STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495388	A. BUILDING _____ B. WING _____	C 03/01/2023

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GAINESVILLE HEALTH AND REHAB CENTER	7501 HERITAGE VILLAGE PLAZA GAINESVILLE, VA 20155

(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 2/27/2023 through 3/1/2023. 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 2/27/2023 through 3/1/2023. Five complaints were investigated during the survey (VA00053719-substantiated with deficiency, VA00055086-substantiated with deficiency, VA00055258-unsubstantiated, VA00056986-substantiated with deficiency, and VA00055836-substantiated without deficiency). Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. The census in this 120 bed certified facility was 108 at the time of the survey. The survey sample consisted of 33 current resident reviews and 13 closed record review.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical	F 578		4/11/23

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

Electronically Signed | 03/20/2023

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F 578	Continued From page 1 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. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to conduct a periodic review of an advance directive for one of 46 residents in the survey sample, Resident # 80 (R80).	F 578	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's	

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F 578	Continued From page 2 The finding include: For (R80), the facility staff failed to evidence a quarterly review for an advance directive. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/06/2023, (R80) scored three out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired of cognition for making daily decisions. The facility's "Social Services Quarterly Review" for (R80) dated 02/16/2022 failed to evidence a review of an advance directive. The physician's order for (R80) documented, "Full code. Order Date: 09/03/2022." On 03/01/2023 at approximately 9:30 a.m., an interview was conducted with OSM (other staff member) #11, assistant director of social services. When asked about the procedure for reviewing a resident's advance directive OSM #11 stated that the review is conducted quarterly. After reviewing the "Social Services Quarterly Review" for (R80) OSM #11 stated that the review was not conducted. The facility's policy "Advance Directives" documented in part, "10. Educational information concerning Advance Directives will be provided to residents and legal representatives on a periodic basis." On 03/01/2022 at approximately 2:38 p.m., ASM (administrative staff member) #1, administrator,	F 578	allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. 1. Resident #80 advanced directive was reviewed and completed in medical record on 3/1/2023. 2. All residents have the potential to be affected by this deficient practice. Social Service Director/Designee will conduct an audit of current residents' Quarterly Assessments to ensure residents Advance Directives were reviewed periodically and have been completed within the last three months. 3. Administrator will educate Social Services Department on completing Social Services Assessments quarterly to ensure Advanced Directives are reviewed periodically. 4. Social Service Director/ Designee will conduct audits of 20 residents to verify residents Social Service Assessments are completed quarterly and Advanced Directives are reviewed and updated as applicable weekly for 4 weeks then monthly for 2 months. The audit findings will be reviewed and/or revised in the QAPI (Quality Assurance Performance Improvement Committee) with any variances addressed.	

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F 578	Continued From page 3 ASM #2, director of nursing and ASM #3, assistant director of nursing and ASM #5, clinical services specialist, were made aware of the above findings. No further information was provided prior to exit.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		4/11/23

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F 580	Continued From page 4 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined the facility staff failed to notify the responsible party (RP) of a change in condition for one of 46 residents in the survey sample, Resident #162. The findings include: The facility failed to notify the RP of Resident #162's new medication order for Depakote (1). Resident #162 was admitted to the facility on 4/6/21 with diagnoses that included but were not limited to: dementia, idiopathic hydrocephalus, and adjustment disorder with anxiety. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/27/21,	F 580	1. It is noted facility failed to notify legal representative of a change of condition for resident #162. Resident no longer resides in facility. 2. All residents who experience a change of condition have the potential to be affected by this deficient practice. Director of Nursing/ Designee will audit medical records of residents who have experienced a change of condition in the past 30 days to ensure legal representative was notified accordingly. 3. Director of Nursing/ Designee will educate current licensed nursing staff on policy for Notification of Changes when a resident experiences a change of condition. 4. Director of Nursing/ Designee will conduct audits of 10 residents per unit to	

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F 580	Continued From page 5	F 580		

coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired.

A review of the physician orders dated 4/9/21, revealed, "Depakote Sprinkles Capsule Delayed Release Sprinkle 125 MG (milligram), Give 1 capsule by mouth two times a day for mood disorder."

A review of the physician orders dated 5/5/21, revealed, "Depakote Sprinkles Capsule Delayed Release Sprinkle 125 MG, Give 1 capsule by mouth at bedtime for mood disorder for 3 Days.

A review of Resident #162's April and May MAR (medication administration record) revealed, the medication administered as ordered.

A review of the progress notes did not reveal the Responsible Party was notified of the start of Depakote.

An interview was conducted on 2/28/23 at 8:00 AM with LPN (licensed practical nurse) #3, the unit manager. When asked who notifies the RP if there is a change in medication, LPN #3 stated, "Nursing notifies the RP and we write a note in the chart." When asked what it means if there is no note documenting the notification, LPN #3 stated if it is not documented, then it is not done.

On 3/1/23 at approximately 1:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing and ASM #5, the clinical services specialist was made aware of the findings.

verify documentation of legal representative notification for changes of condition weekly for 4 weeks, then monthly for 2 months. The audit findings will be reviewed and/or revised in the QAPI (Quality Assurance Performance Improvement Committee) with any variances addressed.

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F 580	Continued From page 6 A review of the facilities' "Notification of Changes" policy dated 5/27/22, revealed the following: "The purpose of this policy is to ensure the Center promptly informs the patient, consults the patient's physician/physician extender; and notifies, consistent with his or her authority, the patient's legal representative when there is a change requiring notification. Circumstances that require a need to alter treatment. This may include new treatment." No further information was provided prior to exit. Reference: (1) Depakote is used to treat complex partial seizures, simple and complex absence seizures, as well as acute manic symptoms in patients with bipolar disorder. https://www.depakote.com/about-depakote#:~:text=Depakote%20is%20one%20of%20the,125%20mg	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined the facility staff failed to conduct an accurate MDS (minimum data set) assessment for two out of 46 residents in the survey sample, Residents #67 and #110. The findings include:	F 641	1. It is noted facility failed to complete an accurate assessment for the following residents. Resident #67 annual assessment did not include dialysis. Assessment modified during survey. Resident #110 discharge assessment was coded as discharge to hospital when the resident	4/11/23

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F 641	Continued From page 7 1. The facility staff failed to complete an accurate annual assessment MDS to include dialysis for Resident #67. Resident #67 was admitted to the facility on 10/17/20 with diagnoses that included but were not limited to: end stage renal disease, peripheral vascular disease, atrial fibrillation and cardiomegaly. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/15/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. Section O-special procedures/treatments coded the resident as dialysis "no." A review of the comprehensive care plan dated 10/17/20, which revealed, "FOCUS: The resident has renal disease requiring dialysis 3 times/week. INTERVENTIONS: Coordinate with Dialysis center for dialysis treatments as ordered. Communicate with dialysis provider regularly via pre/post treatment notes." On 2/27/23 at approximately 4:00 PM, Resident #67 was observed returning from dialysis. A review of physician orders, dated 10/17/20, revealed the following, "Hemodialysis on Mon-Wed-Fridays." On 2/28/23 at 4:35 PM, an interview was conducted with OSM (other staff member) #4, the MDS manager, OSM #5, the MDS coordinator	F 641	in fact had discharged to an assisted living. Assessment modified during survey. 2. Residents who receive dialysis have the potential to be affected by this deficient practice. All discharged residents have a potential to be miscoded as #110 was. Clinical Reimbursement Specialist or designee will audit current patients receiving dialysis to ensure it has been coded and that discharge destinations over the last 3 months are correct on the most recent assessments. 3. Clinical Reimbursement Specialist will educate MDS staff on accurate coding of dialysis and Coding of discharge destinations. 4. Clinical Reimbursement Specialist / Designee will conduct audits to verify coding of dialysis and discharge destinations for 10 patients (or all if less than 10 meet criteria) weekly for 4 weeks, then monthly for 2 months. The audit findings will be reviewed and/or revised in the QAPI (Quality Assurance Performance Improvement Committee) with any variances addressed.	

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F 641	Continued From page 8	F 641		

and OSM #6, the regional corporate reimbursement specialist. When asked to review the 12/15/22 MDS Section O (special treatments and procedures): 0100. J dialysis, OSM #5 stated, "It is coded no. That was my mistake."

On 3/1/23 at approximately 1:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing and ASM #5, the clinical services specialist was made aware of the findings.

2. The facility staff failed to complete an accurate MDS for Resident #110. Resident #110 was coded as discharged to an acute hospital in error.

During the closed record review, Resident #110 was identified as 'hospitalized'.

Resident #67 was admitted to the facility on 1/28/23 with diagnoses that included but were not limited to: diabetes, dementia, Alzheimer's Disease and osteoarthritis.

The most recent MDS (minimum data set) assessment, a discharge return not anticipated assessment, with an ARD (assessment reference date) of 2/6/23, coded the resident as scoring a 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. Section A: Identification Information was coded- A.2100 Discharge Status: acute hospital.

A review of the nursing progress note, dated 2/6/23 at 10:30 AM, revealed, "Resident to discharge to assisted living facility (ALF), vital signs are stable upon discharge, morning

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F 641	Continued From page 9 medications were given. Husband was educated on diagnoses and medications. ALF was sent medications as well as scripts sent with the husband. Resident left the facility with all personal belongings and husband had no further questions at this time." On 3/1/23 at 1:35 PM, an interview was conducted with OSM (other staff member) #4, the MDS manager. When asked to review the 2/6/23 MDS Section A (identification information): A.2100-discharge status-acute hospital, OSM #4 stated, it is coded acute hospital. When asked to review the progress note dated 2/6/21, OSM #4 stated, "The resident went to an ALF, it should not have been coded as acute hospital. We will modify that." On 3/1/23 at approximately 1:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing and ASM #5, the clinical services specialist was made aware of the findings. No further information was provided prior to exit.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		4/11/23

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F 656	Continued From page 10	F 656		

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 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 observations, staff interview, clinical record review, it was determined that the facility

