DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 3/27/23 through 3/29/23. The facility was in substantial compliance with 42 CFR Part 483.73 emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 120 certified bed facility was 111 at the time of the survey. There were three COVID-19 positive residents in the facility at the time of the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey and a COVID-19 Focused Infection Control survey were conducted 3/27/23 through 3/29/23. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Eight complaints were investigated during the survey (VA00058149-substantiated with deficiency, VA00056387-substantiated without deficiency, VA00056295-substantiated with deficiency, VA00058398-unsubstantiated, VA00056151-substantiated with deficiency, VA00056715-substantiated with deficiency, VA00057683-substantiated with deficiency, VA00058240-unsubstantiated). The census in this 120 certified bed facility was 111 at the time of the survey. There were three COVID-19 positive residents in the facility at the time of the survey. The survey sample consisted of 17 current residents and four closed record reviews.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Luis Jimenez	Administrator	4/20/2023

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 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 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).	F 580	F 580 1) Resident # 3 and #4 no longer reside in the center. 2) An audit of current residents with new pressure injuries audited for RP notification. A review of change in condition for new antibiotic orders for current residents reviewed for RP notification. 3) Licensed nurses will receive re-education on notifying resident RP of changes in condition. 4) DON/designee will audit new pressure injuries and changes in conditions for new antibiotic orders weekly for 2 months to ensure appropriate RP notification occurred. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 4/26/2023	

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F 580	Continued From page 2 §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, facility document review, and clinical record review, it was determined that the facility staff failed to notify the resident's responsible party of a change of condition for two of 21 residents in the survey sample; Residents #3 and #4. The findings include: 1. Resident #3 developed a new pressure injury identified on 12/12/22. There was no evidence that the resident's responsible party was notified that this wound had developed until 12/23/22. A Change of Condition note dated 12/12/22 at 9:41 PM documented, "Situation: 5 cm (centimeters) circular pressure wound, Black in color noted by CNA (certified nursing assistant.)....Response: Foam dressing applied. Resident positioned on side to relieve pressure." This note did not evidence that the responsible party was notified of the wound. An Initial Pressure Injury report dated 12/12/22 at 12:13 PM documented, "....Site: Left buttock. Type: Pressure. Length: 5 cm (centimeters)...Stage III (3)...Is there drainage?	F 580		

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F 580	Continued From page 3 No. Is there tunneling or undermining present? No. Describe Current Treatment Plan: Clean with wound cleanser and apply foam boarder dressing QD (everyday)...Care Plan review and updated as needed: (multiple items were listed and checked)." This report did not evidence that the responsible party was notified of the wound. A review of the wound care physician's progress notes revealed that the wound care physician evaluated the resident's wound on 12/15/22 and documented, "...Unstageable necrosis....6 x 4 x not measurable...Thick adherent devitalized necrotic tissue - 100%....Dressing treatment plan: Santyl apply once daily for 30 days; Gauze island w/ bdr (with border) apply once daily for 30 days...Treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 12/15/2022 to the patient who indicated agreement to proceed with the procedure(s)..." This documented that the resident themselves provided consent for the procedure and no evidence that the resident's responsible party was notified. A nurse practitioner note dated 12/23/22 documented, "...Stage 4 sacral wound, acute, possibly infected...New recommendations given for management but family wants pt (patient) to go to the ER (emergency room.)..." This note was the first indication of the responsible party being notified, which was 11 days after the wound was identified. On 3/29/23 at 10:23 AM, an interview was conducted with RN #1 (Registered Nurse). When asked about notifying a resident's responsible party about the development of a new wound, RN	F 580		

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F 580	Continued From page 4 #1 stated that it should be done immediately, and certainly within 24 hours. The facility policy "Reporting Change of Condition: POA, Responsible Party v. Emergency Contact" was reviewed. This policy documented, "...C. When a change of condition is identified the staff must verify if there is a responsible party or a POA. Once they have been verified the staff may notify them of the change of condition....E. Once the appropriate person is contacted it should be noted in the medical record...." On 3/29/23 at 11:33 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Clinical Consultant, and ASM #4 the Regional VP of Operations, were notified of the findings. No further information was provided. 2. For Resident #4 (R4), the facility staff failed to notify the resident's RP (responsible party) of a change in condition and a new physician's order for antibiotics on 11/19/22 and 2/23/23. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/23/23, the resident scored 6 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. A review of R4's clinical record revealed a physician's order dated 11/19/22 for Keflex (an antibiotic used to treat infection) 500 mg (milligrams) twice a day for seven days for cellulitis of a right lower abdomen boil. A nurse's note dated 11/19/22 documented, "Res (Resident) will be starting ABX (antibiotic) for cellulitis of boil on right lower abdomen later this	F 580		

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F 580	Continued From page 5 morning, offers no c/o (complaint of) discomfort." Further review of R4's clinical record (including progress notes) failed to reveal the resident's RP was made aware of the change in condition and the new physician's order. A review of R4's clinical record revealed a physician's order dated 2/23/23 for Keflex 500 mg twice a day for seven days for acute bronchitis. A nurse's note dated 2/24/23 documented, "Res is to start on ABX therapy in the morning for acute bronchitis..." Further review of R4's clinical record (including progress notes) failed to reveal the resident's RP was made aware of the change in condition and the new physician's order. On 3/29/23 at 12:48 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated residents' responsible parties should be notified for any change in condition and any new orders to keep them informed and updated. LPN #1 stated RP notification should be documented in a progress note. On 3/29/23 at 1:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been	F 585		

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F 585	Continued From page 6 furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;	F 585		

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F 585	Continued From page 7 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency	F 585		

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F 585	Continued From page 8 confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to maintain grievance logs prior to September 2022. This is being cited as past non-compliance. The findings include: The facility staff failed to maintain the grievance logs prior to September 2022. Upon entrance to the facility on 3/27/2023, a request was made for the grievance logs from July 2022 to present. The facility presented grievance logs starting 9/19/2022. On 3/28/2023 at 1:05 p.m. ASM (administrative staff member) #1, the administrator, presented a document from their QA (quality assurance) meeting of 10/21/2022. The document documented, "Grievance Binder was possibly taken by former Social Worker as she left abruptly without notice. Some grievances were found that were still laying around her desk area and Social Services Assistant compiled new Grievance Binder. Grievances have now been kept up firm, fair and consistent. Grievances are also reviewed and recorded in Morning Meeting Minutes should binder go missing again. Binder is now kept in Administrator's office for safe keeping." The document further documented, "Date of compliance 9/14/2022, last day of	F 585	Past noncompliance: no plan of correction required.	

