STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495205	A. BUILDING _____ B. WING _____	C 03/23/2023

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AUGUST HEALTHCARE AT ILIFF	8000 ILIFF DRIVE DUNN LORING, VA 22027

(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 03/21/2023 through 03/23/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Emergency Preparedness requirements 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 and abbreviated survey was conducted 3/21/2023-3/23/2023. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. VA00057813- Unsubstantiated. The census in this 124 certified bed facility was 113 at the time of the survey. The survey sample consisted of 31 resident reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		4/17/23

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

Electronically Signed | 04/06/2023

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain residents' dignity when they failed to ensure one (Resident (R) 14) of 35 sampled residents did not have a thick growth of chin hair and one (R160) of 35 sampled residents' urinary bag was covered. Findings include:	F 550	1.On 4/5/23, Resident #14 with thick growth of hair on chin and thick growth of facial hair was trimmed. Resident #160 discharged from the facility on 3/31/23, this deficient practice cannot be retroactively corrected for a discharged resident. 2.The facility will conduct a facility wide	

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F 550	Continued From page 2 1. An observation on 03/21/23 at 1:00 PM, revealed R14 had a thick growth of hair on her chin. Another observation on 03/22/23 at 1:05 PM, revealed R14 still had a thick growth of facial hair. Review of R14's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR) revealed R14 was admitted with diagnoses that included but not limited to: dementia, hemiplegia, and hemiparesis affecting the right side. Review of R14's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 03/12/23, revealed a "Brief Interview for Mental Status (BIMS)" score of three out of 15 indicating R14 had severely impaired cognition. The "MDS" recorded R14 required extensive assistance with dressing and toileting. During an interview on 03/22/23 at 1:07 PM, Certified Nursing Assistant (CNA) C stated R14 was shaved once a week and whenever staff noticed the facial hair was growing. CNA C stated, "We don't usually wait until it (facial hair) is thick before we shave it." CNA C stated R14 was shaved on Wednesdays and Saturdays when she received her showers. CNA C was shown the growth on R14's face and confirmed R14 had not been shaved in more than a week. Review of the facility's policy titled, "Your Rights and Protections As a Nursing Home Resident," dated 01/30/22, revealed, " . . . As a nursing home resident . . . You have the right to be treated with dignity and respect . . . "	F 550	audit to identify all residents with thick facial hair growth. All residents identified will have their facial hair trimmed. Facility will conduct an audit of all residents with a urinary bag to ensure they are covered with privacy bags. 3.The facility Administrator will ensure all employees complete a Healthcare Academy course on Resident's Rights. The facility's Staff Development Coordinator/Designee will ensure all Direct Care staff are educated on resident's dignity. This education will focus on the importance of ensuring urinary catheter bags are covered with privacy bags and trimming of facial hair for residents with thick growth. 4.The Director of Nursing (DON)/Designee will conduct a weekly audit on all residents in the facility to ensure no resident has thick growth of facial hair or urinary catheter bags which are not covered. The weekly audit will be completed weekly for three months until full compliance is achieved. The results of the audit will be reviewed in the Quality Assurance Committee meeting monthly for 3 consecutive months.	

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F 550	Continued From page 3 2. An observation on 03/21/23 at 09:48 AM, revealed R160 had an uncovered urinary catheter bag hanging on the left side of the bag that was visible from the hallway. Observations on 03/21/23 at 4:11 PM, and 03/22/23 at 11:17 AM revealed R160's urinary catheter bag was not covered. Review of R160's "Physician Orders," located under the "Orders" tab of the EMR, revealed an order, dated 03/07/23, for a urinary catheter. During an interview on 03/22/23 at 2:04 PM, CNA C stated she had observed earlier that R160 needed a dignity cover on the urinary catheter bag, but she was not able to find one in the supply room. CNA C stated she was unaware of how long R160's urinary catheter bag was uncovered and that it had skipped her mind to cover it during her shift. CNA C stated she was unaware of who or when the urinary catheter bag was covered. CNA C stated she had received training on the subject and was aware urinary catheter bags needed to be covered. During an interview on 03/22/2023 at 1:46 PM, the Director of Nursing (DON) stated it was his expectation that a dignity cover be placed on every urinary catheter bag to preserve the resident's dignity.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable	F 558		4/17/23