1. It is noted facility failed to develop/ implement the comprehensive care plan

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F 656	Continued From page 11 staff failed to develop and/or implement the comprehensive care plan for four of 46 residents in the survey sample, Resident #15, Resident #11, Resident #80 and Resident #67. The findings include: 1. For Resident #15 (R15), facility staff failed to implement the comprehensive care plan for the use of fall mats and positioning the bed in a low position. (R15) was admitted to the facility with a diagnosis that included but was not limited to epilepsy (1). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/19/2023, (R15) was coded as having both short- and long-term memory difficulties and was coded as being severely cognitively impaired for making daily decisions. On 02/27/2023 at approximately 12:25 p.m., (R15) was observed lying in their bed. There were no fall mats next to the bed and the bed was not in a low position. Using a standard carpenter's ruler, a measurement taken from the bottom of the mattress to the floor revealed the bed was 16 inches from the floor. On 02/27/2023 at approximately 2:45 p.m., (R15) was observed lying in their bed. There were no fall mats next to the bed and the bed was not in a low position. Using a standard carpenter's ruler, a measurement taken from the bottom of the mattress to the floor revealed the bed was 16 inches from the floor. On 02/27/2023 at approximately 3:34 p.m., (R15)	F 656	for residents #15, #11, #80, and #67. Care plan for Resident #15 was reviewed and revised to reflect low bed, and fall mat was discontinued from care plan on 2/28/2023. Care plan for Resident #11 was revised and reviewed to reflect Hospice Services on 2/28/2023, and oxygen care plan was implemented to reflect physician order. Care plan for Resident #80 was revised and reviewed to ensure Advanced Directive was addressed accordingly on 2/28/2023. Care plan for Resident #67 was revised and reviewed to ensure Dialysis care plan was implemented for coordination with Dialysis center. 2. MDS nurse/ Designee will audit current residents□ care plans to ensure accuracy of measurable objectives and timeframes based on MDS assessment and active care needs to include but not limited to, fall prevention interventions, Hospice, and Dialysis. Director of Social Services/ Designee will conduct an audit of current residents to ensure Advanced Directives have been reviewed periodically as per care plan. 3. Regional Reimbursement Specialist will educate MDS nurses on requirements for accuracy when completing comprehensive assessments. Care plans will be completed within 7 days of the CAA completion date on all comprehensive assessments in accordance with the RAI Manual. Administrator/ Designee will provide education to Social Services department regarding Advanced Directive care plan and implementation by ensuring Advanced Directives are reviewed on	

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F 656	Continued From page 12 was observed lying in their bed. There were no fall mats next to the bed and the bed was not in a low position. Using a standard carpenter's ruler, a measurement taken from the bottom of the mattress to the floor revealed the bed was 16 inches from the floor. On 02/28/2023 at approximately 8:50 p.m., (R15) was observed lying in their bed. There were no fall mats next to the bed and the bed was not in a low position. Using a standard carpenter's ruler, a measurement taken from the bottom of the mattress to the floor revealed the bed was 16 inches from the floor. The comprehensive care plan for (R15) dated 06/19/2021 documented in part, "Focus. (Name of (R15) has had actual falls r/t (related to) Traumatic brain injury sustained during a motorcycle accident. Hemiparesis r/t past CVA (cerebral vascular accident - stroke) /balance problems and impulsivity. Has extensive fall history. Date Initiated: 06/19/2021." Under "Interventions / Tasks" it documented in part, "Fall/floor mats at bedside while in bed. Revision on: 03/16/2021, Low bed. Revision on: 03/16/2021." On 02/28/23 at approximately 2:00 p.m., an interview and observation of (R15's) room was conducted with LPN (licensed practical nurse) #3, unit manager. LPN #3 stated that the fall mats were discontinued. After reviewing (R15's) comprehensive care plan LPN #3 stated that the care plan was not accurate for the use of the fall mats. When asked about the height of the bed, LPN #3 stated that the bed did not look low and could be lowered. After measuring the height of the bottom of the mattress from the floor using a	F 656	admission, quarterly and as needed. 4. MDS/ Designee will audit 10 residents' care plans to ensure care plans are accurate based on MDS assessment and active care needs to include but not limited to Advanced Directives, fall prevention interventions, Hospice, and Dialysis weekly for 4 weeks, then monthly for 2 months. Social Services Director/ Designee will audit 10 residents per nursing unit to ensure care plans for Advanced Directives have been implemented by ensuring advanced directives have been reviewed on admission, quarterly, and as needed weekly for 4 weeks, then monthly for 2 months. The audit findings will be reviewed and/or revised in the QAPI (Quality Assurance Performance Improvement Committee) with any variances addressed.	

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standard carpenter's ruler with the surveyor, LPN #3 confirmed that the height was 16 inches from the floor. LPN #3 lowered the bed to its lowest position using the bed remote control and reading the ruler again confirmed that the height was lowered to 10 inches from the floor. When asked if the bed had been placed in the lowest position LPN #3 stated no. When asked if the care plan was followed for placing the bed in a low position LPN #3 stated no.

On 03/01/2023 at approximately 2:38 p.m., a request was made to ASM (administrative staff member) #1, administrator, for evidence that the fall mats for (R15) were discontinued. At 4:45 p.m., ASM #1 provided a copy of the facility's "Edit Intervention" for (R15's) comprehensive care plan dated 02/28/2023. The form documented in part, "Status: Resolved. Description: Fall/floor mats at bedside while in bed." When asked if the care plan was being followed for the use of the fall mats prior to the revision of the care plan ASM #1 stated no.

On 03/01/2022 at approximately 2:38 p.m., ASM #1, administrator, ASM #2, director of nursing and ASM #3, assistant director of nursing and ASM #5, clinical services specialist, were made aware of the above findings.

No further information was provided prior to exit

2 a. For Resident #11 (R11), facility staff failed to implement the comprehensive care plan for the administration of oxygen at two liters per minute according to the physician's orders.

Resident #11 was admitted to the facility with diagnoses that included but were not limited to:

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congestive heart failure (1).

On 02/27/2023 at approximately 12:39 p.m., an observation of (R11) revealed they were lying in bed receiving oxygen via nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between three-and-a-half and four liters per minute.

On 02/27/2023 at approximately 3:52 p.m., an observation of (R11) revealed they were lying in bed receiving oxygen via nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between three-and-a-half and four liters per minute.

On 02/28/2023 at approximately 8:54 a.m., an observation of (R11) revealed they were lying in bed receiving oxygen via nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between three-and-a-half and four liters per minute.

The physician's order for (R11) dated 01/17/2023 documented, "O2 (oxygen) at 2(two) L/min (liters per minute) via nasal cannula continually."

The comprehensive care plan for (R11) dated 11/15/2021 documented in part, "Focus. (Name of R11) has respiratory problem(s) related to acute illness Spine surgery ... Date Initiated: 11/15/202." Under "Interventions / Tasks" it documented in part, "Provide oxygen as ordered. Date Initiated: 11/15/2021."

On 02/28/2023 at approximately 2:20 p.m., an observation of (R11's) oxygen flow rate on the oxygen concentrator was conducted with RN (registered nurse) #3. After reading the flow

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meter RN#3 stated that it was about three and a half liters per minute. When asked what the flow rate should be RN #3 stated that they needed to check the physician's orders. After looking up the physician's order in (R11's) EHR (electronic health record) RN #3 stated that the flow rate was ordered for two liters per minute. When asked to describe how to read the oxygen flow rate on an oxygen concentrator RN #3 stated that the liter line should pass through the middle of the float ball inside the flow meter. When asked if the comprehensive care plan for (R11) was being followed for the administration of oxygen RN #3 stated no.

On 03/01/2022 at approximately 2:38 p.m., ASM #1, administrator, ASM #2, director of nursing and ASM #3, assistant director of nursing and ASM #5, clinical services specialist, were made aware of the above findings.

No further information was provided prior to exit

2.b.. For (R11), facility staff failed to develop a care plan for hospice services.

Resident #11 was admitted to the facility with diagnoses that included but were not limited to: breast cancer.

The physician's order for (R11) dated 02/19/2023 documented, "Hospice orders per the following: Hospice agency (Name of Hospice Agency and Phone Number)."

Review of (R11's) comprehensive care plan dated 11/15/2021 failed to evidence hospice services.

On 03/01/2023 at approximately 9:55 a.m., an

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interview was conducted with OSM (other staff member) #5, MDS coordinator and OSM #6, regional corporate reimbursement specialist. When asked about (R11's) comprehensive care plan dated 11/15/2021 addressing hospice services, OSM #5 and OSM #6 reviewed the care plan. After reviewing the care plan OSM #5 and OSM #6 stated that the care plan did not address hospice services for (R11). When asked to describe the procedure for completing the care plan accurately OSM # 5 stated that they follow the resident assessment instrument (RAI) manual.

The facility's policy "Comprehensive Care Planning Process" documented in part, "The facility must develop a comprehensive care plan for each patient that includes measurable objectives and timetables to meet a patient's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. An interdisciplinary assessment team shall develop a comprehensive assessment and care plan for each patient based on outcomes of assessments and input from the patient, family, and interdisciplinary team members. The team serves as the authority for overseeing patient care services.

On 03/01/2022 at approximately 2:38 p.m., ASM #1, administrator, ASM #2, director of nursing and ASM #3, assistant director of nursing and ASM #5, clinical services specialist, were made aware of the above findings.

No further information was provided prior to exit.

3. For Resident #80 (R80) the facility staff failed to implement the comprehensive care plan for the

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quarterly review of the advance directive.

The facility's "Social Services Quarterly Review" for (R80) dated 02/16/2022 failed to evidence a review of an advance directive.

The physician's order for (R80) documented, "Full code. Order Date: 09/03/2022."

The comprehensive care plan for (R80) dated 10/21/2021 documented in part, "Focus. (Name of (R80)) has a full code status. Will review status during stay. Revision on: 12/30/2022." Under "Interventions / Tasks" it documented in part, "Review code status upon admission, quarterly and as needed with resident/POA/RP (power of attorney/responsible party). Date Initiated: 10/21/2021."

On 03/01/2023 at approximately 9:30 a.m., an interview was conducted with OSM (other staff member) #11, assistant director of social services. When asked about the procedure for reviewing a resident's advance directive OSM #11 stated that the review is conducted quarterly. After reviewing the "Social Services Quarterly Review" for (R80) OSM #11 stated that the review was not conducted. After informed of the information as stated above on the comprehensive care plan for (R80), OSM # 11 was asked if the care plan was being followed for the quarterly review of the advance directive. OSM #11 stated the care plan was not followed.

On 03/01/2022 at approximately 2:38 p.m., ASM #1, administrator, ASM #2, director of nursing and ASM #3, assistant director of nursing and ASM #5, clinical services specialist, were made aware of the above findings.

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No further information was provided prior to exit

4. The facility staff failed to implement the comprehensive care plan for dialysis communication for Resident #67.

Resident #67 was admitted to the facility on 10/17/20 with diagnoses that included but were not limited to: end stage renal disease.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/15/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. Section O-special procedures/treatments coded the resident as dialysis "no".

