STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING _____ B. WING _____	C 02/23/2023

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CANTERBURY REHABILITATION & HEALTH CARE CENTER	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 02/21/23 through 02/23/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Six complaints were investigated during the survey (VA00056509-Substantiated with deficiency, VA00056502-Substantiated without deficiency, VA00055889-Unsubstantiated, VA00056066-Substantiated with deficiency, VA00055517-Substantiated with deficiency, VA00055496-Substantiated with deficiency). The census in this 190 certified bed facility was 175 at the time of the survey. The survey sample consisted of 11 resident reviews.	F 000		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in	F 676	Resident #18 discharged on 5/1/22. All residents who reside at Canterbury Rehabilitation and Healthcare have the potential to be affected by the same practice. A 100% audit was completed by the Unit Manager/Designee on the on the POC documentation of care for completeness.	April 3, 2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3/24/2023

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

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F 676	Continued From page 1 accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence of providing ADL (activities of daily living) care for one of 11 residents, Resident #2. The findings include: The facility staff failed to provide evidence of bathing and personal hygiene care for Resident #2. Resident #2 was admitted to the facility on 4/27/22 with diagnoses that included but were not limited to: atrial fibrillation, hypertension, surgical wound-laminectomy of thoracic 11-lumbar 3 after falls at home. The most recent MDS (minimum data set) assessment, a five-day Medicare assessment,	F 676	EMR / POC documentation of provision of ADL care daily will be monitored utilizing. the POC Compliance Report. This monitoring process will occur on Monday-Friday with the Morning Clinical Review process. Staff Development Coordinator/ Designee will complete an education for C N A staff members on ADL care and the completion of documentation of ADL care in the EMR / POC daily/each shift Submission of the POC Compliance report to the Morning Clinical Team / Director of Nursing by the Unit Manager/designee daily to ensure ongoing compliance. Supporting documentation for the weekend will be submitted on Monday. A monthly audit of the POC compliance will be completed monthly x 4 months by the DON / Designee to ensure ongoing compliance. A weekly rounding audit of 5 residents per unit for ADL completion/ADL care being provided will be accomplished by the Unit	

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F 676	Continued From page 2 with an ARD (assessment reference date) of 4/30/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, bathing and hygiene; supervision in eating. Locomotion and walking require limited assistance. A review of the comprehensive care plan dated 4/28/22, revealed, "FOCUS: The resident has pain related to osteoporosis, repeated falls with Lumbar-1 burst fracture. I have an ADL (activities of daily living) self-care performance deficit related to activity intolerance, limited mobility, musculoskeletal impairment. INTERVENTIONS: Administer analgesia as per orders. Encourage resident participation while providing appropriate ADL care." A review of the April 2022 ADL document included missing documentation of bathing for day shift (7:00 AM-3:00 PM) for one of three shifts on 4/2/229 and night shift (11:00 PM-7:00 AM) for one of three shifts 4/27/22. A review of the April ADL document included missing documentation of personal hygiene for day shift (7:00 AM-3:00 PM) for one of three shifts 4/29/22 and night shift (11:00 PM-7:00 AM) for of three shifts 4/27/22. A review of the shower/bath being provided as scheduled was documented on 4/29/22 as "no." An interview was conducted on 2/21/23 at 12:30 PM with CNA (certified nursing assistant) #1, when asked what the process is for providing personal hygiene care, CNA #1 stated, we give	F 676	Manager/Designee to ensure ongoing compliance. Findings of the audits will be submitted to the QAPI committee for review and recommendations.	

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F 676	Continued From page 3 them toothbrush and paste, help them with oral care, and assist with combing hair and washing their face and hands. When asked about bathing, CNA #1 stated, we schedule them for showers twice a week and give them bed baths if that is their preference. When asked what is included in a bed bath, CNA #1 stated, we start at their face and work our way down to their feet, we change their clothes and linens. An interview was conducted on 2/22/23 at 11:15 AM with CNA #3, when asked what blanks or holes in the documentation means, CNA #3 stated, it means that it was not documented, not that it was not done. On 2/22/23 at approximately 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant administrator was made aware of the finding. A review of the facility's "Bathing and Showering" policy dated 1/22, revealed, "Provision and refusals of showers/tub baths will be documented in the medical record by the certified nursing assistant and/or licensed nurse. Residents who are unable to be provided a shower or tub bath due to a medical condition or other relevant concern will be provided a bed bath. A review of the facility's "Teeth Brushing" policy dated 1/22, revealed, "The following information should be recorded in the residents' medical record: the date and time the resident's teeth were brushed, include am or pm on the ADL record." No further information was provided prior to exit.	F 676		
F 684 SS=D	Quality of Care	F 684		April 3, 2023