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F 558	Continued From page 4 accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to provide services in the facility with reasonable accommodation of resident needs and preferences, for 1 Resident (#32) in a survey sample of 35 Residents. The findings included: For Resident #32, the facility staff failed accommodate 1) an electrical outlet or a power strip available on the right side and 2) family pictures where the Resident could view them. On 3/21/23 at approximately 10:00 AM, Resident #32 was observed sitting upright in her bed watching TV. Resident #32 stated that due to physical limitations of her condition she needed to have the electrical outlet or a power strip available on the right side so that she could charge her phone. Resident #32 also stated that the facility put her family pictures up where there were already hooks in the wall; however it was not located where she could view them. When asked if she had asked the facility for assistance with these issues, she stated that she had told them a few weeks ago but had heard nothing about it. On the morning of 3/22/23 an interview was conducted with Employee D who stated that he was aware of the issue with the outlet and her needing it on the right side due to her physical	F 558	1.Resident #32 has been provided a power strip on the right side of her bed and family pictures have been placed where they can be viewed. Resident #32 was interviewed by a Social Worker (SW) on 4/5/23 and she acknowledged that all reasonable accommodation to her needs/preferences have been met. 2.The facility's SW/Designee will interview all residents who can be interviewed to confirm the facility is providing reasonable accommodation of residents' needs and preferences. Residents who can't be interviewed will be reviewed via a staff interview. 3.The facility's SW/Designees will educate all staff on the importance of ensuring all residents are provided reasonable accommodation of needs and preferences. 4.The facility's SW/Designees will interview all residents who can be interviewed weekly to confirm that the facility is providing reasonable accommodation of their needs. This audit will be conducted weekly for 3 months and results will be reviewed at the Quality Assurance Committee meeting for 3 consecutive months.	

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F 558	Continued From page 5 condition. Employee D stated that he was trying to get approval for a power strip or an additional outlet to be installed. On 3/23/23 Resident #32 stated that she was being moved to the other side of the room because the outlet would be on the right side so she would be able to access it. On 3/23/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 558		
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 observation interview, clinical record review and facility documentation the facility staff failed to provided services that meet professional standards care for 1 Resident (#21) in a survey sample of 35 Residents. The findings included: For Resident #21 the facility staff failed to follow physician orders after a Foley catheter was ordered for 1 week and a voiding trial was to be started the following week. On 3/21/23 at 9:25 AM Resident #21 was observed in her bed with eyes closed resting, the Resident had a Foley catheter with a dignity bag	F 658	1.The corrective action for Resident #21 cannot be retroactively corrected. Clinical record review indicates that the resident was discharged from the facility on 4/1/23. 2.The facility will review all residents' clinical records to audit physician orders and progress notes for the last 30 days. The review is to ensure that the facility staff are providing services that meet professional standards including implementation of orders and treatments in a timely manner. 3.The facility's DON/Designee will educate all nurses and respiratory	4/17/23

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F 658	Continued From page 6 cover in place. On 3/22/23, a review of the clinical record revealed the following: "12/29/22 - 9:00 AM - MD/NP/PA -Progress Note - #Urinary retention: 12/28 resident with urinary retention and Foley inserted. She denies any urinary burning, difficulty urinating, bladder pressure, fever. Stated never had a UTI in the past. Foley draining clear yellow urine. - send urine for U/A & C&S, verbal orders given to nurse. -voiding trial next week." "3/9/23 10:45 AM - MD/NP/PA -Progress Note - # Urinary retention: Foley catheter with mild hematuria. - Do voiding trial and insert new foley if no output in 8 hrs." A review of the clinical record revealed that no voiding trial was started for the order on 12/29/22 or 3/9/23 and the Resident continued to have the Foley catheter. On 3/22/23 at 12:20 PM, an interview was conducted with Licensed Practical Nurse (LPN) C who was asked what the process is for a verbal or telephone order for a voiding trial, LPN C stated that the nurse taking the order would put the order into the system and notify the family. When asked how a voiding trial is done, she stated that on the day of the voiding trial the Foley would be removed and then the nurses would wait 4-6 hours and see if the resident urinates or has a wet brief. If the Resident does not urinate on their own the MD would be notified for further orders. LPN C was asked the purpose of a voiding trial, LPN C stated the purpose of a voiding trial is to see if the Resident can empty	F 658	therapists on the importance of ensuring all residents are provided services that meet professional standards including implementation of treatments and orders in a timely manner. 4.The DON/Nursing Managers/Designee will perform weekly audits on all residents' clinical records to review physician orders and progress notes to ensure they meet professional standards. The audit will include validation that all orders and treatments are carried out in a timely manner. This audit will be conducted weekly for 3 months and results will be reviewed at the Quality Assurance Committee meeting for 3 consecutive months.	