A review of the comprehensive care plan dated 10/17/20, which revealed, "FOCUS: The resident has renal disease requiring dialysis 3 times/week. INTERVENTIONS: Coordinate with Dialysis center for dialysis treatments as ordered. Communicate with dialysis provider regularly via pre/post treatment notes."

A review of physician orders, dated 10/17/20, revealed the following, "Hemodialysis on Mon-Wed-Fridays."

A review of Resident #67's dialysis communication book revealed missing communication to the dialysis facility for 12 of 51 visits from 11/1/22-2/28/23.

An interview was conducted on 2/27/23 at 4:00

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PM with Resident #67. When asked if they take their dialysis communication book with them to the dialysis center, Resident #67 stated, "Yes, the book goes with me."

An interview was conducted on 2/28/23 at 12:45 PM with LPN (licensed practical nurse) #2. When asked what information is provided to the dialysis facility when a resident is sent for hemodialysis, LPN #2 stated, when a resident is going out to dialysis, we take their vital signs, check their weight, give them breakfast and their morning medicines. They take their book with them and we give them a lunch to take with them. When asked if the documentation was complete if missing vital signs and/or weights, LPN #2 stated, no, it is not. When asked if there are blanks on the dialysis communication sheets, is the care plan intervention to provide regular pretreatment notes being followed, LPN #2 stated, no.

On 3/1/23 at approximately 1:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing and ASM #5, the clinical services specialist was made aware of the findings.

A review of the facility's "Comprehensive Care Planning Process" policy dated 2017, revealed, "The facility must develop a comprehensive care plan for each patient that includes measurable objectives and timetables to meet a patient's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment."

No further information was provided prior to exit.

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to revise the comprehensive care plan for one of 46 residents on the survey sample, Resident #165 (R165).	F 657	1. Resident #165's care plan was revised and updated on 2/28/2023 to include use of PICC line and administration of TPN. 2. All residents have the potential to be affected by this deficient practice. MDS nurse/ Designee will audit current residents' care plans to ensure accuracy	4/11/23

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F 657	Continued From page 21 The findings include: The facility staff failed to revise the care plan for the use of a PICC line (peripherally inserted central catheter) (1) and for the administration of TPN (total parenteral nutrition) (2) for R165. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/22/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score indicating the resident was not cognitively impaired for making daily decisions. A significant change MDS assessment was in progress. On 2/27/2023 at approximately 12:30 p.m. R165 was observed in bed with TPN solution being administered through the PICC line. The Nutritional Care Plan dated 10/5/2022 and revised on 1/5/2023, failed to evidence documentation of R165 receiving TPN. The comprehensive care plan dated, 10/5/2022 and last revised on 2/23/2023, failed to evidence documentation for the use and care of a PICC line. An interview was conducted with OSM (other staff member) #12, the dietitian, on 2/28/2023 at 2:10 p.m. When asked who is responsible for updated the care plan for TPN, OSM #12 stated either herself or nursing. When asked if it is expected to see TPN on a care plan, OSM #12 stated, yes, her readmission assessment is not due yet but she is doing it today. An interview was conducted with LPN (licensed	F 657	of revisions based on on MDS assessments and active care needs. 3. Regional Reimbursement Specialist will educate MDS nurses on requirements when completing comprehensive assessments for accurate timing and revisions based on MDS assessment and active care needs. Care plans will be completed within 7 days of the CAA completion date on all comprehensive assessments in accordance with the RAI Manual. 4. MDS/ Designee will audit 10 residents' care plans per unit to ensure care plans have been revised timely based on MDS assessments and active care needs weekly for 4 weeks, then monthly for 2 months. The audit findings will be reviewed and/or revised in QAPI (Quality Assurance Performance Improvement) Committee with any variances addressed.	

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practical nurse) #1, on 2/28/2023 at 2:25 p.m. When asked who updated the care plans, LPN #1 stated if the resident is gone from the facility for more than 24 hours, they would do an actual admission care plan. She further stated, even though the resident is a readmission, we would reenter everything in the system, batch orders and care plans, they would pick what areas are appropriate for that resident. When asked if a resident with a PICC line and TPN should have these things addressed on the care plan, LPN #1 stated, absolutely. When asked the purpose of the care plan, LPN #1 state it's the goals for that patient, what they, the facility staff, are going to do for them.

The facility policy, "Comprehensive Care Planning Process" failed to evidence anything related to reviewing and revising the care plan.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing, and ASM #5 the clinical services specialist, were made aware of the above findings on 3/1/2023 at 2:38 p.m.

No further information was obtained prior to exit.

(1) Peripherally inserted central catheter is a long-line catheter made of soft silicone or Silastic material that is placed peripherally but delivers medications and solutions centrally. Lippincott, Williams & Wilkins, Fundamental of Nursing, 5th edition, 2007, page 1423.

(2) Total parenteral nutrition (TPN) is a method of feeding that bypasses the gastrointestinal tract. A special formula given through a vein provides

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F 657	Continued From page 23 most of the nutrients the body needs. The method is used when someone can't or shouldn't receive feedings or fluids by mouth. https://medlineplus.gov/ency/patientinstructions/000177.htm	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review, it was determined the facility staff failed to follow professional standards of practice for medication administration and monitoring, for one of 46 residents in the survey sample, Resident #163. The findings include: 1.a. For Resident #163 (R163), the facility staff failed to transcribe a telephone order for Tums (1). On the most recent MDS (minimum data set) assessment, a five day admission assessment, with an assessment reference date of 11/15/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact for making daily decisions. The assessment documented R163 receiving hemodialysis. The SBAR (situation, background, assessment,	F 658	1.It is noted facility failed to follow professional standards of practice for medication administration and monitoring for resident #163. Resident no longer resides in facility. 2. All residents have the potential to be affected by this deficient practice. Director of Nursing/ Designee will audit current residents whose medical provider has given a verbal order for the past 14 days to ensure orders have been transcribed accordingly by reviewing progress notes and orders in medical record. Director of Nursing/ Designee will audit current residents who have active PRN medication orders to ensure follow up assessment has been done and documented for the past 14 days. 3. Director of Nursing/ Designee will educate current Licensed Nursing staff on transcription of verbal orders, and assessment post administration of PRN medications to determine effectiveness.	4/11/23

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F 658	Continued From page 24 recommendation) Communication Form for R163 dated 11/13/2022 documented in part, "...NP (nurse practitioner) notified of patients complaint of heartburn new orders received for Tums 500mg (milligram) q4h (every four hours) PRN (as needed). Patient and RP (responsible party) notified..." The physician orders dated 11/10/2022-11/16/2022 failed to evidence an order for Tums. The eMAR (electronic medication administration record) dated 11/1/2022-11/30/2022 failed to evidence an order for Tums. On 2/28/2023 at 2:07 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that R163 had complained of heart burn on 11/13/2022 and they had contacted the nurse practitioner because there was nothing ordered at the time. LPN #1 stated that the nurse practitioner had ordered as needed Tums for R163 to take and as far as they knew R163 had received them. LPN #1 stated that they did not recall a delay in getting the medication however they did not keep a stock supply of the medication and may have had to wait for the medication to come from the pharmacy. LPN #1 stated that when they received a telephone order they entered the new order into the electronic medical record which sent it directly to the pharmacy to be processed and automatically put it on the eMAR after it was verified by the pharmacy. LPN #1 reviewed R163's physician orders dated 11/10/2022-11/16/2022 and eMAR dated 11/1/2022-11/30/2022 and stated that they did not know why the Tums were not on there.	F 658	LPN #1 will receive 1:1 education related to transcription of verbal orders and assessment of Blood Pressure post administration of PRN Midodrine to determine effectiveness. 4. Director of Nursing/ Designee will audit 10 medical records per nursing unit to ensure any verbal orders have been transcribed accordingly weekly for 4 weeks, then monthly for 2 months. Director of Nursing/ Designee will audit 10 medical records of residents who receive PRN medications weekly for 4 weeks, then monthly for 2 months to ensure effectiveness has been assessed and documented in clinical record. The audit findings will be reviewed and/or revised in the QAPI (Quality Assurance Performance Improvement Committee) with any variances addressed.	

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On 2/28/2023 at approximately 5:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of the Tums order being transcribed and/or administered for R163's complaints of heart burn on 11/13/2022.

On 3/1/2023 at approximately 8:00 a.m., ASM #4, the assistant director of nursing/infection preventionist stated that they did not have any evidence of the Tums being transcribed or administered on 11/13/2022 for R163.

The facility policy, "Guidelines for Medication Orders" dated 6/21/2017 documented in part, "...New Verbal Orders: The nurse documents a complete order received by telephone or in person on the appropriate pharmacy approved form (physician's order sheet, Interim Order Form, Telephone order form or approved electronic order entry system). Documentation must include "T.O." for telephone orders, "V.O." for verbal orders or other indication in electronic order entry system. The nurse must indicate the prescriber's name giving the order and the licensed nurse accepting/recording the order. The nurse will sign the order in the appropriate space on the verbal order form. Verbal orders must be signed by the prescriber within the timeframe required by State and Federal regulations...Facility staff transcribes newly prescribed medications on the "Medication Administration Record (MAR/TAR)." When a new order changes the dosage of a previously prescribed medication, staff discontinues the previous entry by writing "DC'd" and the date and yellowing through the entry. Enter the new order on the MAR/TAR..."

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On 2/27/2022 during survey entrance, ASM (administrative staff member) #1, the administrator stated that the facility followed Lippincott as their nursing standard of practice and provided a copy of the cover of "Lippincott Manual of Nursing Practice, 10th Edition."

According to Fundamentals of Nursing Lippincott Williams and Wilkins, 2007 pages 167-168 it documented in part, "...anytime you accept a verbal order, it's your responsibility to ensure the accuracy of the communication...afterward write and sign the order that was given to you verbally by the prescriber and have the prescriber sign your written copy as soon as possible ..."

On 3/1/2023 at approximately 2:38 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing/infection preventionist and ASM #5, the clinical services specialist were made aware of the findings.

No further information was provided prior to exit.

(1) Tums
Calcium carbonate also is used as an antacid to relieve heartburn, acid indigestion, and upset stomach. It is available with or without a prescription...This information was obtained from the website:
https://medlineplus.gov/druginfo/meds/a601032.html

1.b. For Resident #163 (R163), the facility staff failed to reassess the blood pressure after administration of Midodrine (1) on 11/15/2022 at 11:06 a.m. prior to the resident being sent to the emergency room at 1:00 p.m., and failed to notify the nurse practitioner of the need for a dose of

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Midodrine on 11/15/2022 due to continued hypotension and it being on a non-dialysis day.