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F 684	Continued From page 4 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review and facility document review, it was determined that the facility staff failed to follow professional standards of practice for medication administration two of 11 residents in the survey sample; Resident #9. The findings include: 1. For Resident #9, facility staff failed to administer a medication that was available to be administered. Resident #9 was admitted to the facility on 2/15/23 for a dislocated shoulder after a fall at home. On 2/21/23 at 12:00 PM during an observation of Resident #9 and their room, a family member alleged that the resident was not getting their medication as ordered. A review of the physician's orders revealed one dated 2/15/23 for Potassium Chloride (1) ER (extended release) Tablet Extended Release 10 MEQ (milliequivalents) Give 1 tablet by mouth	F 684	Resident # 9 discharged from the facility on 2/15/2023. Resident # 3 discharged from the facility on 6/16/2022. All residents who reside at Canterbury Rehabilitation and Healthcare who have ordered medications have the potential to be affected by the same practice. All residents who reside at Canterbury Rehabilitation and Healthcare who have ordered medications and go out for dialysis services have the potential to be affected by the same practice. A 100% audit of EMR / MAR administration was completed by the Unit Manager/Designee for completeness /unavailability/and missed medication. EMR / MAR Administration Audit report will be utilized daily to monitor for any medications unavailable for administration, and/or missed due to appointments out of the facility. This monitoring process will occur on Monday-Friday with the Morning Clinical Review process.	

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F 684	Continued From page 5 one time a day. The medication was scheduled to begin on 2/16/23 at 9:00 AM. A review of the clinical record revealed the February 2023 eMAR (electronic Medication Administration Record). The resident was noted to be on potassium and that it was not signed out as being administered on 2/16/23 at 9:00 AM. The code documented was "22" which correlated with the reason "Drug / Treatment not administered." There was no documentation that evidenced why it was not given. A review of the facility's list for the backup stock of medication in the Pyxis (2) documented that the medication, at this same dose and extended release formulation was available to be administered. On 2/22/23 at 2:40 PM an interview was conducted with LPN #1 (Licensed Practical Nurse). LPN #1 stated that it should have been given as it was available in the backup supply. On 2/23/22 at 9:24 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing and ASM #3 the Assistant Administrator, were made aware of the findings. No further information was provided by the end of the survey. The facility policy, Administering Medications, documented, "...Medications are administered in accordance with prescriber orders, including any required time frame..." References:	F 684	The Staff Development Coordinator will complete an education for the LPN/RN staff members on utilization of the backup medication supplies, and medication administration process when a resident is not in the building due to appointments. Submission of the Medication Administration Audit report to the Morning Clinical Team / Director of Nursing by the Unit Manager/designee daily to ensure ongoing compliance. Supporting documentation for the weekend will be submitted on Monday. An audit of MAR Administration compliance will be completed monthly x 4 months by the DON / Designee monthly to ensure ongoing compliance with this process. Findings of the audits will be submitted to the QAPI committee for review and recommendations.	

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F 684	Continued From page 6 (1) Potassium - Potassium is a mineral that your body needs to work properly. It is a type of electrolyte. It helps your nerves to function and muscles to contract. It helps your heartbeat stay regular. It also helps move nutrients into cells and waste products out of cells. A diet rich in potassium helps to offset some of sodium's harmful effects on blood pressure. Information obtained from https://medlineplus.gov/potassium.html (2) Pyxis - BD Pyxis (Trademark) connected medication and supply management solutions help increase inventory visibility and address your medication error challenges to ensure medications and supplies are available when and where they are needed across care settings. Information obtained from https://www.bd.com/en-us/products-and-solutions/products/product-brands/pyxis 2. Resident #3, Atorvastatin, a medication used to lower cholesterol (1) was not administered as ordered. Resident #3 was admitted to the facility on 5/23/22 with diagnosis that included but were not limited to: end stage renal disease, Sjogren's syndrome. The most recent MDS (minimum data set) assessment, a discharge return not anticipated assessment, with an ARD (assessment reference date) of 6/16/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired.	F 684		

