at 11:09 A.M.
01/29/2023 at 11:10 A.M.
01/30/2023 at 10:27 A.M.
01/31/2023 at 11:47 A.M.

On 02/03/2023 at 5:30 P.M., the Administrator and Director of Nursing were notified of the delay in assessment and treatment of Resident #144's left leg pain on 02/01/2023.

According to Resident #144's Minimum Data Set with an Assessment Reference Date of 10/21/2022, the Brief Interview for Mental Status was coded as "14" out of "15" indicative of intact cognition.

On 02/06/2023, Resident #144's care plan was reviewed. A focus initiated on 11/29/2021 contained goals and interventions for Resident #144's osteoarthritis and low back pain. There was no evidence of goals or interventions addressing Resident #144's left leg pain/muscle spasms.

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On 02/06/2023 at 3:40 P.M., the Director of Nursing (DON) was interviewed. When asked about Resident #144's left leg pain/muscle spasms, the DON stated that they would have to get a physician in to evaluate why Resident #144 was having muscle spasms in her left leg.

The facility staff provided a copy of their policy entitled, "Pain Management - Stop the Pain Program." Excerpts in Section 2 entitled, "The principles of the STOP program include:" documented, "prompt and accurate assessment of pain; use of non-drug approaches as important parts of a pain management program; use of pharmacological interventions individualized for each resident ..."

2) For Resident #376, the facility staff delayed assessment and treatment of Resident #376's chest pain and lower right leg pain on 02/02/2023.

On 02/02/2023 at 9:46 A.M., this surveyor observed a therapist (Employee J) approach Licensed Practical Nurse F (LPN F) while she was passing medications to explain that Resident #376's right lower leg was tender and swollen. LPN F asked the therapist if Resident #376 was in pain and the therapist stated, "Yes." LPN F did not go to Resident #376 at that time to assess the pain. LPN F did continue with passing medications to three Residents (Resident #378, Resident #379, Resident #166). After completing passing medications at approximately 10:15 A.M. on the three Residents, LPN F called to schedule Resident #376 for a doppler study to rule out deep vein thrombus of the right lower leg.

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On 02/02/2023 at 10:20 A.M., Resident #376 was interviewed. Resident #376 was observed in her bed. When asked about her right leg pain, Resident #376 stated her right leg had been "hurting all night." Resident #376 stated it hurt from her knee to her ankle. Resident #376 was observed to be grimacing and moaning at times. When asked to rate the severity of the pain [0=no pain to 10=worst pain], Resident #144 stated the pain severity was "10."

On 02/02/2023 at 10:34 A.M., Certified Nursing Assistant C (CNA C) entered Resident #376's room to assist with Activities of Daily Living (ADL) care. Three times during ADL care, Resident #376 verbalized to the CNA C that "my leg hurts" "my leg is sore" and "my leg hurts so bad." As CNA C was assisting Resident #376 to her wheelchair at 10:52 A.M., Resident #376 stated, "My chest hurts, too." When asked about the severity level of the chest pain, Resident #376 stated, "10." Resident #376 stated she thinks the pain is related to fall she had prior to coming to the facility. At 11:00 A.M., CNA C notified LPN F that Resident #376 complained of chest pain. LPN F did not go to Resident #376 to assess the chest pain or the right lower leg pain as reported to her at 9:46 A.M. At 11:37 A.M., LPN F entered Resident #376's room and assessed Resident #376's right lower leg pain. Resident #376 stated she had pain in leg "all night long but now it's "not as bad as it was." Resident #376 currently rated the right leg pain severity "5." LPN F administered Tylenol to Resident #376 at 11:41 A.M. and left the room. When asked why it took so long to assess and treat Resident #376's leg pain, LPN F stated that she "should've gotten there sooner" but was doing other things. At 11:55 A.M., LPN F was asked if she assessed Resident #376 for the

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F 697	Continued From page 42	F 697		

chest pain. LPN F indicated she did not assess for chest pain but would do so now. LPN F entered Resident #376's room, listened to her heart and lungs, and asked about current chest pain severity. Resident #376 stated she currently didn't have chest pain so LPN F left the room. When asked about what else would be done concerning Resident #376, LPN F stated she could let the physician know.

On 02/02/2023 at 1:55 P.M., LPN F was interviewed. When asked if physician was notified, LPN F stated she put a call out and was waiting for a call back.

On 02/02/2023 at approximately 2:00 P.M., this surveyor interviewed Resident #376. When asked chest pain, Resident #376 stated it was better than it was. When asked to rate the pain severity, Resident #376 stated, "2." And that the pain "comes and goes."

On 02/02/2023 at approximately 2:10 P.M., the Director of Nursing was notified of findings.