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F 585	Continued From page 9 employment for Social Services." The Grievance Logs presented were dated 9/19/2022 through 3/24/2023. All grievances were documented with resolutions. ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional clinical consultant, and ASM #4, the regional vice president of operations, were made aware of the above concern on 3/29/2023 at 11:37 a.m.	F 585		
F 656 SS=E	Past Non-Compliance. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656	F 656 1) Resident #3 no longer resides in the facility. Resident #6 comprehensive care plan is being implemented for insulin. Resident #13 comprehensive care plan is being implemented for wound care orders. 2) An audit of current residents' comprehensive care plans that have pressure injuries, and insulin orders were completed to ensure they are being implemented. 3) Licensed nurses will receive re-education on the implementation of resident's comprehensive care plans.	

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F 656	Continued From page 10 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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for three of 21 residents in the survey sample, Residents #3, #13, #6. The findings include: 1. For Resident #3, the facility staff failed to implement the comprehensive care plan for administering treatments as ordered for a pressure injury. The facility staff did not perform a physician ordered treatment on 12/17/22, and did not implement a new treatment that was ordered on 12/15/22.	F 656	4) DON/designee will audit residents with pressure injuries and insulin orders weekly x2 months to ensure comprehensive care plans are being implemented. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 4/26/2023	

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F 656	Continued From page 11 A review of the comprehensive care plan revealed one dated 11/17/22 and most recently revised on 12/15/22 documented, "at risk for skin breakdown r/t Assistance required in bed mobility current tx for unstag [unstageable] ulcer." Interventions included, "Treatments as ordered (added 12/15/22)." A Change of Condition note dated 12/12/22 at 9:41 PM documented, "Situation: 5 cm (centimeters) circular pressure wound, Black in color noted by CNA (certified nursing assistant.)....Response: Foam dressing applied. Resident positioned on side to relieve pressure." An Initial Pressure Injury report dated 12/12/22 at 12:13 PM documented, "...Site: Left buttock. Type: Pressure. Length: 5 cm (centimeters)...Stage III (3)...Is there drainage? No. Is there tunneling or undermining present? No. Describe Current Treatment Plan: Clean with wound cleanser and apply foam boarder dressing QD (everyday)..." A review of the physician's orders revealed one dated 12/12/22 for "Cleanse coccyx wound with wound cleanser, pat dry, apply foam dressing QD (everyday), and PRN (as needed) every evening shift for Pressure wound." A review of the wound care physician's progress notes revealed that the wound care physician first evaluated the resident's wound on 12/15/22 and documented, "...Unstageable necrosis....6 x 4 x not measurable...Thick adherent devitalized necrotic tissue - 100%....Dressing treatment plan: Santyl apply once daily for 30 days; Gauze island w/ bdr (with border) apply once daily for 30	F 656		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 12 days..." A review of the December 2022 TAR (Treatment Administration Record) revealed that the initial treatment that was started on 12/12/22 was administered each day through 12/23/22, with the exception of 12/17/22. Further review revealed that the above wound physician note dated 12/15/22 contained a treatment order that was never transcribed and implemented. The resident did not get this treatment from the time it was ordered, through their discharge on 12/23/22. On 3/29/23 at 10:23 AM, an interview was conducted with RN #1 (Registered Nurse). When asked what was the purpose of the care plan, she stated that it was to make sure the staff followed through with what needed to be done to meet the resident's needs. When asked, if a care plan documented to do treatments as ordered, and a treatment was not done, was the care plan followed, she stated it was not. The facility policy, Care Plan Preparation" was reviewed. This policy documented, "A care plan direct's the patient's nursing care from admission to discharge. This written action plan is based on nursing diagnoses that have been formulated after reviewing assessment findings, and it embodies the components of the nursing process: assessment, diagnosis, planning, implementation and evaluation..." On 3/29/23 at 11:33 AM, ASM #1 the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Clinical Consultant, and ASM #4 the Regional VP of Operations, were	F 656		

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F 656	Continued From page 13 notified of the findings. No further information was provided. 2. For Resident #13, the facility staff failed to implement the comprehensive care plan to administer treatments as ordered for pressure injuries. A review of the clinical record revealed that Resident #13 had a history of pressure injuries. A left ischial stage 3 pressure injury which was being treated with negative pressure wound therapy (wound vac) upon admission on 4/13/22, an unavoidable stage 4 sacral wound that developed on or about 5/20/22, an unavoidable right lower back stage 3 wound that develop on or about 8/25/22 (at which time the left ischial wound was determined to be resolved), and an unavoidable re-emergence of the left ischial wound on or about 1/12/23. A review of the comprehensive care plan revealed one dated 4/15/22 for "Pressure ulcer actual to: Stage 4 on left ischium and stage 4 on sacrum" which included the intervention, dated 4/15/22 for "Treatments as ordered." First left ischial wound: A review of the nurse's notes, physicians orders and TAR revealed the following: A review of the clinical record revealed that the resident was admitted on 4/13/22 with a wound vac to a pressure injury. A physician's order dated 4/13/22 documented "Change wound Vac. 3 x weekly to under left ischial. Ensure proper	F 656		