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F 684	Continued From page 7 A review of the comprehensive care plan dated 5/25/22, revealed, "FOCUS: The resident has coronary artery disease related to atherosclerosis, hypercholesterolemia, hypertension..." "INTERVENTIONS: Give meds for hypertension and document response to medication and any side effects. Monitor blood pressure. Notify physician of any abnormal readings..." A review of the physician's orders dated 5/23/22 revealed, "Atorvastatin Calcium Tablet 40 milligram. Give 1 tablet by mouth at bedtime related to hypertension." A review of Resident #3's MAR (medication administration record) for June 2022 revealed, Atorvastatin was not administered in the evenings of 6/8, 6/10, and 6/16/22. A review of Resident #3's blood pressures on 6/9/22 =161/61, 6/11/22=157/98 and 6/17/22=170/56. On 2/23/23 at 9:00 AM, the charge nurse from that unit, LPN (licensed practical nurse) #6 who remembered the resident, stated, this resident would be brought back from dialysis by a friend or family member and would stop for supper and miss the evening medication. When asked if the resident was out overnight or slept at the facility, LPN #6 stated, she slept at the facility. When asked why medications were not administered when the resident was back at bedtime and slept at the facility, LPN #6 stated, they were not here when the medications were distributed, we did not go back. (1) Atorvastatin is used together with a proper	F 684		

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F 684	Continued From page 8 diet to lower cholesterol and triglyceride (fats) levels in the blood. This medicine may help prevent medical problems (eg, chest pain, heart attack, or stroke) that are caused by fats clogging the blood vessels. It may also be used to prevent certain types of heart and blood vessel problems in patients with risk factors for heart problems. https://www.mayoclinic.org/drugs-supplements/atorvastatin-oral-route/description/drg-20067003	F 684		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide physician supervision to ensure that required medications were ordered upon admission for one of 11 residents in the survey sample; Resident #4.	F 710	Past noncompliance: no plan of correction required.	

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F 710	Continued From page 9 This was cited as past non-compliance. The findings include: The facility staff failed to initiate the medication Mycophenolate (1) upon admission, and for the first 15 days of the resident's stay. Two different physicians and two different nurse practitioners reviewed Resident #4's medications multiple times and all failed to identify that this medication was not ordered for 15 days. A review of the facility policy, Physician Services, documented, "The medical care of each resident is supervised by a licensed physician...Once a resident is admitted, orders for the resident's care and needs can be provided by a physician, physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS)...Supervising the medical care of residents includes (but is not limited to)...prescribing medications and therapy..." A review of the facility policy, Physician Visits, documented, "...The attending physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation..." Resident #4 was admitted to the facility on 8/11/22. Resident #4 had a history of a kidney transplant in 2020. A review of the clinical record revealed the following as documented by and identified as: ASM #4 (Administrative Staff Member), a Nurse Practitioner	F 710		

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F 710	Continued From page 20 ml (4) levofloxacin - is an antibiotic Information obtained from https://medlineplus.gov/druginfo/meds/a697040.html	F 710		April 3,2023
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755	Resident #3 was discharged on 6/16/2022. Residents who are newly admitted to Canterbury Rehabilitation and Healthcare who take medications have the potential to be affected by this practice. A 100% audit of EMR / MAR administration was completed by the Unit Manager/Designee for completeness/unavailability of medication. Newly admitted residents will have medications reviewed/verified by Nursing/Physician and then ordered STAT if after hours, through PharMerica for delivery. Medications available through the emergency drug box, or automated dispensing system will be dispensed as ordered. Physician notification, with orders obtained on Medications that are not available and/or do not arrive from the pharmacy timely.	