On the most recent MDS (minimum data set) assessment, a five day admission assessment, with an assessment reference date of 11/15/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact for making daily decisions. The assessment documented R163 received hemodialysis.

The physician orders for R163 documented in part, "Midodrine HCl (hydrochloride) Tablet 10 MG (milligram) Give 1 tablet by mouth as needed for Hypotension (low blood pressure). On dialysis day. If Systolic less than 100. Order Date: 11/11/2022." The physician orders further documented, "Dialysis days Monday, Wenesday [sic], and Fridays At [Name of dialysis center]. Order Date: 11/12/2022."

The eMAR (electronic medication administration record) dated 11/1/2022-11/30/2022 for R163 documented Midodrine 10 mg administered on 11/15/2022 at 8:58 a.m. for a blood pressure of 90/58 and at 11:06 a.m. for a blood pressure of 88/54.

The SBAR (situation, background, assessment, recommendation) Communication Form for R163 dated 11/15/2022 documented in part, "...Vital Signs: BP (blood pressure): 88/54...Primary Care Clinician Notified: Yes, Date: 11/15/2022; Time: 8:00 AM; Recommendations of Primary Clinicians (if any): Midodrine 10 mg (milligram) as needed..."

The progress notes for R163 documented in part,

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- "11/15/2022 08:58 (8:58 a.m.) eMAR Administration Note. Note Text: Midodrine HCL Tablet 10mg Give 1 tablet by mouth as needed for Hypotension on dialysis day if systolic less than 100."
- "11/15/2022 11:06 (11:06 a.m.) eMAR Administration Note. Note Text: Midodrine HCL Tablet 10mg Give 1 tablet by mouth as needed for Hypotension on dialysis day if systolic less than 100."
- "11/15/2022 12:06 (12:06 p.m.) eMAR Administration Note. Note Text: Midodrine HCL Tablet 10mg Give 1 tablet by mouth as needed for Hypotension on dialysis day if systolic less than 100. PRN administration was Ineffective."
- "11/15/2022 12:07 (12:07 p.m.) eMAR Administration Note. Note Text: Midodrine HCL Tablet 10mg Give 1 tablet by mouth as needed for Hypotension on dialysis day if systolic less than 100. PRN administration was Effective."
- "11/15/2022 18:58 (6:58 p.m.) Transfer Out (Acute/Emergency) Reason for transfer and requires higher level of care (describe): Abnormal vital sign/Low blood pressure 88/54. Symptoms exhibited: anxiety, n/v (nausea/vomiting), Current TX (treatment) (if applicable): Midodrine 10mg PRN...daughter called 911..."

The SNF/NF (skilled nursing facility/nursing facility) to hospital transfer form for R163 dated 11/15/2022 documented in part, "...Reason(s) for transfer: Abnormal vital signs (low/high BP, high respiratory rate)...Vital signs BP 88/54 11/15/2022 11:06 (11:06 a.m.)...Date of Transfer: 11/15/2022 13:00 (1:00 p.m.)..."

The blood pressure summary for R163 documented blood pressures on 11/15/2022 as 121/79 at 2:03 a.m., 90/58 at 8:40 a.m. and 88/54

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at 11:06 a.m.

Review of R163's clinical record failed to evidence a blood pressure taken after the administration of the Midodrine on 11/15/2022 at 11:06 a.m. or notification of the physician/nurse practitioner of the continued low blood pressure after administration of the Midodrine at 8:58 a.m. and need for second dose of Midodrine at 11:06 a.m.

On 2/28/2023 at 3:01 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that R163 had been sent to the emergency room on 11/15/2022 for unstable vital signs. LPN #4 stated that R163's blood pressure had been low when they had checked it that morning and they had rechecked it and it was still low so they had called the nurse practitioner who had told them to administer the as needed Midodrine. LPN #4 stated that R163 was a dialysis resident but did not go that day [it was a Tuesday]. LPN #4 stated that R163's blood pressure was still low when they rechecked it a couple of hours later and they complained of weakness so they administered a second dose of Midodrine. LPN #4 stated that they did not recall calling the nurse practitioner but thought that they were in the building and saw the resident. LPN #4 stated that R163's daughters arrived to the facility and wanted the resident to go to the emergency room and called 911. LPN #4 stated that they did not recall checking the blood pressure before they went out to the emergency room and thought that they went out before lunch. LPN #4 stated that it was their normal practice to go back and recheck the blood pressure when it was running low.

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On 2/28/2023 at approximately 5:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of the blood pressure being re-checked after administration of the Midodrine 10mg on 11/15/2022 at 11:06 a.m. or evidence that the medication was effective as documented in the progress note dated 11/15/2022 at 12:07 a.m.

On 3/1/2023 at approximately 8:00 a.m., ASM #1, the administrator provided a written statement from LPN #4 which stated that that they had mistakenly documented the Midodrine 10mg as being effective on 11/15/2022 at 12:07 a.m.

On 3/1/2023 at 1:43 p.m., an interview was conducted with LPN #3. LPN #3 stated that when Midodrine was administered to residents for low blood pressure they would follow up with a blood pressure recheck in an hour to see if the medication was effective. LPN #3 stated that the eMAR prompted them to go back to recheck the blood pressure and enter the results and effective or ineffective. LPN #3 stated that they would also document a progress note regarding the medication and whether or not the medication worked. LPN #3 stated that if the blood pressure continued to be low they would call the physician to notify them for further orders or evaluation. LPN #3 stated that orders for as needed Midodrine on dialysis days were for those days only and should be clarified with the physician if needed on non-dialysis days.

The manufacturers product instructions for use for Midodrine Hydrochloride Tablets documented in part, "...Doses may be given in 3-hour intervals, if required, to control symptoms, but not more frequently... The supine and standing blood

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pressure should be monitored regularly, and the administration of Midodrine hydrochloride tablets should be stopped if supine blood pressure increases excessively..."

The facility policy, "Medication Monitoring" dated 6/1/21 documented in part, "...Licensed nurses, with periodic oversight by nurse managers, shall: ...b. Adhere to facility policies and current standards of practice for administration and monitoring of medications..."

According to the facility provided "Lippincott Manual of Nursing Practice, 10th Edition." "Lippincott Procedures" page 556, it documented in part, "...Oral Drug Administration...Verify the order on the patient's medication record by checking it against the practitioner's order...Assess the patient's condition to determine the need for medication and the effectiveness of previous therapy..."

On 3/1/2023 at approximately 2:38 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing/infection preventionist and ASM #5, the clinical services specialist were made aware of the findings.

No further information was provided prior to exit.

(1) Midodrine
Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). Midodrine is in a class of medications called alpha-adrenergic agonists. It works by causing blood vessels to tighten, which increases blood pressure. This information was obtained from the website:

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical record review, it was determined that the facility staff failed to implement fall interventions for one of 46 residents in the survey sample, Resident #15. The findings include: For Resident #15 (R15), the facility staff failed to place the bed in a low position while (R15) was lying in their bed. (R15) was admitted to the facility with a diagnosis that included but was not limited to epilepsy (1). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/19/2023, (R15) was coded as having both short and long term memory difficulties and was coded as being severely cognitively impaired for making daily decisions. On 02/27/2023 at approximately 12:25 p.m.,	F 689	1. Resident #15 fall mats were discontinued from the care plan on 2/28/2023. Resident #15 bed was placed in low position on 3/1/2023. 2. All residents have the potential to be affected by this deficient practice. Director of Nursing/Designee conducted an audit of current Residents with High Risk for falls to ensure fall interventions are implemented as per care plan. 3. Director of Nursing/ Designee educated current nursing staff on ensuring residents fall interventions are implemented as per care plan. 4. Director of Nursing/ Designee will audit 10 residents per unit to verify residents with High Risk for falls have care plan interventions implemented as indicated weekly for 4 weeks, then monthly for 2 months. The audit findings will be reviewed and/or revised in QAPI (Quality Assurance Performance Improvement) Committee with any variances addressed	4/11/23

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(R15) was observed lying in their bed. There were no fall mats next to the bed and the bed was not in a low position. Using a standard carpenter's ruler, a measurement taken from the bottom of the mattress to the floor revealed the bed was 16 inches from the floor.

On 02/27/2023 at approximately 2:45 p.m., (R15) was observed lying in their bed. There were no fall mats next to the bed and the bed was not in a low position. Using a standard carpenter's ruler, a measurement taken from the bottom of the mattress to the floor revealed the bed was 16 inches from the floor.

On 02/27/2023 at approximately 3:34 p.m., (R15) was observed lying in their bed. There were no fall mats next to the bed and the bed was not in a low position. Using a standard carpenter's ruler, a measurement taken from the bottom of the mattress to the floor revealed the bed was 16 inches from the floor.

On 02/28/2023 at approximately 8:50 p.m., (R15) was observed lying in their bed. There were no fall mats next to the bed and the bed was not in a low position. Using a standard carpenter's ruler, a measurement taken from the bottom of the mattress to the floor revealed the bed was 16 inches from the floor.

The comprehensive care plan for (R15) dated 06/19/2021 documented in part, "Focus. (Name of (R15) has had actual falls r/t (related to) Traumatic brain injury sustained during a motorcycle accident. Hemiparesis r/t past CVA (cerebral vascular accident - stroke) /balance problems and impulsivity. Has extensive fall history. Date Initiated: 06/19/2021." Under

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"Interventions / Tasks" it documented in part, "Fall/floor mats at bedside while in bed. Revision on: 03/16/2021, Low bed. Revision on: 03/16/2021."

On 02/28/23 at approximately 1:50 p.m., an interview and observation of (R15's) room was conducted with LPN (licensed practical nurse) #2. When asked about fall mats and the bed being in a low position for (R15), LPN #2 stated that they were new and just started a month ago and did not know if (R15) needed fall mats or if the bed needed to be in a low position. LPN #2 stated that they would get their supervisor.

On 02/28/23 at approximately 2:00 p.m., an interview and observation of (R15's) room was conducted with LPN (licensed practical nurse) #3, unit manager. LPN #3 stated that the fall mats were discontinued. After reviewing (R15's) comprehensive care plan LPN #3 stated that the care plan was not accurate for the use of the fall mats. When asked about the height of the bed, LPN #3 stated that the bed did not look low and could be lowered. After measuring the height of the bottom of the mattress from the floor using a standard carpenter's ruler with the surveyor, LPN #3 confirmed that the height was 16 inches from the floor. LPN #3 lowered the bed to the lowest position using the bed remote control and reading the ruler again confirmed that the height was lowered to 10 inches from the floor. When asked if the bed had been placed in the lowest position LPN #3 stated no. When asked if the care plan was followed for placing the bed in a low position LPN #3 stated no. When asked why it was important to place the bed in a low position LPN #3 stated that it helped prevent an injury if the fell out of bed.