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F 658	Continued From page 7 their bladder naturally on their own. When asked what the risk is for having an indwelling Foley catheter LPN C stated that there is a risk of bacteria entering the urinary tract and causing and infection. On 3/22/23 at 11:45 AM an interview was conducted with the Director of Nursing (DON.) The DON was asked how physician orders get put into the system. The DON stated that then nurses enter the orders into the system the physicians do not enter them directly. When asked about the expectations of nurses following physician orders, he stated that it is the expectation of the nurse to enter orders correctly into the system and to follow the physician orders. When asked what the protocol is when an order is missed, he stated that the physician and Resident Representative be notified. When asked to provide voiding trial documentation for the voiding trial ordered on 12/29/22 and 3/9/23 he was unable to provide it by end of survey. According to Lippincott "Manual of Nursing Practice", Eleventh Edition, 2019, page 15, "Standards of Practice", Box 2-1 entitled, "Common Legal Claims for Departure from Standards of Care", read in part, "Failure to perform a nursing treatment or procedure properly" and "Failure to implement a physician's, advanced practice nurse's, or physician assistant's order properly or in a timely fashion". On 3/23/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		4/17/23

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F 689	Continued From page 8 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure that the Residents have an environment free from accident hazards to prevent avoidable accidents for 1 Resident (#20) in a survey sample of 35 Residents. The findings included: For Resident #20 the facility staff failed to identify potential hazard and implement interventions to reduce hazard and monitoring for proper functioning and effectiveness the wander guard bracelet. On 3/21/23 Resident #20 was observed sitting in his wheelchair in his room reading his bible. Attempts to converse with the Resident were unsuccessful in as resident does not speak English and has a diagnosis of dementia. A review of the clinical record revealed an order for checking the placement and function of wander guard every night. Excerpts from the care plan are as follows: "INTERVENTIONS	F 689	1.On 3/23/23, the physician order of Resident #20 was changed from checking functioning of wander guard daily on night shift to day shift until ordered wander tester arrives. On 4/5/23, the facility ordered from the wander guard manufacturer a testing device which can check the functioning of a wander guard without taking residents to exit doors. 2.All residents on wander guard have the potential to be affected by this deficient practice. All residents with wander guard orders will be changed from checking functioning on night shift to day shift until ordered wander tester arrives. 3.All nurses will be educated on the importance of identifying potential hazards by implementing interventions to reduce hazards which includes monitoring for proper functioning and effectiveness of a resident's wander guard bracelet. 4.The DON/Designee will conduct a weekly visual audit of the newly ordered wander guard tester to ensure it is readily available for nurses' use and is properly	

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F 689	Continued From page 9 Check function of safety device as ordered by physician Reorient/validate and redirect as needed the resident needs activities that minimize the potential to wander while providing diversion and distraction Date Initiated: 03/17/2022." 3/22/23 at 1:30 PM, an interview was conducted with LPN C who was asked about the wander guard and how it worked. He then demonstrated by wheeling Resident #20 to the door and watching as the alarms set off and door locked. He stated that the Resident would not be able to leave as the door would lock and staff would be aware that someone was trying to leave if they heard that alarm. On 3/22/23 at 2:33 PM, an interview with RN B was conducted and she stated that the night shift checks for the functioning of wander guards. On 3/22/23 at 2:39 PM, an interview was conducted with LPN B who stated that night shift checks the wander guard to see if they are working. She said that day shift is not responsible for checking the functioning of the wander guard. When asked if she knows how to check the wander guard, she said she brings the Resident near the door and if the alarm sounds it's working. On 3/22/23 at 2:51 PM, an interview was held with the DON who was asked about checking wander guard bracelets and he stated they should be checked nightly for functioning. When asked who was responsible for doing this, he stated the night shift nurses. When asked how this was done, he stated that old system we had a wand that we pass over the bracelet, and it would	F 689	functioning. The DON/Designee will also randomly interview nurses weekly to confirm that they are checking the functioning of wander guards daily to prevent potential hazards. These audits will be conducted for 3 months and results reviewed at the Quality Assurance Committee meeting for 3 consecutive months.	