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F 755	Continued From page 21 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure medications were available for administration for one of 11 residents, Resident #3. The findings include: The facility staff failed to ensure Atorvastatin and Acular eye drops were available for administration for Resident #3. Resident #3 was admitted to the facility on 5/23/22 with diagnosis that included but were not limited to: respiratory failure, diabetes, end stage renal disease, Sjogren's syndrome and asthma. The most recent MDS (minimum data set) assessment, a discharge return not anticipated assessment, with an ARD (assessment reference date) of 6/16/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the comprehensive care plan dated 5/25/22, revealed, "FOCUS: The resident has coronary artery disease related to atherosclerosis, hypercholesterolemia, hypertension..." "INTERVENTIONS: Give meds for hypertension and document response to medication and any side effects. Monitor blood pressure. Notify physician of any abnormal readings..."	F 755	EMR / MAR Administration Audit report will be utilized daily to monitor for any medications unavailable for administration. This monitoring process will occu r on Monday-Friday with the Morning Clinical Review process. The Staff Development Coordinator will complete an education for the LPN/RN staff members on utilization of the backup medication supplies, and medication administration process when a resident is newly admitted and/or medication is unavailable for administration. Submission of the Medication Administration Audit report to the Morning Clinical Team / Director of Nursing by the Unit Manager/designee daily to ensure ongoing compliance with this process. Supporting documentation for the weekend will be submitted on Monday. An audit of medication unavailability will be completed monthly x 4 months by the DON / Designee to ensure ongoing compliance with this process.	

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F 755	Continued From page 22 A review of the physician's orders dated 5/23/22 revealed, "Atorvastatin Calcium Tablet 40 milligram. Give 1 tablet by mouth at bedtime related to hypertension. Acular Solution 0.5 % (Ketorolac Tromethamine) Instill 1 drop in both eyes two times a day related to glaucoma." A review of the nursing notes dated 5/23/22, at 5:13 PM, revealed, "Physician orders entered." On 2/21/23 at 10:36 AM, ASM (administrative staff member) #2, the director of nursing, provided the emergency drug box list for Westham and Grove units that have a breakaway key entrance to box. On the Tuckahoe unit, there is an automated dispensing machine accessed by individual key number entry. A review of Resident #3's MAR (medication administration record) for May 2022 revealed the following: Atorvastatin and Acular were not administered on 5/23/22, the day of admission due to the eye drops not being in the emergency medication cabinet and the Atorvastatin was ordered for 40 milligram and only 10 milligram tablet was available in the emergency medication cabinet. On 2/22/23 at 12:00 PM, and interview was conducted with LPN (licensed practical nurse) #2. When asked the process for obtaining medications for new admissions, LPN #2 stated, once we receive the physician orders, we check to see if we have the medication in the emergency drug box or the automated dispensing machine. If the medication is not there, we order it from pharmacy. When asked when pharmacy delivers the medication, LPN #2 stated, if the resident comes in the evening, we may not get	F 755	Findings of the audits will be submitted to the QAPI committee for review and recommendations.	

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F 755	Continued From page 23 the medications till the next day. We try to have the residents admitted as early as possible in the day to make sure everything is in place.	F 755		
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- (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	F 842	Resident #1 discharged on 7/26/22. Resident #3 discharged on 6/16/22. Resident #5 discharged on 8/22/22. Residents who reside at Canterbury Rehabilitation and Healthcare have potential to be affected by this practice. A 100% audit of EMR / MAR administration was completed by the Unit Manager/Designee for completeness/unavailability of medication. 100% audit of wound care documentation of healing was completed by the Unit Manager /Designee for completeness.	April 3,2023

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F 842	Continued From page 24 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide complete and accurate documentation for three of 11 residents, Residents #1, #3 and #5.	F 842	EMR / MAR- TAR Administration Audi t report will be utilized daily to monitor for documentation completeness. EMR / POC documentation of provision of ADL care daily will be monitored utilizing the POC Compliance Report. The Weekly Wound Updated log listing / Healing Partners will be utilized weekly to ensure supporting documentation is completed in the EMR for changes in healing status of a wound. The monitoring of this process will occur on Monday-Friday with the Morning Clinical Review IDT members. The Staff Development Coordinator will complete an education for the LPN/RN and C N A staff members on Completion of EMAR / Medication administration record – Treatment Administration record and POC documentation of the of ADL Care.	