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F 689	Continued From page 35 On 03/01/2022 at approximately 2:38 p.m., ASM #1, administrator, ASM #2, director of nursing and ASM #3, assistant director of nursing and ASM #5, clinical services specialist, were made aware of the above findings. A request was made to ASM (administrative staff member) #1, administrator, for evidence that the fall mats for (R15) were discontinued. At 4:45 p.m., ASM #1 provided a copy of the facility's "Edit Intervention" for (R15's) comprehensive care plan dated 02/28/2023. The form documented in part, "Status: Resolved. Description: Fall/floor mats at bedside while in bed." No further information was provided prior to exit. References: (1) A brain disorder that causes people to have recurring seizures. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it	F 695	1. Resident #11 oxygen meter flow was corrected to physician's order of 2 liters on	4/11/23

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F 695	Continued From page 36 was determined that facility staff failed to provide respiratory care and services for one of 46 residents in the survey sample, Resident #11. The findings include: For Resident #11 (R11), the facility staff failed to maintain the physician ordered oxygen flow rate at two liters per minute. Resident #11 was admitted to the facility with diagnoses that included but were not limited to: congestive heart failure (1). On 02/27/2023 at approximately 12:39 p.m., an observation of (R11) revealed they were lying in bed receiving oxygen via nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between three-and-a-half and four liters per minute. On 02/27/2023 at approximately 3:52 p.m., an observation of (R11) revealed they were lying in bed receiving oxygen via nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between three-and-a-half and four liters per minute. On 02/28/2023 at approximately 8:54 a.m., an observation of (R11) revealed they were lying in bed receiving oxygen via nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between three-and-a-half and four liters per minute. The physician's order for (R11) dated 01/17/2023 documented, "O2 (oxygen) at 2(two) L/min (liters per minute) via nasal cannula continually."	F 695	3/1/2023. Resident #11 was not negatively affected by the oxygen liter flow rate not matching the physician□s order. 2. Residents on oxygen have the potential to be affected by this deficient practice. Director of Nursing/Designee will conduct an audit of current Residents with oxygen to ensure oxygen meter flow matches the physician□s order. 3. Director of Nursing/ Designee educated current licensed nursing staff on ensuring residents' oxygen meter flow matches the physician□s order to ensure residents receive oxygen as per the physician order. 4. Director of Nursing/ Designee will conduct audits on residents with ordered oxygen to ensure the oxygen meter flow matches the physician's order weekly for 4 weeks, then monthly for 2 months. The audit findings will be reviewed and/or revised in the QAPI (Quality Assurance Performance Improvement Committee) with any variances addressed.	

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F 695	Continued From page 37	F 695		

The comprehensive care plan for (R11) dated 11/15/2021 documented in part, "Focus. (Name of R11) has respiratory problem(s) related to acute illness Spine surgery ... Date Initiated: 11/15/202." Under "Interventions / Tasks" it documented in part, "Provide oxygen as ordered. Date Initiated: 11/15/2021."

On 02/28/2023 at approximately 2:20 p.m., an observation of (R11's) oxygen flow rate on the oxygen concentrator was conducted with RN (registered nurse) #3. After reading the flow meter RN#3 stated that it was about three and a half liters per minute. When asked what the flow rate should be RN #3 stated that they needed to check the physician's orders. After looking up the physician's order in (R11's) EHR (electronic health record) RN #3 stated that the flow rate was ordered for two liters per minute. When asked to describe how to read the oxygen flow rate on an oxygen concentrator and how often a resident's oxygen flow rate should be checked RN #3 stated that the liter line should pass through the middle of the float ball inside the flow meter and the flow rate should be checked at the beginning of each shift and whenever the nurse goes into the room.

On 03/01/2022 at approximately 2:38 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, assistant director of nursing and ASM #5, clinical services specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A condition in which the heart can't pump enough blood to meet the body's needs. This

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F 695	Continued From page 38 information was obtained from the website: https://medlineplus.gov/heartfailure.html	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, clinical record review, staff interview and facility document review it was determined that the facility staff failed to provide a complete pain management program including implementation of non-pharmacological interventions prior to the administration of as needed pain medications for one of 46 residents in the survey sample, Resident #58. The findings include: For Resident #58 (R58), the facility staff failed to evidence implementation of non-pharmacological interventions prior to administration of the as needed pain medication, Percocet (1). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/15/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section J documented R58 receiving as needed pain medications and not receiving	F 697	1. Resident #58 is receiving non-pharmacological interventions prior to administration of PRN pain medication. 2. Residents with PRN pain medication have the potential to be affected by this deficient practice. Director of Nursing/Designee will conduct an audit of current Residents on PRN pain medication to ensure residents are receiving non-pharmacological interventions prior to the administration of PRN pain medications by reviewing documentation in medical record. 3. Director of Nursing/ Designee will provide education to current licensed Nursing staff to ensure non-pharmacological interventions are implemented and documented prior to the administration of PRN pain medication. 4. Director of Nursing/ Designee will conduct audits on 10 residents per nursing unit with PRN pain medication to ensure non-pharmacological interventions are implemented and documented prior to receiving PRN pain medication weekly for	4/11/23

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F 697	Continued From page 39 non-medication interventions for pain. Section N documented R58 receiving Opioid medications 2 of the 7 days during the assessment period. On 2/27/2023 at 2:04 p.m., an interview was conducted with R58 in their room. R58 stated that they had frequent pain and took pain medications as needed. When asked if the staff attempted non-pharmacological interventions prior to administering the medication, R58 stated, "Sometimes they do, it depends on the nurse." The physician order's for R58 documented in part, - "Percocet Tablet 5-325 MG (milligram) (oxyCODONE Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for Pain. Order Date: 09/07/2022." - "NON-PHARMACOLOGICAL INTERVENTION and OUTCOME during your shift that were attempted prior to medication being administered: A) Non-Pharmacological Intervention: 0= No Pain Issues Observed 1= Reposition 2= Massage 3= Music/TV (distraction) 4= Warm Compress 5= Therapy Pain Management B) Outcome: 0= No pain 1= Intervention Effective 2= Intervention NOT Effective requires pharmacological intervention (medication, etc..) every shift for pain management Document the corresponding code associated with intervention initiated or attempted. Order Date: 09/08/2022." The eMAR (electronic medication administration record) dated 1/1/2023-1/31/2023 documented the Percocet was administered to R58 on 1/9/2023 for a pain level of five, on 1/17/2023 for a pain level of zero, on 1/25/2023 at 12:05 a.m. for a pain level of five, on 1/25/2023 at 1:23 p.m. for a pain level of six, and 1/29/2023 for a pain	F 697	4 weeks, then monthly for 2 months. The audit findings will be reviewed and/or revised in the QAPI (Quality Assurance Performance Improvement Committee) with any variances addressed.	

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F 697	Continued From page 40	F 697		

level of seven. The eMAR failed to evidence documentation of non-pharmacological interventions attempted prior to the administration of Percocet on 1/25/2023 at 1:23 p.m.

The eMAR dated 2/1/2023-2/28/2023 documented the Percocet administered to R58 on 2/1/2023 at 7:34 p.m. for a pain level of eight, on 2/2/2023 at 9:47 p.m. for a pain level of eight, on 2/11/2023 at 10:23 p.m. for a pain level of six, on 2/19/2023 at 7:47 p.m. for a pain level of eight, on 2/21/2023 at 9:31 p.m. for a pain level of seven, on 2/22/2023 at 1:24 p.m. for a pain level of five and 2/25/2023 at 5:08 p.m. for a pain level of six. The eMAR failed to evidence documentation of non-pharmacological interventions attempted prior to the administration of Percocet on 2/19/2023 at 7:47 p.m., 2/21/2023 at 9:31 p.m. or 2/22/2023 at 1:24 p.m.

The progress notes for R58 failed to evidence documentation of non-pharmacological interventions attempted or offered prior to the administration of the Percocet on the dates and times listed above.

The comprehensive care plan for R58 dated 9/2/2022 documented in part, "[Name of R58] has pain or potential for pain. Date Initiated: 09/07/2022. Revision on: 09/08/2022..."

On 2/28/2023 at approximately 5:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of non-pharmacological interventions being provided for 1/25/2023, 2/19/2023, 2/21/2023 and 2/22/2023 prior to the administration of Percocet as documented above.

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On 3/1/2023 at approximately 8:00 a.m., ASM #1 stated that they did not have evidence of non-pharmacological interventions being provided for the dates requested.

On 3/1/2023 at 11:16 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that when a resident complained of pain they assessed the pain location and level and attempted non-pharmacological interventions prior to administering ordered as needed pain medications. RN #1 stated that they attempted to reposition residents, provide music or a snack and if the interventions were not effective they administered the medication. RN #1 stated that they documented the non-pharmacological interventions on the eMAR or in the progress notes each time an as needed pain medication was administered.

The facility policy "Pain Management" dated 5/27/22 documented in part, "...The Center must ensure that pain management is provided to patients who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the patients ' goals and preferences...Non-pharmacological interventions will include but are not limited to: a. Environmental comfort measures (e.g., adjusting room temperature, smoothing linens, comfortable seating or assistive devices) b. Loosening any constrictive bandage, clothing, or device c. Applying splinting (e.g., pillow or folded blanket) d. Physical modalities (e.g., cold compress, warm shower/bath, massage, turning and repositioning) e. Exercises to address stiffness and prevent contractures as well as restorative nursing programs to maintain joint mobility f.