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F 689	Continued From page 10	F 689		

light up green or red. Green meant the battery was good and the bracelet was functional and red meant we needed a new bracelet. When asked how you can determine functionality with the new bracelets, and he stated they can bring the Residents to the door. The DON was asked if he was aware of the physician order that stated wander guard bracelets are to be checked nightly for function. He stated that he was aware of the order. When asked if night shift is waking people up to take them to the door to check the bracelet, and he stated they were not. When asked if there have been any elopements since the new system was in place and he stated that there had not been.

On 3/22/23 at 3:30 PM, Employee D brought up the log where maintenance checks the alarms at the doors. When asked how he checks the alarms he stated he takes one of the wander guard bracelets to each exit door to see if it will lock and alarm. When asked how the bracelets are checked that are on the Residents, he stated he did not know because it was a nursing responsibility. He stated he was only responsible for checking and logging the door response to a functional bracelet. When asked if a bracelet is not functioning what would happen, he stated that the Resident would be able to leave the building because the door would not lock, and it would not sound an alarm. Employee D showed this surveyor the "wand" that was used to check the old wander guard bracelets when asked if this works to check the new bracelets, he stated that it does not. When asked when the new system and new bracelets started, he stated that it was started in June of 2022.

On 3/23/23 during the end of day meeting the

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F 689	Continued From page 11 Administrator was made aware of the concerns and no further information was provided.	F 689		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as	F 690		4/17/23

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AUGUST HEALTHCARE AT ILIFF	8000 ILIFF DRIVE DUNN LORING, VA 22027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 12 possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure that a Resident who received a indwelling (Foley) catheter after admission, was assessed for removal of the catheter as soon as possible for 1 Resident (#'s 21) in a survey sample of 35 Residents. This is harm. The findings included: 1. For Resident #21, the facility staff failed reassess the need of an indwelling (Foley) catheter after Resident #21 had one episode of urinary retention. The resident experienced Urinary Tract Infections (UTIs) that required antibiotics. This is harm. On 3/21/23 at 9:25 AM Resident #21 was observed in her bed with eyes closed resting, the Resident had a Foley with a dignity bag cover in place. On 3/22/23 a review of the clinical record revealed the following: "12/28/2022 -4:46 PM-Nursing Progress Note Text: Charge nurse observed patient not voiding throughout this shift. Assessment done. Denied pain, abdomen soft, non-distended. I/O done, collected 550 cc clear urine. MD notified. Gave an order to insert 16F Foley catheter. RP [name redacted] called no answer, message left with a call back number. Pt now lying comfortable in bed, call light within reach. Will continue to monitor."	F 690	1.The corrective action for Resident #21 cannot be retroactively corrected. Clinical record review indicates that the resident was discharged from the facility on 4/1/23. 2.All residents using a foley catheter are at risk of this deficient practice. The facility will review the clinical record of all current residents using an indwelling foley catheter and conduct an assessment for removal. 3.The DON/Designee will educate all nurses on the importance of ensuring all residents with an indwelling catheter are assessed for removal as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary. 4.The DON/Designee will perform weekly audits of all residents with an indwelling catheter to review if an assessment for removal is present or if documentation by the practitioner is present and indicates a clinical condition which demonstrates that catheterization is necessary. The audit will be conducted weekly for 3 months and results will be reviewed at the Quality Assurance Committee meeting for 3 consecutive months.	