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F 842	Continued From page 25 The findings include: 1. For Resident #1, the facility staff failed to evidence complete and accurate documentation for urine output. Resident #1 was admitted to the facility on 5/19/22 with diagnoses that included but were not limited to: neurogenic bladder. The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 7/19/22, coded the resident as being in a persistent vegetative state 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 bed mobility, transfer, dressing, eating, bathing and hygiene. A review of the comprehensive care plan dated 5/20/22, revised 6/17/22 and 7/13/22, which revealed, "FOCUS: The resident readmitted from hospital on 6/17 with MASD (moisture associated skin damage) in groin and lower back. Fungal infection noted to back and buttocks. Resident have [sic] indwelling foley catheter: INTERVENTIONS: Administer treatments as ordered and monitor for effectiveness. Apply barrier cream after each incontinence care. Check tubing for kinks during care and repositioning and each shift. Urinary Catheter Care: Clean area around catheter with soap and water every shift for care." A review of the physician orders dated 6/17/22, revealed, "Urinary Catheter: Maintain indwelling	F 842	Submission of the Medication Administration / Treatment Administration Audit report and POC Compliance report to the Morning Clinical Team / Director of Nursing by the Unit Manager /designee daily to ensure ongoing compliance with this process. Supporting documentation for the weekend will be submitted on Monday. An audit of Medication / Treatment Administration report and POC Compliance report will be completed monthly x 4 months by the DON / Designee to ensure ongoing compliance with this process. Findings of the audits will be submitted to the QAPI committee for review and recommendations	

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F 842	Continued From page 26 foley catheter with 16 French 30 milliliter balloon for dysfunction bladder and change as needed for obstruction every shift for catheter care. Document urinary output every shift. A review of Resident #1's TAR (treatment administration record) for July 2022, revealed no urine output was documented for day shift on 7/3, 7/4, 7/17, 7/24, 7/25; no urine output documented for evening shift on 7/4, 7/25 and 7/26 and none documented on night shift on 7/3, 7/22 and 7/25. There was no urine output documented from 7:00 AM on 7/25/22 to 7:00 AM on 7/26/22 and no urine output documented after 3:00 PM on 7/26/22 until Resident #1 was transferred to the hospital at 11:49 PM on 7/26/22. A review of Resident #1's ADL (activities of daily living) document for 7/26/22, revealed urine incontinence on evening shift. An interview was conducted on 2/23/23 at 8:40 AM with LPN (licensed practical nurse) #6. LPN #6 stated, the Foley was not obstructed as he had 1050 milliliters of urine out at 3:00 PM on 7/26 and had some urine incontinence on evening shift. When asked what the blanks/holes in the urine output documentation meant, LPN #6 stated, it means it was not documented. When asked if that was a complete and accurate medical record, LPN #6 stated, not with the blanks, no. On 2/23/23 at approximately 9:00 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant administrator was made aware of the findings.	F 842		

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F 842	Continued From page 27 A review of the facility's "Charting and Documentation" policy, dated 1/22, revealed, "The following information is to be documented in the resident medical record: objective observations, medications administered, treatments or services performed, changes in the residents' conditions, events, incidents or accidents involving the resident and progress toward or changes in the care plan goals and objectives. Documentation in the medical record will be objective, complete and accurate. Entries may be recorded in the resident's clinical record by licensed personnel. Certified nursing assistants may make entries in the resident's medical record related to resident care tasks and activities of daily living." No further information was provided prior to exit. 2. For Resident #3, the facility staff failed to evidence complete and accurate documentation for incontinence care. Resident #3 was admitted to the facility on 5/23/22 with diagnosis that included but were not limited to: end stage renal disease, and Sjogren's syndrome. The most recent MDS (minimum data set) assessment, a discharge return not anticipated assessment, with an ARD (assessment reference date) of 6/16/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring supervision for bed mobility, transfer, dressing, bathing and hygiene; independence in eating. Locomotion and walking require limited	F 842		

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F 842	Continued From page 28 assistance. A revi ' of the comprehensive care plan dated 5/2F 22, revealed, "FOCUS: The resident has cr onary artery disease related to atherosclerosis, hypercholesterolemia, hypertension. Resident has bladder incontinence related to activity intolerance, Impaired mobility, physical limitations. Resident has renal failure related to end stage disease. INTERVENTIONS: Give meds for hypertension and document response to medication and any side effects. Monitor blood pressure. Notify physician of any abnormal readings. Apply moisture barrier to perianal and perineal area as indicated. Assist with perineal care as needed. Monitor for signs/symptoms of hypovolemia or hypervolemia. Monitor for signs/symptoms of infection, urinary tract infection. A review of Resident #3's ADL (activities of daily living) record, revealed that incontinence care was not documented in May 2022 for three of eight-day shifts: 5/26, 5/27 and 5/28; three of eight evening shifts: 5/24, 5/28, 5/29 and for two of eight-night shifts: 5/23 and 5/30. A review of Resident #3's ADL record, revealed that incontinence care was not documented in June 2022 for seven of 16-day shifts: 6/2, 6/7, 6/9, 6/11, 6/12, 6/13 and 6/15; five of 16 evening shifts: 6/7, 6/9, 6/11, 6/12, 6/14 and for two of 16-night shifts: 6/12 and 6/13. An interview was conducted on 2/22/23 at 8:40 AM with CNA (certified nursing assistant) #1, when asked the frequency of incontinence care, CNA #1 stated, "We round every two hours and if	F 842		