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F 697	Continued From page 42 Cognitive/behavioral interventions (e.g., music, relaxation techniques, activities, diversions, spiritual and comfort support, teaching the patient coping techniques and education about pain)..." On 3/1/2023 at approximately 2:38 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing/infection preventionist and ASM #5, the clinical services specialist were made aware of the findings. was made aware of the concern. No further information was provided prior to exit. Reference: (1) Percocet Oxycodone is used to relieve moderate to severe pain. Oxycodone extended-release tablets and extended-release capsules are used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview,	F 698	1. It is noted that facility staff failed to	4/11/23

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F 698	Continued From page 43 clinical record review and facility document review, it was determined the facility staff failed to provide complete dialysis care and services per the comprehensive plan of care for two of 46 residents in the survey sample, Resident #67 and Resident #71. The findings include: 1. For Resident #67, the facility failed to provide communication to the dialysis facility for one of 13 visits in November 2022, 4 of 13, visits in December 2022, 5 of 13, visits in January 2023 and 2 of 12 visits in February 2023. Resident #67 was admitted to the facility on 10/17/20 with diagnoses that included but were not limited to: end stage renal disease. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/15/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. Section O-special procedures/treatments coded the resident as dialysis "no". A review of the comprehensive care plan dated 10/17/20, which revealed, "FOCUS: The resident has renal disease requiring dialysis 3 times/week. INTERVENTIONS: Coordinate with Dialysis center for dialysis treatments as ordered. Communicate with dialysis provider regularly via pre/post treatment notes." A review of physician orders, dated 10/17/20, revealed the following, "Hemodialysis on	F 698	provide dialysis care coordination and services for a complete dialysis program for resident #67 and #71. Dialysis books were updated to include communication with Dialysis center. 2. Any resident who receives Dialysis treatment has the potential to be affected by this deficient practice. An audit of current residents who receive dialysis will be conducted to ensure the center has implemented an effective dialysis communication process for these residents. 3. The Director of Nursing/ Designee will educate current licensed nurses and clinical nurse leaders on dialysis policy including communication. 4. Director of Nursing/ Designee will audit dialysis residents to ensure dialysis program and dialysis communication books are current and up to date weekly for 4 weeks, then monthly for 2 months. The audit findings will be reviewed and/or revised in the QAPI (Quality Assurance Performance Improvement Committee) with any variances addressed.	

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Mon-Wed-Fridays."

A review of Resident #67's dialysis communication book revealed missing communication to the dialysis facility for 12 of 51 visits from 11/1/22-2/28/23.

An interview was conducted on 2/27/23 at 4:00 PM with Resident #67. When asked if they take their dialysis communication book with them to the dialysis center, Resident #67 stated, "Yes, the book goes with me."

An interview was conducted on 2/28/23 at 12:45 PM with LPN (licensed practical nurse) #2. When asked what information is provided to the dialysis facility when a resident is sent for hemodialysis, LPN #2 stated, when a resident is going out to dialysis, we take their vital signs, check their weight, give them breakfast and their morning medicines. They take their book with them and we give them a lunch to take with them. When asked if the documentation was complete if missing vital signs and/or weights, LPN #2 stated, no, it is not.

On 3/1/23 at approximately 1:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing and ASM #5, the clinical services specialist was made aware of the findings.

A review of the facility's "Care and Management of a Patient Receiving Hemodialysis" policy revised 5/27/22, revealed, "The center will coordinate and collaborate with the dialysis center to ensure that there is ongoing communication and collaboration for the development and

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implementation of the dialysis care plan by the healthcare center and the dialysis center. The licensed nurse will communicate to the hemodialysis center that will include but is not limited to medication administration (initiated, held or discontinued) by the healthcare center, Physician / treatment orders, laboratory values and vital signs. Nutritional/fluid management including documentation of weights, patient compliance with food/fluid restrictions or the provision of meals before, during and/or after hemodialysis and monitoring intake and output measurements as necessary."

No further information was provided prior to exit.

2. For Resident #71 (R71), the facility failed to provide communication to the dialysis (1) facility for seven of 25 visits in January/February 2023, on the dates of 1/16/2023, 1/18/2023, 1/20/2023, 1/23/2023 and 2/20/2023.

Resident #71 (R71) was admitted to the facility on 1/21/2022 with diagnoses that included but were not limited to ESRD (end stage renal disease) and dependence on renal dialysis.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/13/2023, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact for making daily decisions. Section O documented R71 receiving dialysis while a resident.

The comprehensive care plan dated 1/21/2022, documented in part, "[Name of R71] has End Stage Renal Disease requiring dialysis. She

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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refuses at times. Date Initiated: 01/21/2022. Revision on: 09/07/2022." Under "Interventions/Tasks" it documented in part, "...Coordinate with Dialysis center for dialysis treatments as ordered. Communicate with dialysis provider regularly via pre/post treatment notes. Date Initiated: 12/28/2021..."

The physician orders for R71 documented in part,
- "Monitor PermaCath site for signs of bleeding and infection. Order Date: 1/22/2022."
- "Dialysis [Name and location of dialysis center] MWFri p/u (pick up) 215pm for 315 chair, return 530pm. Order Date: 1/22/2022."

On 2/28/2023 at 8:36 a.m., an interview was conducted with R71 in their room. R71 stated that they went to dialysis three days a week on Monday, Wednesday and Fridays. When asked if a book was sent with them to dialysis, R71 stated that it was and that the book was in the chair in the room in the open duffel bag at the end of their bed. R71 stated that they had gone to dialysis the day before and the book had been there since they got back.

On 2/28/2023 at 8:37 a.m., review of the dialysis communication book for R71 failed to evidence communication to the dialysis facility on 1/16/2023, 1/18/2023, 1/20/2023, 1/23/2023 and 2/20/2023.

Review of R71's clinical record failed to evidence dialysis communication for the dates listed above or refusal of dialysis on those dates.

On 2/28/2023 at 8:39 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 stated that prior to R71 going to dialysis

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they weighed them, obtained vital signs and filled out the dialysis communication form in the book and reviewed the book when they came back for communication from the dialysis center. LPN #6 stated that the dialysis communication form should be completed each time the resident went to dialysis.

The facility policy, "Care and Management of a Patient Receiving Hemodialysis" dated 5/27/22 documented in part, "The Center will ensure that each patient receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include: 1. The ongoing assessment of the patient's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. 2. Ongoing communication and collaboration with the dialysis center regarding dialysis care and services...3. The licensed nurse will communicate to the hemodialysis center that will include, but is not limited to: a. Medication administration (initiated, held or discontinued) by the healthcare center, b. Physician/treatment orders, laboratory values, and vital signs...."

On 3/01/2023 at 2:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing/infection preventionist and ASM #5, the clinical services specialist were made aware of the findings.

No further information was provided prior to exit.

Reference:
(1) hemodialysis
When your kidneys are healthy, they clean your

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F 698	Continued From page 48 blood. They also make hormones that keep your bones strong and your blood healthy. When your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water.: Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually go to a special clinic for treatments several times a week. Peritoneal dialysis uses the lining of your abdomen, called the peritoneal membrane, to filter your blood. This information was obtained from the website: https://medlineplus.gov/dialysis.html	F 698		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 700		4/11/23

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F 700	Continued From page 49 §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to follow the assessment for the use of side rails for one of 46 residents in the survey sample, Resident #165. The findings include: For Resident #165 (R165), the facility staff had side rails up while the resident was in bed, however the bed/side rail evaluation indicated no bed rails were required. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/22/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score indicating the resident was not cognitively impaired for making daily decisions. In Section G - Functional Status, R165 was coded as requiring extensive assistance of one staff member for moving in the bed and extensive assistance of two staff member for transfers. On 2/27/2023 at approximately 12:00 p.m. R165 was observed in their bed with both side rails up at that time. A second observation was made on 2/27/2023 at 3:12 p.m. R165 was in bed with bilateral bed side rails up. The clinical record was reviewed. The most recent Bed Rail Evaluation, dated, 2/22/2023,	F 700	1. Resident # 165 was not negatively affected by usage of bilateral bedrails without a current bed rail evaluation. A bed rail evaluation was completed on 3/1/2023. Based on bed rail evaluation, resident #165 is a candidate for bilateral bedrails. Body pillow was attempted prior to implementation of bed rails. Risk/benefits of bedrail including entrapment reviewed with resident #165 and legal representative. Consent collected, physician order was obtained for use of bed rail and care plan was updated to reflect use of bilateral bed rails. 2. All residents with bedrails have the potential to be affected by this deficient practice. Director of Nursing/Designee will conduct an audit of current residents to verify a Bed Rail assessment and evaluation has been accurately completed prior to the implementation of bed rails, including interventions attempted prior to the implementation of bed rails. Informed consents will be reviewed and obtained as applicable, and care plans will be reviewed. 3. Director of Nursing/ Designee will provide education to current Licensed Nurses on center□s bed rail policy and on the process to determine eligibility of resident to have bed rails implemented along with intervention attempted prior to bed rail implementation. Process for bed	

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F 700	Continued From page 50 documented, "NO bed rails required." Review of the physician orders failed to evidence a physician order for the use of side rails. The comprehensive care plan dated, 11/30/2022, documented in part, "Focus: (R165) demonstrates the need for ADL (activities of daily living) assistance r/t (related to) decreased mobility and generalized weakness." The "Interventions" documented in part, "Bed rails as ordered." An interview was conducted with LPN (licensed practical nurse) #6, the unit manager, on 3/1/2023 at 8:20 a.m. The above bed rail assessment and observation was reviewed with LPN #6. When asked if the resident should have side rails on their bed, LPN #6 stated there should be another assessment completed. The facility policy, "Proper Use of Side Rails" documented in part, "It is the policy of this Center to utilize a person-centered approach when determining the use of side rails, also known as bed rails. Alternative approaches are attempted prior to installing a side or bed rail. If used, the Center ensures correct installation, use, and maintenance of the rails. Policy Explanation:1. As part of the patient's comprehensive assessment, the following components will be considered when determining the patient's needs, and whether or not the use of side/bed rails meets those needs: a. Medical diagnosis, conditions, symptoms, and/or behavioral symptoms. b. Size and weight, c. Sleep habits, d. Medication(s), e. Acute medical or surgical interventions, f. Underlying medical conditions, g. Existence of delirium, h. Ability to toilet self safely,	F 700	rail includes assessment, care plan, physician order, and informed consent. 4. Director of Nursing/ Designee will conduct audits on 10 residents per nursing unit to verify a bed rail assessment has been completed accurately with prior interventions documented, informed consent obtained from resident (as able) or legal representative with education for risk and benefits documented and completed, and a physician order for bedrails obtained, care plan for bedrails initiated, updated, or discontinued weekly for 4 weeks then monthly for 2 months. The audit findings will be reviewed and/or revised in the QAPI (Quality Assurance Performance Improvement Committee) with any variances addressed.	