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F 690	Continued From page 13	F 690		

"12/29/22 - 9:00 AM - MD/NP/PA -Progress Note - #Urinary retention: 12/28 resident with urinary retention and Foley inserted. She denies any urinary burning, difficulty urinating, bladder pressure, fever. Stated never had a UTI [Urinary Tract Infection] in the past. Foley draining clear yellow urine. - send urine for U/A & C&S [Urinalysis and Culture and Sensitivity], verbal orders given to nurse. -voiding trial next week."

Review of the clinical records showed the voiding trial was not done.

Review of the clinical records revealed that Resident #21 developed urinary tract infections after receiving a Foley catheter at the facility. Excerpts from physician notes are as follows:

"1/5/23 10:25 AM - MD/NP/PA progress note -#UTI- pending culture, UA positive. will start Macrobid while awaiting culture results. order staff to exchange for new foley cath. Will cont. to monitor."

"1/9/23 11:20 AM - MD/NP/PA -Progress Note - #UTI- will cont. Macrobid Will cont. to monitor. no changes to current poc. [plan of care]"

"1/11/23 10:32 AM - MD/NP/PA -Progress Note - #Urinary retention: 12/28 resident with urinary retention and Foley inserted. No dysuria [painful or difficult urination]. Getting treated for UTI #UTI: Cuter grew >100,000 E-coli. Getting treated with antibiotics till 1/12. Tolerating Macrobid well. C/W current dose."

"1/18/23 8:29 AM - MD/NP/PA -Progress Note #UTI- resolved. Will cont. to monitor."

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F 690	Continued From page 14	F 690		

"1/25/23 8:56 AM - MD/NP/PA -Progress Note - #WBC elevated- asked for labs and urine to be checked on Monday-pending.

"2/6/23 9:58 AM - MD/NP/PA -Progress Note - #UTI- Macrobid was started. cont. as prescribed will trend labs. Patient seen and examined. "

On 3/9/23 at 10:45 AM, a physician note read that Resident #21 was to have a second voiding trial. It read in part, "Foley catheter with mild hematuria [blood in urine]. - Do voiding trial and insert new foley if no output in 8 hrs."

However, the second voiding trial ordered on 3/9/23 was never carried out.

On 3/22/23 at 12:20 PM, an interview was conducted with Licensed Practical Nurse (LPN) C who was asked what the process is for a verbal or telephone order for a voiding trial, LPN C stated that the nurse taking the order would put the order into the system and notify the family. When asked how a voiding trial is done, she stated that on the day of the voiding trial the Foley would be removed and then the nurses would wait 4-6 hours and see if the resident urinates or has a wet brief. If the Resident does not urinate on their own the MD would be notified for further orders. LPN C was asked the purpose of a voiding trial, LPN C stated the purpose of a voiding trial is to see if the Resident can empty their bladder naturally on their own. When asked what the risk is for having an indwelling Foley catheter LPN C stated that there is a risk of bacteria entering the urinary tract and causing and infection.

On 3/23/23 during the end of day meeting the

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F 690	Continued From page 15 Administrator was made aware of the concerns and no further information was provided.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure tube feeding bags were properly labeled for two of five residents (Resident (R)161 and R15) sampled for tube feeding. Findings include: 1. Review of R161's "Admission Record," located under the "Profile" tab of the electronic medical	F 693	1.On 3/22/23, when this deficient practice was identified, Residents #161 and #15 tube feeding bags were revised to be properly labeled to include name, date, time, rate of flow and initial of nurse who hung the feeding bag. 2.A facility-wide audit will be conducted for all residents with enteral tube feedings to	4/17/23