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F 656	Continued From page 14 seal and suctioning at all times. 125 mmhg (millimeters of mercury) negative pressure every day shift every Mon, Wed, Fri (Monday, Wednesday, Friday) for Wound." The resident was readmitted to the hospital on 4/14/22 and this order was subsequently discontinued on 4/19/22. Further review of the clinical record revealed that the resident was readmitted on 4/21/22. A nurse's note dated 4/22/22 documented, "Wound [name of wound care physician] into see this resident for the 2 pressure wounds. Left ischium improved. Size: 2.3x2.5x3.6cm (centimeters). Moderate serous. 15% slough and 85% granulated tissue....Wound vac intact and draining properly. No s/s distress or discomfort. Will continue to monitor." A nurse's note dated 4/24/22 documented, "...wound vac that is attached & functioning properly to left ischium...." A nurse's note dated 4/29/22 documented, "....Wound vac intact and draining properly...." Further review of the clinical record revealed a physician's order dated 4/29/22 that documented, "Change wound Vac. 3 x weekly to under left ischial. Ensure proper seal and suctioning at all times. 125 mmhg negative pressure every day shift every Mon, Wed, Fri." This order was set with a start date of 5/2/22. This order was discontinued on 5/9/22. A review of the physician's orders failed to reveal any evidence that an order was in place for this treatment from the time of readmission on 4/21/22 through 4/29/22 when the above order	F 656		

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F 656	Continued From page 15 was written. A review of the treatment administration record (TAR) for April and May 2022 revealed that the wound vac was not included as an order to be followed upon the resident's readmission on 4/21/22 through 4/29/22. Based on the notes that documented the presence of the wound vac from the time of readmission on 4/21/22, the resident was receiving wound vac therapy at times, but without an order, and therefore, the use of the wound vac therapy was not evidenced on the treatment administration record from the readmission on 4/21/22 through 4/29/22. Therefore, there was no evidence other than the sporadic nurses' note, that the treatment was provided daily, and that the required settings of 125 mmhg was implemented, and that the three times a week associated dressing change for wound vac dressings was completed. Therefore the facility could not evidence that the wound vac therapy, if provided, was provided in accordance to standards of wound vac therapy to include machine settings and dressing changes. Sacral wound: A review of the physicians orders and TAR revealed the following: On 5/20/22, the wound physician ordered calcium alginate, dressing, daily, to the sacral wound. This order was discontinued on 10/17/22. A review of the TAR from May 2022 through October 2022 revealed this treatment was not provided on 8/1/22, 8/9/22, 9/24/22, 10/1/22, 10/5/22, and 10/10/22.	F 656		

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F 656	Continued From page 16 On 8/25/22, an order was written for calcium alginate and Santyl, daily. This order was discontinued on 11/10/22. A review of the TAR from August 2022 through November 2022 revealed this treatment was not provided on 9/24/22, 10/1/22, 10/5/22, 10/10/22, 10/20/22, 10/22/22, 10/23/22, 11/5/22, and 11/6/22. On 11/10/22, an order was written for collagen sheet with silver alginate cream, daily. This order was discontinued on 3/17/23. A review of the TAR from November 2022 through March 2023 revealed this treatment was not provided on 11/30/22, 12/3/22, 12/12/22, 12/25/22, 1/9/23, 1/17/23, 1/31/23, 2/9/23, and 2/11/23. On 3/17/23 an order was written for collagen sheet and cover with gauze island with border, daily. A review of the March 2023 TAR revealed this treatment was not provided on 3/19/23, 3/20/23, and 3/26/23. Lower right back wound: A review of the physicians orders and TAR revealed the following: On 8/25/22, an order was written for calcium and alginate. This order was discontinued on 11/10/22. A review of the TAR from August 2022 through November 2022 revealed this treatment was not provided on 9/24/22, 10/5/22, 10/10/22, 10/22/22, 10/23/22, 11/5/22, and 11/6/22. On 11/22/22 an order was written for collagen with silver sheet, daily. This order was discontinued on 3/17/23. A review of the TAR from November 2022 through March 2023	F 656		

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F 656	Continued From page 17 revealed this treatment was not provided on 11/30/22, 12/3/22, 12/12/22, 1/9/23, 1/17/23, 1/31/23, 2/9/23, and 2/11/23. On 3/17/23 an order was written for collagen with silver sheet and cover with boarder gauze, daily. A review of the TAR for March 2023 revealed this treatment was not provided on 3/19/23, 3/20/23, and 2/26/23. Re-emerged left ischial wound: On 1/12/23 an order was written by the wound physician on the wound evaluation notes for alginate calcium with silver, to be done daily. This order was not transcribed and implemented. Therefore it wasn't done. The wound physician documented on 1/19/23 on the weekly wound evaluation note to discontinue this order. On 1/19/23 an order was written for alginate calcium and Santyl, daily. This order was discontinued on 3/17/23. A review of the TAR for January 2023 through March 2023 revealed this treatment was not done on 1/31/23, 2/9/23, and 2/11/23. On 3/17/23 an order was written for alginate calcium and island gauze with border. A review of the TAR for March 2023 revealed this treatment was not provided on 3/19/23, 2/20/23, and 2/26/23. On 3/29/23 at 10:23 AM, an interview was conducted with RN #1 (Registered Nurse). When asked what does it mean if a wound treatment is not signed off as being done, she stated that if it isn't charted it isn't done.	F 656		