On 02/02/2023, Resident #376's clinical record was reviewed. A nurse's note dated 02/02/2023 at 2:34 P.M. documented, "Resident reassessed s/p [status post] chest pain rates pain 2/10 currently in room participating with therapy, spoke with MD [medical doctor] made aware of change in condition v/s [vital signs] and pain level 97.0 [temperature] 20 [respirations] 126/66 [blood pressure] 82 [pulse] 98% [oxygen saturation]. Received new order from MD to send to ER [emergency room] for further evaluation r/t [related to] pervious [sic] medical history. Rp [responsible party] made aware of change in condition and MD order to send resident to the

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F 697	Continued From page 43 hospital for further evaluation." According to the physician's admission note dated 01/27/2023, Resident #376 was admitted to the facility having "chest pain around where she was caught by her son from her fall." Resident #376's baseline care plan was reviewed. The chest pain was not addressed on the care plan. There was no recent Minimum Data Set completed due to Resident #376's recent admission. According to Resident #376's admission nursing progress note dated 01/26/2023 at 8:52 P.M., Resident #376 was alert and oriented. On 02/02/2023 at 5:30 P.M., the Administrator and Director of Nursing were notified of findings.	F 697		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency	F 790		3/27/23

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F 790	Continued From page 44 dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, the facility failed to ensure routine dental services were offered to one of one Resident (R)26 reviewed for dental services. Findings include: Review of R26's "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/03/23 indicated that R26 had a "Brief Interview for Mental Status" (BIMS) of 14 out of 15, indicating the resident was cognitively intact. During an interview on 02/02/23 at 10:10 AM,	F 790	F 790 Corrective Action(s): Resident #26 was evaluated by the Dental clinic. A plan of care has been developed to address the dental care needs identified. The facility has completed a Risk Management Incident and Accident form for this incident to include the physician and responsible party. Identification of Deficient Practice &	

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F 790	Continued From page 45 R26 stated that she knew she needed dental work or dentures but was unsure if she could get an appointment with a dentist. She revealed she had been at the facility for two years and has not had seen a dentist. Review of R26's "Face Sheet" located in the electronic medical record (EMR) under the "Profile" tab, revealed an admission date in February 2021. During an interview on 02/03/23 at 2:00 PM with the Social Services Director, Staff D, who is responsible for arranging resident dental appointments, with the in house free dental clinic stated, "We do not automatically get everyone a dental appointment, unless their family or the resident requests it, or unless they have weight issues." During an interview on 02/03/23 at 3:45 PM with the Director of Nursing, (DON) she stated her expectations of residents being made dental appointments was if the resident or family request an appointment, if the nurse notices a concern (no teeth, broken teeth, or pain), or have dietary issues.	F 790	Corrective Action(s): The facility has determined that all residents have the potential to be affected. Systemic Change(s): The facility Policies and Procedures have been reviewed. No revisions are warranted at this time. The Administrator, or designee, will conduct in-service education for all Licensed Nurses, all Social Service Staff, Director of Nursing and all Unit managers regarding obtaining Dental Services. Monitoring: The Director of Nursing is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The Director of Nursing or designee will monitor the provision of residents to obtain Dental services. An audit of all resident records who have dental service referrals will be conducted to ensure routine dental services were provided weekly for twelve (12) weeks. Any/all negative findings will be corrected at the time of discovery and communicated to the Administrator. Aggregate findings of these audits will be	

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F 790	Continued From page 46	F 790	provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 27, 2023	
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.	F 868		3/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495079	A. BUILDING _____ B. WING _____	C 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE CENTER LUCY CORR	6800 LUCY CORR BLVD CHESTERFIELD, VA 23832

(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 868	Continued From page 47 §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure Committee Members were present for QAPI meetings for 4 of 4 QAPI meetings. The Findings included: For the QAPI meetings, the facility staff failed to ensure core members were present for each meeting. On 02/06/23 at 2:56 p.m., Meeting with DON and Administrator- Administrator stated the QAA, QAPI meets quarterly, The dates of the meetings in the past year were 11/15/2022, 8/31/2022, 5/18/2022 and 2/9/2022. Those in attendance were: 11/15/2022- The Administrator, Director of Nursing, Medical Director and 3 LPNs. (the Infection Preventionist was not present) 8/31/2022- The Administrator, Director of Nursing, Medical Director and 1 LPN. (the Infection Preventionist was not present and 1 other facility staff was not present) 5/18/2022- There were no signatures. All names were printed in the same penmanship. There were 3 listed on the top section as Healthcare	F 868	F 868 Corrective Action(s): A QAPI meeting has been scheduled to include all core members. The facility has completed a Risk Management Incident and Accident form. Identification of Deficient Practice & Corrective Action(s): The facility has determined that all residents the potential to be affected. Systemic Change(s): The facility Policies and Procedures have been reviewed. No revisions are warranted at this time. The Administrator, or designee, will in-service all QAPI team members on the required participation to scheduled meetings. Monitoring:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 868	Continued From page 48 Center Advisory Members on "Web-ex". The bottom section listed 6 printed names including the Administrator, Director of Nursing, Chief Executive Officer, Unit Managers, one unidentified position and one via "Web ex" (The printed names did not document the positions held by each person.) 2/9/2022-The Administrator, Director of Nursing, Medical Director and 1 LPN. the Infection Preventionist was not present and 1 other facility staff was not present) On 2/6/23 at 2:52 p.m., Administrator stated "We need to get back on track Post COVID- some members were not present" She also stated "Core group meets every day. The Administrator stated "Clin ops (Clinical Operations) meeting is Campus wide,Transparent with each other and meet daily" The Administrator stated Department heads, Certified Nursing Assistants, Rehab, Administrator, DON (Director of Nursing) Staffing, Unit Secretary, Dietary, etc were involved in the daily meeting. The Administrator stated the Infection Preventionist did not attend any of the QAPI meetings. She also stated a Certified Nursing Assistant did not attend the QAPI meetings. No further information was provided.	F 868	The Administrator is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The Administrator, or designee, will conduct an audit monthly for three (3) months for the presence of the required core Committee members to the QAPI meetings. Any/all negative findings will be communicated to the Administrator and Director of Nursing for corrective action. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 27, 2023	