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F 693	Continued From page 16 record (EMR), revealed R161 was admitted with diagnoses that included tracheostomy and gastrostomy care. Review of R161's "Order Summary," located under the "Orders" tab of the EMR, revealed a physician's order for a tube feeding. During an observation on 03/21/23 at 12:09 PM, the label on the tube feeding bag for R161 was reviewed. The label did not indicate the time the bag was hung, the rate of flow, or the initials of the person who hung the tube feeding bag. Only the first name of the resident and the date were indicated. During an observation on 03/22/23 at 2:37 PM, the label on the tube feeding bag for R161 still lacked the time, rate of flow, and initials of the person who hung the tube feeding. During an interview on 03/22/23 at 3:00 PM, Licensed Practical Nurse (LPN D) stated that tube feeding bag labels were pre-printed from the computer daily with the requisite information. LPN D reviewed the label for R161 and confirmed the label only indicated the resident's first name and the date. LPN D stated the bag of tube feeding was hung by a night shift employee and confirmed that the label lacked the time, rate of flow, amount, and initials of the person who hung the bag. LPN D stated she could not tell who hung the bag or when it was hung based on the information documented on the label. Review of the facility's undated policy titled "Enteral Nutrition Policy" revealed, " . . . The feeding bag should be dated and initialed by the nursing hanging the feeding . . . "	F 693	ensure feeding bags are properly labeled to include name, date, time, rate of flow and initial of nurse who hung the feeding bag. 3.The DON/Designee will re-educate all nurses to ensuring they are properly labeling enteral feeding bags to include name, date, time, rate of flow and initial of nurse hanging the feeding bag. 4.The DON/Designee will conduct weekly visual inspection audits on all residents with enteral feeding to ensure their feeding bags are properly labelled to include name, date, time, rate of flow and initial of nurse hanging the feeding bag. The audits will be conducted weekly for 3 months and results will be reviewed at the Quality Assurance Committee meeting for 3 consecutive months.	

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F 693	Continued From page 17 2. Review of R15's "Admission Record," located under the "Profile" tab of the EMR, revealed R15 was admitted to the facility with diagnoses that included quadriplegia, spastic quadriplegic cerebral palsy, dysphagia, and gastrostomy care. Observation on 03/22/23 at 1:42 PM revealed LPN C initiating a tube feeding for R15. The bag of tube feeding was labeled with R15's last name, current date, time, rate of infusion, and type of tube feeding. LPN C's initials were not documented on the label. LPN C initiated the tube feeding and was asked to review the label on the tube feeding bag. LPN C confirmed he had not added his initials to the tube feeding label. During an interview with the Director of Nursing (DON) on 03/22/2023 at 2:38 PM, the DON stated it was his expectation that tube feeding bags should be labeled with the name, date, time, and initials of the nurse initiating the feeding. Review of the facility's undated policy titled "Enteral Nutrition Policy" revealed, " . . . The feeding bag should be dated and initialed by the nursing hanging the feeding . . . "	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		4/17/23

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F 695	Continued From page 18 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to provide respiratory care, consistent with professional standards of practice, for 1 Resident (#104) in a survey sample of 35 Residents. The findings included: For Resident #104 the facility staff failed to label and date and properly store the tubing for her nebulizer. A review of Resident #104's orders revealed the following: 3/14/23 6:00 PM - Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML via nebulizer three times a day x 7 days. On 3/21/23 at approximately 10:00 AM, an observation was made of a nebulizer machine on the bedside table. the tubing and mouthpiece were still connected to the machine and it was laying in the open no date on the tubing and it was not in a bag or covered in any way. At that time an interview was conducted with Resident #104 who stated the staff always leave the nebulizer there on the bedside table, when asked if they clean it after each use, she stated that she has never seen them take it apart. On the afternoon of 3/22/23 at 9:30 AM, another observation was made of the nebulizer with tubing and mouthpiece intact on the bedside table tubing and mouthpiece again not dated or in a	F 695	1.The corrective action for Resident #104 cannot be retroactively corrected. Clinical record review indicates that the resident was discharged 3/29/23. 2.A facility-wide audit will be conducted to identify all residents receiving respiratory care such as suctioning, oxygen therapy, tracheostomy care and vent care to ensure respiratory care has been provided is consistent with professional standards of practice. 3.The DON/Designee will educate all nurses and respiratory therapists on the importance of providing respiratory care consistent with professional standard of practice. This includes dating of respiratory tubing and storing respiratory devices in a bag or in a sanitary manner. 4.The DON/Designee will conduct weekly visual inspection audits on all residents to ensure those with respiratory equipment will have its tubing dated and stored in a sanitary manner. The audits will be conducted weekly for 3 months and results will be reviewed at the Quality Assurance Committee meeting for 3 consecutive months.	

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F 695	Continued From page 19	F 695		

bag.