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F 656	Continued From page 18 On 3/29/23 at 11:33 AM, ASM #1 the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Clinical Consultant, and ASM #4 the Regional VP of Operations, were notified of the findings. No further information was provided. 3. For Resident #6 (R6), the facility staff failed to implement the resident's comprehensive care plan for diabetic medication administration. R6's comprehensive care plan dated 12/1/21 documented, "Alteration in Blood Glucose due to: dm (diabetes mellitus). Administer medications as ordered..." A review of R6's clinical record revealed a physician's order dated 2/8/23 for insulin glargine (Lantus) (used to treat diabetes) 40 units two times a day (scheduled at 9:00 a.m. and 9:00 p.m.) and a physician's order dated 2/8/23 for insulin lispro (used to treat diabetes), the amount to be given based on the resident's blood sugar and not to exceed 12 units, before meals and at breakfast. A facility synopsis of events dated 3/8/23 documented that on 3/2/23 at 9:00 a.m., a nurse mistakenly administered the incorrect insulin to R6 (40 units of Lispro instead of the physician ordered 40 units of Lantus). Per the synopsis, the director of nursing attempted to notify the nurse practitioner but R6 called 911 to transfer to the hospital and would not allow staff to provide further care. R6 returned to the facility on the same date without any new orders. A physician's note dated 3/3/23 documented, "Patient was sent to the ER (emergency room) yesterday 3/2/23 after resident was given Lispro	F 656		

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F 656	Continued From page 19 40 units SC (subcutaneously). (The resident) was monitored for hypoglycemia (low blood sugar). Accuchecks were @ 144-190. (The resident) was sent back to the facility. Upon return to the facility, resident continues to be clinically stable with accuchecks of 167 and 254 mg/dl (milligrams/deciliter)..." On 3/28/23 at 2:37 p.m., an interview was conducted with LPN (licensed practical nurse) #3, in regard to the purpose of residents' care plans. LPN #3 stated, "It's to get some sort of goal orientation for that patient. What are we trying to do? Where are our problems? Where should we be in three weeks, four weeks?" In regard to care plan implementation, LPN #3 stated, "Usually if it's anything significant, it comes up on our MAR (medication administration record)." In regard to ensuring the correct medication is administered to a resident, LPN #3 stated, "You compare it to the MAR. Look at the MAR, look at what you got, make sure it matches." On 3/29/23 at 1:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657	F 657 1) Resident #15 is no longer on isolation precautions and midline catheter has been discontinued. 2) Comprehensive care plans of current residents on isolation and with midline venous catheters will be audited to ensure they were reviewed and revised.	

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F 657	Continued From page 20 (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, the facility staff failed to review and revise the care plan for one of 21 residents in the survey sample, Resident # 15. The findings include: For Resident #15 (R15), the facility staff failed to review and revise the comprehensive care plan to include a urinary tract infection resulting in isolation precautions, and the care for a midline venous catheter (1). On the following dates and times, R15 was observed sitting up in bed in the room. The door to the room contained signs which read that the resident was on isolation precautions, and PPE	F 657	3) Nurse management will be provided re-education on reviewing and revising comprehensive care plan. 4) DON/designee will audit residents comprehensive care plan weekly x2 months to ensure the residents comprehensive care plan has been reviewed and revised for isolation precautions and midline venous catheter. Results will be provided to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 4/26/2023	

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F 657	Continued From page 21 (personal protection equipment) hung on the outside of the door: 3/27/23 at 3:42 p.m., 3/28/23 at 7:53 a.m. and 11:45 a.m. A review of R15's progress notes revealed the following note dated 3/23/23: "[POA] (power of attorney) notified of recent labs and new orders for midline placement and iv (intravenous) antibiotics...gave verbal consent for new orders. Resident will start IV antibiotics...Droplet isolation in place. Will continue to monitor." A review of R15's comprehensive care plan dated 3/9/22 revealed no information related to the resident's infection, isolation status, antibiotics or midline venous catheter. On 3/28/23 at 4:17 p.m., LPN (licensed practical nurse) #2 interviewed. She stated "everyone" is responsible for updating care plans, including floor nurses, unit managers, and the MDS (minimum data set) nurse. She stated when any new orders are generated for a resident, or if a resident's status changes, the care plan should be updated as soon as possible. She stated a new antibiotic, an infection, and midline catheter placement should be included in a resident's care plan. She stated, "The care plan tells us how to provide care for the resident. It gives us an idea of what we are supposed to be doing." On 3/29/23 at 1:35 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional clinical consultant, and ASM #4, the regional vice president of operations, were informed of these concerns. A review of the facility policy, "Care Plan	F 657		

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F 657	Continued From page 22 Preparation," revealed no information related to reviewing and revising a care plan. No further information was provided prior to exit. Reference: (1) "Midline catheters are peripheral venous access devices between 3 to 10 inches in length (8 to 25 cm). Midlines are usually placed in an upper arm vein, such as the brachial or cephalic, and the distal extreme ends below the level of the axillary line." This information is taken from the website https://pubmed.ncbi.nlm.nih.gov/24624619/.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 21 residents in the survey sample, Resident #13. The findings include: For Resident #13, the facility staff failed to obtain an order for the use of negative pressure wound therapy (wound vac); and failed to clarify conflicting treatment orders with the physician.	F 658	F 658 1) Resident # 13 treatment orders clarified for pressure injury. 2) An audit of current residents with pressure injury completed to ensure professional standards of practice are being followed for treatment orders. 3) Licensed nurses will be re-educated on professional standards of practice for obtaining and/or clarifying treatment orders for pressure injuries.	