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F 842	Continued From page 29 the resident needs incontinence care more frequently they call us." An interview was conducted on 2/22/23 at 11:15 AM with CNA #4. When asked the frequency of incontinence care, CNA #4 stated, "There are every two-hour rounds and more frequently if the resident needs it." On 2/23/23 at approximately 9:00 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant administrator was made aware of the findings. A review of the facility's "Charting and Documentation" policy, dated 1/22, revealed, "The following information is to be documented in the resident medical record: objective observations, medications administered, treatments or services performed, changes in the residents' conditions, events, incidents or accidents involving the resident and progress toward or changes in the care plan goals and objectives. Documentation in the medical record will be objective, complete and accurate. Entries may be recorded in the resident's clinical record by licensed personnel. Certified nursing assistants may make entries in the resident's medical record related to resident care tasks and activities of daily living." No further information was provided prior to exit. 3. For Resident #4, the facility staff failed to document an assessment of a wound that prompted new orders for wound care for a healed surgical site on 9/15/22.	F 842		

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F 842	Continued From page 30 A review of the clinical record revealed the following: Resident #4 was admitted to the facility on 8/11/22 status post surgical below the knee amputation of the right leg. A nurse's note dated 8/30/22 documented, "Right upper medial leg, right medial leg, right lower medial leg, and right lateral leg wounds healed. Resident went to surgical appointment on 8/29. Surgeon removed all staples. BKA (below knee amputation) site secure with steri-strips." A physician's note 9/6/22 documented, "...c/o pain at the wound sites. wound looks clean and no drainage or redness...." A physician's note dated 9/9/22 documented, "...wound looks clean and no drainage or redness...." A nurse practitioner note dated 9/11/22 documented, "...Right BKA with steri strips and has a small open area with slough tissue but no significant drainage, erythema or dehiscence...." A physician's order dated 9/15/22, which was entered into the electronic health record system by the facility's in-house wound nurse, RN #2 (Registered Nurse) at the time, documented, "Right BKA site: wound cleanser, silver alginate, border gauze. QD (daily) or PRN (as-needed) if soiled or removed." There were no wound assessments documented by RN #2 that precipitated the need for this order. A nurse's note dated 9/16/22 documented, "....resident and [family member] notified of new	F 842		

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F 842	Continued From page 31 orders, also given update of condition of surgical site on stump, given report of all upcoming appointments..." The resident was seen by the wound nurse practitioner on 9/19/22. That note documented, "Length: 1.82 cm. Width: 3.50 cm....Depth (cm) 0.10...% granulation 10.00. % slough/eschar 90.00... Etiology Surgical Wound Dehiscence. Margin Detail Attached edges. Drain Amount Moderate. Drain Description Sanguinous. Odor No Odor. Periwound Intact..." On 2/23/22 at 8:25 AM an interview was conducted with LPN #6 (Licensed Practical Nurse). She stated that RN #2 should have written a note on the 9/15/22 about the change in wound condition prompting the new orders. When asked if the record was complete and accurate without this documentation, she stated that it was not. On 2/23/22 at 9:24 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing and ASM #3 the Assistant Administrator, were made aware of the findings. ASM #2 stated that she thought she might have more information on this. On 2/23/22 at approximately 11:30 AM, ASM #2 stated that the orders that were written were consistent with a wound dehiscence and that the information about this wound was relayed to her on 9/15/22 as she stated she noted it on her wound tracking to be sent to corporate, but that RN #2 did not document it in the clinical record. No further information was provided by the end of the survey.	F 842		

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F 842	Continued From page 32 A review of the facility policy, Guidelines for Charting and Documentation, documented, "...The purpose of charting and documentation is to provide: 1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., and the progress of the resident's care..."	F 842		