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F 700	Continued From page 51 i. Cognition, j. Communication, k. Mobility (in and out of bed), and/or l. Risk of falling...g. Document the medical diagnosis, condition, symptom, or functional reason for the use of the side/bed rail. h. Obtain physician/physician extender orders for the use of side/bed rails." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing, and ASM #5 the clinical services specialist, were made aware of the above findings on 3/1/2023 at 2:38 p.m. No further information was obtained prior to exit.	F 700		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		4/11/23

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F 761	Continued From page 52 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on resident interview, clinical record review, staff interview and facility document review, it was determined the facility staff failed to store medications in a secure manner for one of 46 residents in the survey sample, Resident #71. The findings include: The facility failed to secure medications for Resident #71 (R71). On 2/28/2023 at 8:36 a.m., three Midodrine 2.5 mg tablets (1) were observed unsecured in R71's dialysis communication book in the residents room in an open duffel bag. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/13/2023, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact for making daily decisions. Section O documented R71 receiving dialysis while a resident. The physician orders for R71 documented in part, - "Midodrine HCl (hydrochloride) Tablet 10 MG (milligram) Give 1 tablet by mouth every day shift every Mon, Wed, Fri for Hypotension. Send 1 tab (tablet) with pt (patient) to dialysis every M,W,F. Order Date: 12/15/2022." On 2/28/2023 at 8:36 a.m., an interview was conducted with R71 in their room. R71 stated	F 761	1. Resident #71 dialysis binder has been inspected and there are no medications stored in the dialysis binder. Resident #71 was not negatively affected by the medication being left in the resident□s dialysis binder and not stored properly. 2. Residents on dialysis have the potential to be affected by this deficient practice. Director of Nursing/Designee will conduct an audit of residents who receive dialysis to ensure medications returning from dialysis are stored appropriately. 3. Director of Nursing/ Designee will educate current licensed nursing staff to ensure medications are stored in a secure manner post dialysis treatment. 4. Director of Nursing/ Designee will conduct audits on residents post dialysis treatment to ensure any returned medications are stored and secured properly weekly for 4 weeks, then monthly for 2 months. The audit findings will be reviewed and/or revised in the QAPI (Quality Assurance Performance Improvement Committee) with any variances addressed.	

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that they went to dialysis three days a week on Monday, Wednesday and Fridays. When asked if a book was sent with them to dialysis, R71 stated that it was and that the book was in the chair in the room in the open duffel bag at the end of their bed. R71 stated that they had gone to dialysis the day before and the book had been there since they got back.

On 2/28/2023 at 8:37 a.m., a review of the dialysis communication book for R71 was conducted. Observation of the dialysis communication book revealed three tablets in separate packaging labeled Midodrine tab 2.5 mg in a plastic sleeve inside the binder. R71 stated that the medicine went with them to dialysis each time.

On 2/28/2023 at 8:39 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 stated that prior to R71 going to dialysis they weighed them, obtained vital signs and filled out the dialysis communication form in the book. LPN #6 stated that they sent the book and the Midodrine with R71 each time they went to dialysis. LPN #6 stated that the nurses should get the book back when the resident returned to the facility to read any communication the dialysis center sent back and store the book at the nurses station. LPN #6 stated that R71 went to dialysis the day before and normally came back to the facility between 3-4 p.m. LPN #6 stated that the dialysis book was normally kept at the nurses station and the medication should not be kept in the binder in the residents room unsecured. LPN #6 stated that any resident could go into the room and pick it up and it needed to be locked up.

The facility policy, "Medication Storage" dated

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F 761	Continued From page 54 7/23/2019 documented in part, "...Only licensed nurses, the Consultant Pharmacist, and those authorized to administer medications (e.g. medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access..." On 3/01/2023 at 2:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing/infection preventionist and ASM #5, the clinical services specialist were made aware of the findings. No further information was provided prior to exit. Reference: (1) Midodrine Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). Midodrine is in a class of medications called alpha-adrenergic agonists. It works by causing blood vessels to tighten, which increases blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a616030.html	F 761		
F 825 SS=E	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental	F 825		4/11/23

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F 825	Continued From page 55 illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to provide rehabilitation services for one of 46 residents in the survey sample, Resident #261. The findings include: For Resident #261 (R261), the facility staff failed to provide physical and occupational therapy services from 03/18/2022 through 03/23/2022. (R261) was admitted to the facility with diagnoses that included but were not limited to muscle weakness. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 03/11/2022, (R261) scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R261) was cognitively intact for making daily decisions.	F 825	1. Resident #261 no longer resides in facility. 2. The Rehab Director/Designee will conduct an audit of residents who were on appeal in the last 30 days to ensure they are receiving therapy services according to the physician□s order. 3. The Administrator or designee educated the therapy department staff on ensuring residents who are on appeal receive therapy according to the physician□s order. 4. The Rehab Director/ Designee will conduct audits to verify residents who are in appeal are receiving therapy according to the physician□s order weekly for 4 weeks, then monthly for 2 months. The audit findings will be reviewed and/or revised in the QAPI (Quality Assurance Performance Improvement Committee) with any variances addressed.	

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The physician's order sheet dated 03/01/2022 - 04/30/2022 documented in part,
"PT/OT/ST (Physical therapy/occupational therapy/speech therapy) to eval (evaluate) as indicated. Order Date: 03/04/2022."
"OT Clarification Order: OT to see 5x/wk x 4 (five times per week times four) weeks ...Order Date: 03/07/2022."
"PT Clarification Order: skilled PT to see 5x a wk for 4 weeks ...Order Date: 03/05/2022."

The facility's PT "Service Log Matrix" for (R261) dated March 2022 failed to evidence that (R261) received physical therapy from 03/18/2022 through 03/23/2022.

The facility's OT "Service Log Matrix" for (R261) dated March 2022 failed to evidence that (R261) received occupational therapy from 03/18/2022 through 03/23/2022.

The NOMNC (Notice of Medicare Non-Coverage) dated 03/15/2022 documented in part, "The Effective Date Coverage of Your Current Skilled Nursing Facility Services Will End: 03/17/2022." Under the statement "I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO (Quality Improvement Organization)" documented (R261's) signature and dated "3/15/22."

The "Determination Letter" from (Name of QIO) for (R261) dated "March 17, 2022" documented in part, "Based on the Physical Therapy and Occupational Therapy evaluations, the patient has achieved reasonable goals for intensive therapy. There are no medical issues to support the need for daily skilled nursing care ...You were

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notified by telephone on March 17, 2022 at 2:45 PM (p.m.) Eastern time that the decision to end these services was upheld. These services will no longer be paid for by the Medicare program beginning on March 18, 2022."

The "Determination Letter" from (Name of QIO) for (R261) dated "March 17, 2022" documented in part, "Thank you for your patience while we completed a thorough review of your provider's decision to end services ... You were notified by telephone on March 30, 2022 at 1:50 PM Eastern time that the decision to end these services was upheld. These services will no longer be paid for by the Medicare program."

On 02/28/2023 at approximately 11:05 a.m., an interview was conducted with OSM (other staff member) #1, rehabilitation director. When asked about the missing documentation of PT and OT services on the "Service Log Matrix" from 03/18/2022 through 03/23/2022 OSM #1 stated that on 03/15/2022 a NOMNC (notice of Medicare non-coverage) dated 03/15/2022 was given to (R261) indicating that skilled nursing facility services would be ending on 03/17/2022. OSM #1 stated that they were informed that skilled services would not be cover by (R261's) insurance so they discontinued PT and OT services on March 17, 2022.

On 02/28/2023 at approximately 1:15 p.m., an interview was conducted with OSM #9, director of social services. When asked to describe the process of a NOMNC OSM #9 stated that when the resident receives the NOMNC they have the right to appeal it by contacting the QIO and social services receives a letter stating that the resident has made an appeal and the QIO will request

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GAINESVILLE HEALTH AND REHAB CENTER	7501 HERITAGE VILLAGE PLAZA GAINESVILLE, VA 20155

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documentation from the facility to review the case. A decision is made usually within 48 hours and a determination letter is sent to the resident and social services stating weather or not the appeal was upheld or not. OSM #9 further stated that the resident can file a second appeal. When asked if a second NOMNC is given to the resident for a second appeal OSM #9 stated no, that the resident contacts the QIO directly by telephone. When asked how social services is informed that a resident has filed a second appeal OSM #9 stated that every Thursday at 10:00 a.m., they have a "Utilization Review" with the facility's interdisciplinary team, which includes the director of rehabilitation and the company's (owner of the nursing facility) case manager to discuss the status of all the facility's residents on managed care. When asked about a resident who may be receiving therapy service and they file an appeal OSM #9 stated therapy services would continue until they received a determination letter. After being informed of the lack of documentation on the March 2022 PT and OT service logs for (R261) from 3/18/2022 through 03/23/2022, OSM #9 stated that services should have continued while the second appeal was being reviewed.

On 03/01/2023 at approximately 10:05 a.m. an interview was conducted with ASM (administrative staff member) #1, the administrator regarding therapy services for (R261). ASM #1 stated that an email was sent by the case manager asking if (R261) was going to file a second appeal and (OSM #9), director social services, sent an email to the interdisciplinary team that (R261) was filing a second appeal. ASM #1 provided the surveyor with a copy of the emails.

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The email dated March 17, 2022 from the case manager to OSM #9 documented in part, "Per (Name of QIO) (R261's) appeal was upheld. Is she planning to file a recon (reconsideration?"

The response email dated March 18, 2022 documented in part, "From (OSM #9) to central case management, OSM #1, rehabilitation director,...Subject: (Last Name of R261). She did yesterday."

On 03/01/2023 at approximately 10:10 a.m., an interview was conducted with OSM #1. After reviewing the emails dated March 17 and 18, 2022 OSM #1 stated that it was an oversight on their part for not continuing therapy for (R261) during the second appeal process. OSM #1 further stated that they didn't recall seeing the emails. When asked to describe the procedure for a resident receiving therapy when they file an appeal for continued services OSM #1 stated that therapy continues until the resident receives a determination letter and based on the letter therapy will either continue or be discontinued.

After reviewing (R261's) PT and OT service logs for March 2022, OSM #1 was asked how many therapy sessions were not provided. OSM #1 stated that there were six PT and six OT sessions were not provided.

On 03/01/2022 at approximately 2:38 p.m., ASM #1, administrator, ASM #2, director of nursing and ASM #3, assistant director of nursing and ASM #5, clinical services specialist, were made aware of the above findings.

No further information was provided prior to exit.