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F 658	Continued From page 23 A review of the clinical record revealed that the resident was admitted on 4/13/22 with a wound vac to a pressure injury. A physician's order dated 4/13/22 documented "Change wound Vac. 3 x weekly to under left ischial. Ensure proper seal and suctioning at all times. 125 mmhg (millimeters of mercury) negative pressure every day shift every Mon, Wed, Fri (Monday, Wednesday, Friday) for Wound." The resident was readmitted to the hospital on 4/14/22 and this order was subsequently discontinued on 4/19/22. Further review of the clinical record revealed that the resident was readmitted on 4/21/22. A nurse's note dated 4/22/22 documented, "Wound [name of wound care physician] into see this resident for the 2 pressure wounds. Left ischium improved. Size: 2.3x2.5x3.6cm (centimeters). Moderate serous. 15% slough and 85% granulated tissue. Stage 2 on her left heel improved. Size 1.4x1.5cm. No exudate. Dry. Continue with same treatment orders. No s/s (signs/symptoms) infection. Wound vac intact and draining properly. No s/s distress or discomfort. Will continue to monitor." A nurse's note dated 4/24/22 documented, "...wound vac that is attached & functioning properly to left ischium...." A nurse's note dated 4/29/22 documented, "....Wound vac intact and draining properly.... Further review of the clinical record revealed a physician's order dated 4/29/22 that documented, "Change wound Vac. 3 x weekly to under left ischial. Ensure proper seal and suctioning at all times. 125 mmhg negative pressure every day	F 658	4) DON/designee will audit resident with pressure injuries weekly x2 months to ensure professional standards of practice are being followed for obtaining and/or clarifying treatment orders for pressure injuries. Results will be provided to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 4/26/2023	

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F 658	Continued From page 24 shift every Mon, Wed, Fri." This order was set with a start date of 5/2/22. As evidenced in the nurses notes, the resident was receiving wound vac therapy from the time of readmission on 4/21/22 through the start date of 5/2/22, without a physician's order in place. On 5/9/22 the above order for the wound vac was discontinued and an order dated 5/9/22 documented, "Cleanse stage 4 on left ischium with cleanser, apply calcium with silver and cover with a border gauze dressing daily every day shift for Stage 4." This treatment was implemented starting on 5/10/22 and discontinued on 6/2/22. Wound care physician notes dated 5/12/22, 5/20/22, 5/27/22 documented, "...Dressing treatment plan: Negative pressure wound therapy apply three times per week..." This treatment conflicted with the treatment dated 5/9/22. The treatment dated 5/9/22 was implemented and documented as being done daily. The wound vac treatment was not being implemented. Facility staff failed to clarify with the wound care physician regarding which above treatment modality he wanted to utilize as both could not be done at the same time. On 3/29/23 at 10:23 AM, an interview was conducted with RN #1 (Registered Nurse). When asked if the use of a wound vac requires an order, she stated that it does because there are settings that have to be ordered and frequency of the dressing change for the wound vac have to be ordered. When asked what should be done if there were conflicting treatment orders, she	F 658		

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F 658	Continued From page 25 stated that the nurse should clarify which order the physician wants. According to Lippincott at LWW.Com (1), "...Confirm the medical order for the application of NPWT (negative pressure wound therapy). Check the patient's chart and question the patient about current treatments and medications that may make the application contraindicated. Assess the situation to determine the need for a dressing change. Confirm any medical orders relevant to wound care and any wound care included in the nursing plan of care..." On 3/29/23 at 11:33 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Clinical Consultant, and ASM #4 the Regional VP of Operations, were notified of the findings. No further information was provided. References: (1) Lippincott at LWW.com: https://downloads.lww.com/wolterskluwer_vitalstream_com/sample-content/9780781793841_lynn/samples/chapter08.pdf	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, it was determined the	F 677	F677 1) Resident #1 no longer resides in the center. Resident #9 is currently receiving ADL bathing assistance. 2) Current residents have the potential to be affected.	

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F 677	Continued From page 26 facility staff failed to provide showers/bathing per physician orders for two of 21 residents in the survey sample, Resident #1 and Resident #9. The findings include: 1. For Resident #1 (R1), the facility staff failed to provide showers/bathing during their stay at the facility. On the most recent MDS (minimum data set) assessment, an admission assessment with an assessment reference date (ARD) of 7/24/2022, the resident scored a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section G - Functional Status, for the activity of bathing, R1 was coded as the activity did not occur. On the discharge MDS assessment, with an ARD of 8/1/2022, in Section G - Functional Status, for the activity of bathing, R1 was coded as the activity did not occur. The physician order dated, 7/23/2022, documented, "Shower days every day shift, every Wed (Wednesday) and Sat (Saturday) for weekly." The July 2022 TAR (treatment administration record) documented the above order. It was documented on 7/27/2022 that a shower was given. Review of the POC (point of care) documentation for July 2022, where the CNAs (certified nursing assistants) document activity of daily living care, the above order was documented, with the shower days being Tuesday and Friday. Nothing	F 677	3) Certified nursing assistants will be re-educated on providing showers per schedule. 4) DON/designee will review shower documentation weekly x2 months for accuracy to ensure that residents are receiving showers per schedule. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 4/26/2023	

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F 677	Continued From page 27 was documented for the day shift for the month of July. The evening and night shifts documented, "N/A" which indicated not applicable. On 3/28/2023 at 2:37 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN stated she thought residents were provided showers twice a week. When asked if she verifies that showers are given when she signs them off on the treatment administration record, LPN #3 stated, "You are hoping and praying they have been done. Sometimes you have time to check and sometimes you don't." An interview was conducted with CNA #4 on 3/28/2023 at 3:30 p.m. CNA #4 stated residents get showers twice a week and it is documented in the computer program. On 3/28/2023 at 4:53 p.m. ASM (administrative staff member) #3, the regional clinical consultant, presented the POC documentation for July 2022 and stated this resident did not get any showers. ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, and ASM #4, the regional vice president of operations, were made aware of the above concern on 3/29/2023 at 11:37 a.m. A request was made for the facility policy on showers on 3/29/2023 at approximately 11:45 a.m. On 3/29/2023 at 2:55 p.m., ASM (administrative staff member) #1, the administrator, stated the facility does not have a policy for showers. No further information was provided prior to exit. 2. For Resident #9 (R9), the facility staff failed to	F 677		

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F 677	Continued From page 28 provide the resident with a shower between 3/8/23 and 3/15/23. A review of R9's clinical record revealed a physician's order dated 7/29/22 for showers every Wednesday and Saturday. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/12/23, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section G coded R9 as requiring physical help in part of bathing activity. On 3/27/23 at 11:03 a.m., an interview was conducted with R9. The resident voiced concern about not getting showers. Further review of R9's clinical record (including the activities of daily living documentation, nurses' notes, shower sheets and the treatment administration record) failed to reveal R9 received a shower between 3/8/23 and 3/15/23. On 3/28/23 at 3:44 p.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated residents should be provided showers twice a week and this should be documented in the computer (electronic clinical record) and on shower sheets. On 3/29/23 at 1:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 677		
F 684 SS=E	Quality of Care	F 684	F684 1) Resident #11 no longer resides in the center.	