On 3/22/23 at approximately 2:00 PM an interview was conducted with LPN C who stated that night shift was supposed to change and date tubing for Nebulizer and oxygen tubing weekly. She stated if the Resident got an order for Nebulizer treatments, then the nurse that receives the order should date the tubing when she opens it and uses it. Then after giving the treatment, she should rinse the mouthpiece and medication chamber and place it in a bag. The tubing and set up should not be left on the table open without any cover. When LPN C asked what the risks are for leaving the nebulizer connected and, on the table, she stated that means it was not disconnected and cleaned and leaving it in the open is a risk germ getting into the mouthpiece or tubing.

On 3/23/23 at approximately 2:45 PM, an interview was conducted with RN B who stated that the nebulizer and oxygen tubing are to be dated and stored in a bag at the bedside and that the aero chamber and the mouthpiece are to be rinsed out after each use.

Excerpts from the website Medlineplus.gov about standard care of the nebulizer are as follows: (https://medlineplus.gov/ency/patientinstructions/000006.htm)

"After each use:
You will need to clean your nebulizer to prevent bacteria from growing in it, since bacteria can cause a lung infection. It takes some time to clean your nebulizer and keep it working properly. Be sure to unplug the machine before cleaning it.

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F 695	Continued From page 20 Wash the medicine cup and mouthpiece with warm running water. Let them air dry on clean paper towels. Later, hook up the nebulizer and run air through the machine for 20 seconds to make sure all the parts are dry. Take apart and store the machine in a covered area until the next use." On 3/23/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		4/17/23

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F 758	Continued From page 21 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to ensure that as needed (PRN) orders for psychotropic drugs are limited to 14 days for 1 Resident (#'s 13) in a survey sample of 35 Residents. The findings included: 1. For Resident #13 the facility staff failed to ensure that proper evaluation and documentation by physician was obtained for a PRN Ativan order that lasted 6 weeks (4/25/22-6/4/22).	F 758	1.The corrective action for Resident #104 cannot be retroactively corrected. Clinical record review indicates that the resident was discharged from the facility on 4/1/23. 2.All residents on as needed (PRN) psychotropic medications are at risk for this deficient practice. The facility will audit the medication orders for all residents on PRN psychotropic drugs to ensure they are only ordered initially for 14 days. 3.All nurses will be in-serviced on the	

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F 758	Continued From page 22 On 3/22/23, during clinical record review, it was discovered that Resident #13 had orders for a routine dose of Ativan 0.5 mg twice a day and a PRN order that read: Ativan Tablet 0.5 MG (Lorazepam) - Give 1 tablet by mouth every 4 hours as needed for Anxiety -Start Date 04/25/2022 5:00 PM D/C Date 06/06/2022 9:37 AM A review of the pharmacy recommendations revealed that on 5/20/22 the pharmacy sent a form to the physician that read: "Dr [name redacted] -Recommend discontinuing PRN use of Ativan for this resident [#13 name redacted] or REORDER for a specific number of days, per the federal guideline: §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. NOTE: HOSPICE RESIDENTS ARE NOT EXCLUDED PER REGULATION" A review of the clinical record revealed that the physician did not address this notice from the pharmacy until 6/6/22, when he wrote "HOSPICE continue for 14 days" on the form and sent to the pharmacy. On 3/22/23 at approximately 3:00 PM, an	F 758	importance of ensuring PRN orders for psychotropic drugs are limited to 14 days which cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. If extended beyond 14 days, the physician must document the rationale in the resident's clinical record and specify the duration of the PRN order. 4.The DON/Designee will perform weekly audits on all residents with psychotropic medications to confirm that they don't have any PRN psychotropic medications ordered for more than 14 days. This audit will be conducted weekly for 3 months and results will be reviewed at the Quality Assurance Committee meeting for 3 consecutive months.	

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F 758	Continued From page 23 interview was conducted with the Director of Nursing (DON) who was asked about the administration of PRN anti-anxiety drugs. The DON stated that he knew they should be limited to 14 days unless otherwise documented in the chart. By the end of survey date, the DON was unable to locate appropriate documentation to support the physician ordering PRN Ativan for a period of more than 14 days. On 3/23/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 758		