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F 840 SS=E	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to have a written dialysis agreement for the facility for two of two residents who utilized the dialysis center, Resident #67 and Resident #71. The findings include: The facility failed to evidence a written dialysis agreement for one dialysis center that Resident #67 and Resident #71 received dialysis at. During the entrance conference to the facility on 2/27/23, a request was made for the dialysis	F 840	1. Resident #67 and #71 were not negatively affected by the facility not having a contract with the dialysis center. The contract with the dialysis center has been initiated. 2. Administrator/ Designee completed audit of current residents on dialysis services to ensure contracts with dialysis are in place. 3. The Regional Director of Operations educated the Administrator on having contracts for residents receiving dialysis services. 4. The Administrator/ Designee will	4/11/23

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F 840	Continued From page 61 contracts or agreements. On 2/27/23, a review of the dialysis contracts evidenced no contract for the one dialysis company utilized by Resident #67 and Resident #71.. On 2/28/23 at approximately 3:23 PM, ASM (administrative staff member) #1, the administrator stated, there was no contract for this dialysis center. On 3/1/23 at approximately 1:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing and ASM #5, the clinical services specialist was made aware of the findings. No further information was provided prior to exit.	F 840	conduct audits to verify residents who are receiving dialysis services have a contract with the dialysis center monthly x 3 months. The audit findings will be reviewed and/or revised in the QAPI (Quality Assurance Performance Improvement Committee) with any variances addressed.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 842		4/11/23

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(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;

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F 842	Continued From page 63 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review it was determined the facility staff failed to maintain an complete and accurate clinical record for three of 46 residents in the survey sample, Residents #105, #162, and #261. The findings include: 1. For Resident #105 (R105) the facility staff failed complete the "Social Services Admission Assessment" upon admission to the facility. R105 was admitted to the facility on 1/30/2023. The Admission MDS (minimum data set) assessment, with an ARD (assessment reference date) of 2/5/2023 was completed. Review of the clinical record failed to evidence any Social Services Assessments for R105. A request was made for any social services notes or assessments completed for R105. The following documentation was provided. An assessment for the "Brief Interview for Mental Status" was completed on 1/31/2023. A "Patient Mood Interview" was presented, dated 1/31/2023.	F 842	1.It is noted facility failed to maintain an accurate medical record for Resident #105, #162, and #261. Social Services Admission Assessment for Resident #105 was completed on 3/1/2023. Residents #162 and #261 no longer reside in facility. 2. All residents have the potential to be affected by this deficient practice. Social Services Director/ Designee will audit new admissions in the past 30 days to ensure Social Services Admission Assessment is completed in medical record. Director of Nursing/ Designee will audit current residents' medical records for the past 7 days to ensure Point of Care documentation has been completed accordingly. Director of Nursing/ Designee will review current residents' eMARs for the past 7 days to ensure medication administration documentation has been completed. 3.Administrator/ Designee will educate Director of Social Services on completion and documentation of Social Services admission assessment for all new admissions as applicable. Director of Nursing/ Designee will educate current	

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F 842	Continued From page 64 A "Room Change Notification" note, written by the social services staff, was dated 2/21/2023. On 3/1/2023 at 12:14 p.m., ASM (administrative staff member) #1, the administrator, presented a "Social Services Admission Assessment" dated 3/1/2023. When asked if this form was in the clinical record, ASM #1 stated, no, it was just completed today. When asked if this assessment should have been completed before 3/1/2023 since the resident was admitted on 1/30/2023, ASM #1 stated, yes. The facility policy, "Social Services Periodic Assessment and Documentation" documented in part, "2. Initial Psychosocial Assessment and Social History will be completed on each resident within 48- 72 hours after admission using the following sources of information: the resident, the resident family members, friends, caregivers, etc. and the medical record. a. Refer to Social Services Admission Assessment in the EMR (electronic medical record)." ASM #1, ASM #2, the director of nursing, ASM #4, the assistant director of nursing, and ASM #5 the clinical services specialist, were made aware of the above findings on 3/1/2023 at 2:38 p.m. No further information was obtained prior to exit. 2. a. The facility staff failed to evidence complete and accurate documentation for incontinence care for Resident #162. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/27/21,	F 842	Certified Nursing Assistants on completion of documentation for care provided in clinical record. Director of Nursing/ Designee will educate current Licensed Nursing staff on the accurate documentation of medication administration by signing eMAR to demonstrate complete medical record. 4. Social Services Director/ Designee will audit new admissions for completion of Social Services Assessment weekly for 4 weeks, then monthly for 2 months. Director of Nursing/ Designee will audit Point of Care documentation on 10 residents per nursing unit weekly for 4 weeks, then monthly for 2 months to ensure complete and accurate record. Director of Nursing/ Designee will audit medication administration records (eMAR) for 10 residents per nursing unit for accuracy and completion weekly for 4 weeks, then monthly for 2 months. The audit findings will be reviewed and/or revised in the QAPI (Quality Assurance Performance Improvement) Committee with any variances addressed.	

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coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as being totally dependent for bathing and requiring extensive assistance for bed mobility, transfer, locomotion, dressing, eating and hygiene.

A review of the comprehensive care plan dated 4/6/21, which revealed, "FOCUS: The resident had an actual fall and remains at risk for falls related to difficulty walking, dementia. Skin integrity issue present on admission. Current reopening of Pressure injury to sacrum. Remains at risk for further skin breakdown r/t decreased mobility...Observe for moisture and incontinence issues and provide care as indicated."

A review of Resident #162's TAR (treatment administration record) for August 2021, revealed, no incontinence care was documented for day shift on 8/31; none documented for evening shifts on 8/5, 8/6, 8/10, 8/11, 8/22, 8/29 and 8/31 and none documented on night shift on 8/18 and 8/21.

A review of Resident #162's TAR for September 2021, revealed no incontinence care was documented for evening shift on 9/4, 9/11, 9/18 and 9/25; and none documented for night shift on 9/10 and 9/14.

A review of Resident #162's TAR for October 2021, revealed, no incontinence care was documented for day shift on 10/19 and 10/21; none documented for evening shift on 10/9, 10/15, 10/16, 10/18 and 10/31; and none documented for night shift on 10/14 and 10/17.

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A review of Resident #162's TAR for November 2021, revealed no incontinence care was documented for day shift on 11/2, all incontinence care was documented for evening and night shifts.

An interview was conducted on 2/28/23 at 1:40 PM with CNA (certified nursing assistant) #1. When asked what is means if there are blanks/holes in incontinence care documentation, CNA #1 stated, it just was not documented.

An interview was conducted on 2/28/23 at approximately 2:00 PM with LPN (licensed practical nurse) #2. When asked what is means if there are blanks/holes in incontinence care documentation, LPN #2 stated, it would mean that the care was not documented.

On 3/1/23 at approximately 1:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing and ASM #5, the clinical services specialist was made aware of the findings.

A review of the facility's "Documentation in Medical Record" policy, dated 6/1/21, revealed, "Each resident's medical record should contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy."

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No further information was provided prior to exit.

2. b. The facility staff failed to evidence complete and accurate documentation for feeding assistance for Resident #162.

A review of Resident #162's TAR (treatment administration record) for August 2021, revealed, no feeding assistance was documented for day shift on 8/31; none documented for evening shift on 8/31; and none documented on night shift on 8/29 and 8/31. Resident was coded on the MDS as requiring extensive assistance for eating on 8/28/21.

A review of Resident #162's TAR for September 2021, revealed all feeding assistance was documented for day shift and evening shift; no feeding assistance was documented for night shift on 9/4, 9/11, 9/18 and 9/25.

A review of Resident #162's TAR for October 2021, revealed no feeding assistance was documented for day shift on 10/19 and 10/21; none documented for evening shift on 10/19 and 10/21; and none documented for night shift on 10/1, 10/9, 10/15, 10/16, 10/18 and 10/31.

A review of Resident #162's TAR for November 2021, revealed, no feeding assistance was documented for day and evening shift on 11/2.

An interview was conducted on 2/28/23 at 1:40 PM with CNA (certified nursing assistant) #1. When asked what is means if there are blanks/holes in incontinence care documentation, CNA #1 stated, it just was not documented.

An interview was conducted on 2/28/23 at

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approximately 2:00 PM with LPN (licensed practical nurse) #2. When asked what is means if there are blanks/holes in incontinence care documentation, LPN #2 stated, it would mean that the care was not documented.

On 3/1/23 at approximately 1:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing and ASM #5, the clinical services specialist was made aware of the findings.

A review of the facility's "Documentation in Medical Record" policy, dated 6/1/21, revealed, "Each resident's medical record should contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy."

No further information was provided prior to exit.
3. For Resident #261 (R261), the facility staff failed to complete the eMAR (electronic medication administration record) for the administration of levothyroxine (1) on 03/15/2022 and 03/16/2022.

(R261) was admitted to the facility with diagnoses that included but were not limited to hypothyroidism (2).

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment

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reference date) of 03/11/2022, (R261) scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R261) was cognitively intact for making daily decisions.

The physician's order sheet for (R261's) dated 03/01/2022 - 04/30/2022 documented in part, "Levothyroxine Sodium Tablet 150 MCG (micrograms). Give 2 (two) tablet [sic] by mouth one time a day for low thyroid hormone. Order Date: 03/04/2022. Start Date: 03/05/2022."

The eMAR for (R261) dated March 2022 documented the physician's order as stated above. Further review of the eMAR revealed blanks for the dates 03/15/2022 and 03/16/2022 for the medication levothyroxine.

On 03/01/2023 at approximately 11:02 a.m., an interview was conducted with RN (registered nurse) #1. After reviewing the March 2022 eMAR for the administration of levothyroxine on 03/15/2022 and 03/16/2022, RN #1 was asked to interpret the dates being blank. RN #1 stated that two things could have occurred, one, that the medication was administered but the nurse failed to check it off on the eMAR or the nurse failed to administer the medication. When asked to speak with the nurse who administered medications to (R261) on 03/15/2022 and 03/16/2022, surveyor was informed that the nurse no longer worked at the facility.

On 03/01/2023 at approximately 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #3. After reviewing the March 2022 eMAR for the administration of levothyroxine on 03/15/2022 and 03/16/2022, RN #1 was asked to interpret the dates being blank.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495388	A. BUILDING _____ B. WING _____	C 03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GAINESVILLE HEALTH AND REHAB CENTER	7501 HERITAGE VILLAGE PLAZA GAINESVILLE, VA 20155

(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
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LPN #3 stated the nurse gave the medication and forgot to check it off or the medication was not given.

On 03/01/2022 at approximately 2:38 p.m., ASM #1, administrator, ASM #2, director of nursing and ASM #3, assistant director of nursing and ASM #5, clinical services specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Used to treat hypothyroidism (condition where the thyroid gland does not produce enough thyroid hormone). This information was obtained from the website: Levothyroxine: MedlinePlus Drug Information

(2) Not enough thyroid hormone to meet your body's needs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html.