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F 684	Continued From page 29 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 resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to administer medications in a timely manner for one of 21 residents in the survey sample, Resident #11. The findings include: For Resident #11 (R11), the facility staff failed to administer Clonidine (1) and Doxazosin as scheduled multiple times in March 2023. R11 was admitted to the facility with a diagnosis of high blood pressure. On 3/27/23 at 10:40 a.m., R11 was interviewed. The resident stated they had not been receiving medications to treat high blood pressure at the correct times, and had received these medications after midnight at least one time. A review of R11's physician orders revealed: "Clonidine HCl Oral Tablet 0.1 MG (milligram) (Clonidine HCl) Give 1 tablet by mouth two times a day for Hypertension." This order was written 3/10/23 at 6:07 a.m., and scheduled to be	F 684	2) Medication administration observation audits completed to ensure medications administered timely per physician order. 3) Licensed nursing staff will be re-educated on medication administration. 4) DON/designee will complete random medication observations weekly x2 months to ensure medications are administered timely. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 4/26/2023	

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F 684	Continued From page 30 administered at 9:00 a.m. and 9:00 p.m. daily. "Doxazosin Mesylate Oral Tablet 2 MG (Doxazosin Mesylate) Give 1 tablet by mouth every 12 hours for HTN (hypertension)." This order was written 3/7/23 at 5:23 p.m., and scheduled to be administered at 9:00 a.m. and 9:00 p.m. daily. A review of R11's March 2023 MAR (medication administration record) revealed the following medications (due times in parentheses) were administered at the following times: 3/7/23 Doxazosin (9:00 p.m.) at 10:39 p.m. 3/7/23 Clonidine (9:00 p.m.) at 11:04 p.m. 3/10/23 Clonidine and Doxazosin (9:00 p.m.) at 11:14 p.m. 3/11/23 Clonidine and Doxazosin (9:00 a.m.) at 12:15 p.m. 3/14/23 Clonidine and Doxazosin (9:00 a.m.) at 11:10 a.m. 3/15/23 Clonidine and Doxazosin (9:00 a.m.) at 11:13 a.m. 3/16/23 Clonidine and Doxazosin (9:00 p.m.) 12:43 a.m. on 3/17/23 3/24/23 Clonidine and Doxazosin (9:00 a.m.) at 11:51 a.m. 3/27/23 Clonidine and Doxazosin (9:00 a.m.) at 11:46 a.m. On 3/28/23 at 4:20 p.m., LPN (licensed practical nurse) #8 was interviewed. When asked if there was a time frame for administering medications, she stated: "We should give medications within either an hour before or an hour after it is scheduled to be given." She stated sometimes she forgets to "click on" the medication at the time she administers it. When asked if she can	F 684		

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F 684	Continued From page 31 remember exactly which times and for which medications this has happened, she stated she could not. On 3/28/23 at 5:34 p.m., LPN #9 was interviewed. When asked if there was a time frame for administering medications, she stated she tries to give the medications exactly when they are due. She stated this is not always possible, so she tries to administer the medications within either 30 minutes before or after the medication is scheduled. She stated she had been trained that it is acceptable to give a medication either an hour before or after it is scheduled to be given. She stated she floats to R11's unit sometimes, and is unfamiliar with those residents. She stated there are more residents on R11's unit than the other facility unit, and she gets behind in her medication administration sometimes. On 3/29/23 at 1:35 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional clinical consultant, and ASM #4, the regional vice president of operations, were informed of these concerns. A review of the facility policy, "Medication Administration General Guidelines," revealed, in part: "Medications are administered within 60 minutes of scheduled time, except before or after meal orders...Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the nursing care center." No further information was provided prior to exit.	F 684		

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F 684	Continued From page 32 References: (1) "Clonidine tablets (Catapres) are used alone or in combination with other medications to treat high blood pressure. Clonidine extended-release (long-acting) tablets (Kapvay) are used alone or in combination with other medications as part of a treatment program to control symptoms of attention deficit hyperactivity disorder (ADHD; more difficulty focusing, controlling actions, and remaining still or quiet than other people who are the same age) in children. Clonidine is in a class of medications called centrally acting alpha-agonist hypotensive agents. Clonidine treats high blood pressure by decreasing your heart rate and relaxing the blood vessels so that blood can flow more easily through the body. Clonidine extended-release tablets may treat ADHD by affecting the part of the brain that controls attention and impulsivity." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682243.html. (2) "Doxazosin is used in men to treat the symptoms of an enlarged prostate (benign prostatic hyperplasia or BPH), which include difficulty urinating (hesitation, dribbling, weak stream, and incomplete bladder emptying), painful urination, and urinary frequency and urgency. It is also used alone or in combination with other medications to treat high blood pressure. Doxazosin is in a class of medications called alpha-blockers." This information is taken from the website https://medlineplus.gov/druginfo/meds/a693045.html#:~:text=Doxazosin%20is%20used%20in%20men,and%20urinary%20frequency%20and%20urgency.	F 684		

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F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide care and services to prevent and/or treat pressure injuries for two of 21 residents in the survey sample, Residents #3 and #13, resulting in harm for Resident #3. The findings include: 1. For Resident #3, the facility staff failed to prevent an avoidable pressure injury from developing and being found at an advanced stage. The facility staff also failed to transcribe and implement the wound physician's treatment order dated 12/15/22. Resident #3 subsequently went to the hospital for surgical debridement (1) and had findings consistent of osteomyelitis (2). A "Braden Scale for Predicting Pressure Sore Risk" document dated 11/22/22 scored the	F 686	F686 1) Resident #3 no longer resides in the facility. Resident #13 seen by wound care physician on 3/30/2023. All current treatment orders are in place 2) Current residents skin assessed to determine if any pressure injury found have been provided care and services to be prevented and treated. An audit was completed on Vohra wound care documentation to ensure facility is providing care and services to prevent and treat pressure injuries. Center will follow wound care program to include but not be limited to assessing risk for breakdown, weekly skin checks, weekly wound meeting, and evaluation for unavoidable criteria. 3) DON/designee will provide re-education to licensed nurses and certified nursing assistants on providing care and services to prevent and treat pressure injuries.	

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F 686	Continued From page 34 resident as a "17 - Low Risk" for developing pressure injuries. A weekly skin assessment dated 12/6/22 revealed no findings, documenting, "Skin clear, no change of condition assessed." A Change of Condition note dated 12/12/22 at 9:41 PM documented, "Situation: 5 cm (centimeters) circular pressure wound, Black in color noted by CNA (certified nursing assistant.)....Response: Foam dressing applied. Resident positioned on side to relieve pressure." An Initial Pressure Injury report dated 12/12/22 at 12:13 PM documented, ".... Site: Left buttock. Type: Pressure. Length: 5 cm (centimeters)...Stage III ...Is there drainage? No. Is there tunneling or undermining present? No. Describe Current Treatment Plan: Clean with wound cleanser and apply foam boarder dressing QD (everyday)..." A review of the physician's orders revealed one dated 12/12/22 for "Cleanse coccyx wound with wound cleanser, pat dry, apply foam dressing QD (everyday), and PRN (as needed) every evening shift for Pressure wound." There was no documentation between the 12/6/22 skin assessment and the 12/12/22 identification of the wound, to indicate that any skin breakdown was identified and treated before becoming an advanced stage wound, or that preventative measures were in place. A review of the wound care physician's progress notes revealed that the wound care physician first evaluated the resident's wound on 12/15/22 and	F 686	4) Weekly x 2 months DON/designee will audit wound care physician notes to ensure care and services provided to prevent and treat pressure injuries. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately and re-education as needed. 5) Compliance Date: 4/26/2023	

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F 686	Continued From page 35 documented, "...Unstageable necrosis....6 x 4 x not measurable...Thick adherent devitalized necrotic tissue - 100%.... Dressing treatment plan: Santyl apply once daily for 30 days; Gauze island w/ bdr (with border) apply once daily for 30 days..." Further review of the clinical record revealed that this treatment plan order was not transcribed and implemented. A review of the December 2022 TAR (Treatment Administration Record) revealed that the initial treatment (foam dressing) that was started on 12/12/22 was administered each day through 12/23/22, except for 12/17/22, however, the new treatment should have been ordered and implemented, per the above wound care physician's note dated 12/15/22. Further review of the clinical record revealed a second wound physician progress note dated 12/23/22, one week after the above note of 12/15/22. This note documented, "...Stage 4 (3)...5 x 6.5 x 0.1...Thick adherent devitalized necrotic tissue - 100%....Wound progress: Improved...Dressing treatment plan: Santyl apply once daily for 22 days; Gauze island w/ bdr (with border) apply once daily for 22 days....Additional Note: Post-debridement assessment of this previously unstageable necrotic wound has revealed the underlying deep tissue at the muscle/fascia level, which had been obscured by necrosis (4) prior to this point. This wound has now revealed itself to be a Stage 4 pressure injury. This is not a wound deterioration." A nurse practitioner note dated 12/23/22 documented, "...Stage 4 sacral wound, acute,	F 686		

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F 686	Continued From page 36 possibly infected...New recommendations given for management but family wants pt (patient) to go to the ER (emergency room.)..." A review of the hospital record, dated 12/26/22 documented, "...Date of Operation: 12/24/22...Operative Procedure: INCISIONAL DEBRIDEMENT & IRRIGATION OF SACRAL WOUND, INCLUDING SKIN, SUB Q FAT, AND BONE - Wound Class: Dirty or Infected...Findings: Extensive necrotic tissue involving skin subcutaneous fat muscle and bone, stage 4 sacral decub, purulent drainage..." As part of the hospital record, a 12/25/22 radiology exam documented, "...Large posterior decubitus ulcer with components extending into the gluteus maximus muscle bilaterally with greatest involvement on the left. Marrow changes in the S4, S5, and proximal coccyx, adjacent to the ulceration, suggesting osteomyelitis. Abscess collection along the inferior medial aspect of the left gluteus maximus measuring 3 cm in greatest dimension...." Also, as part of the hospital record was an MRI exam dated 12/25/22 that documented, "...There is a large decubitus ulcer in the midline measuring 10.2 cm in width by 2.6 cm in depth by 7.8 cm in craniocaudad dimension.... findings consistent with osteomyelitis..." A review of the comprehensive care plan revealed one dated 11/17/22 and most recently revised on 12/22/22, documented, "at risk for skin breakdown r/t Assistance required in bed mobility current tx for unstag ulcer." Interventions that were in place prior to the wound, all dated 11/17/22, included: Complete Braden Scale.	F 686		

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F 686	Continued From page 37 Conduct weekly skin inspection. Moisturize skin with lotion as needed. Turning and repositioning schedule per assessment. Interventions added after the wound developed included: For residents who are ambulatory, encourage activity as tolerated (added 12/15/22). Provide pressure reduction/relieving mattress (added 12/15/22). Treatments as ordered (added 12/15/22). Weekly Wound assessment (added 12/15/22). On 3/28/23 at 11:37 AM, an interview was conducted with ASM #3 (Administrative Staff Member) the Regional Clinical Consultant, who provided information regarding the resident's pressure injury. When asked if it was a concern that the wound was not identified until an advanced stage, she stated that it was, and should have been identified before reaching an advanced stage. When asked if there was a concern that the Santyl treatment ordered by the wound care physician on 12/15/22 was not transcribed and implemented, she stated that it was. On 3/29/23 at 10:23 AM, an interview was conducted with RN #1 (Registered Nurse). When asked what it means if a wound treatment is not signed off as being done, she stated that if it isn't charted it isn't done. When asked if the wound physician writes a treatment plan on his wound evaluation notes, what is to be done with that, she stated that it should be transcribed as an order and implemented. When asked what systems are in place to prevent pressure injuries, she stated that residents who are not able to turn themselves should be turned every two hours and that during incontinent care, staff should apply barrier cream to the resident. RN #1 stated the main thing is to keep residents off the pressure	F 686		

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F 686	Continued From page 38 points and to keep them clean and dry; and that skin assessments are done weekly and that this assessment is a head to toe assessment. When asked about identifying wounds at the earliest possible time, before it becomes an advanced stage, RN #1 stated that the aides are trained to identify if something is new or different with a resident's skin and should be identifying these changes during bathing and incontinent care. The aides cannot identify what a wound is or the stage, but can identify if something wasn't there before, but is now, that the nurse should be notified, or if something looks different than it did before, they should notify the nurse, and the aides should be looking for this every time they provide care to a resident. She stated that if residents are being turned and repositioned, provided bathing and frequent incontinent care, that wounds could and should be identified early and treatment initiated before a wound becomes an advanced stage. It would be rare for a wound to not be identified at an early stage if the skin is being monitored as it should be. On 3/29/23 at 11:33 AM, ASM #1 the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Clinical Consultant, and ASM #4 the Regional VP of Operations, were notified of the findings and the concern for harm. ASM #3 stated that the facility had no further information regarding this pressure injury. References: (1) Debridement: This is a type of debridement where devitalized tissue (slough, necrotic, or eschar) in the presence of underlying infection is removed using sharp instruments such as a scalpel, Metzenbaum, and curettes, among	F 686		

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F 686	Continued From page 39 others. This can be done bedside, in the office or wound care center, or the operating room, depending on the adequacy of anesthesia and the ability to control perioperative complications like bleeding. https://www.ncbi.nlm.nih.gov/books/NBK507882/ (2) Osteomyelitis: Osteomyelitis is an infection in a bone. Infections can reach a bone by traveling through the bloodstream or spreading from nearby tissue. Infections can also begin in the bone itself if an injury exposes the bone to germs. https://www.mayoclinic.org/diseases-conditions/osteomyelitis/symptoms-causes/syc-20375913 (3) Stage 4: full thickness ulcer with the involvement of the muscle or bone. https://www.ncbi.nlm.nih.gov/books/NBK532897/#:~:text=Stage%201%3A%20just%20erythema%20of,of%20the%20muscle%20or%20bone (4) Necrosis: Necrosis is the medical term for the death of your body tissue. When the cells in your tissues die, it can affect many different areas of your body, including your bones, skin and organs. Necrosis can occur because of illness, infection, injury, disease or lack of blood flow to your tissues. https://my.clevelandclinic.org/health/diseases/23959-necrosis#:~:text=Necrosis%20is%20the%20medical%20term,Questions%20216.444.2538 2. For Resident #13, the facility staff failed to provide care and services to treat pressure injuries. A review of the clinical record revealed that Resident #13 had a history of pressure injuries. A left ischial stage 3 pressure injury which was	F 686		

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F 686	Continued From page 40 being treated with negative pressure wound therapy (wound vac) upon admission on 4/13/22, an unavoidable stage 4 sacral wound that developed on or about 5/20/22, an unavoidable right lower back stage 3 wound that develop on or about 8/25/22 (at which time the left ischial wound was determined to be resolved), and an unavoidable re-emergence of the left ischial wound on or about 1/12/23. First left ischial wound: A review of the nurse's notes, physicians' orders and TAR revealed the following: A review of the clinical record revealed that the resident was admitted on 4/13/22 with a wound vac to a pressure injury. A physician's order dated 4/13/22 documented "Change wound Vac. 3 x weekly to under left ischial. Ensure proper seal and suctioning at all times. 125 mmhg (millimeters of mercury) negative pressure every day shift every Mon, Wed, Fri (Monday, Wednesday, Friday) for Wound." The resident was readmitted to the hospital on 4/14/22 and this order was subsequently discontinued on 4/19/22. Further review of the clinical record revealed that the resident was readmitted on 4/21/22. A nurse's note dated 4/22/22 documented, "Wound [name of wound care physician] into see this resident for the 2 pressure wounds. Left ischium improved. Size: 2.3x2.5x3.6cm (centimeters). Moderate serous. 15% slough and 85% granulated tissue.... Wound vac intact and draining properly. No s/s distress or discomfort. Will continue to monitor."	F 686		

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F 686	Continued From page 41 A nurse's note dated 4/24/22 documented, "...wound vac that is attached & functioning properly to left ischium...." A nurse's note dated 4/29/22 documented, "... Wound vac intact and draining properly...." Further review of the clinical record revealed a physician's order dated 4/29/22 that documented, "Change wound Vac. 3 x weekly to under left ischial. Ensure proper seal and suctioning at all times. 125 mmhg negative pressure every day shift every Mon, Wed, Fri." This order was set with a start date of 5/2/22. This order was discontinued on 5/9/22. A review of the physician's orders failed to reveal any evidence that an order was in place for this treatment from the time of readmission on 4/21/22 through 4/29/22 when the above order was written. A review of the treatment administration record (TAR) for April and May 2022 revealed that the wound vac was not included as an order to be followed upon the resident's readmission on 4/21/22 through 4/29/22. Based on the notes that documented the presence of the wound vac from the time of readmission on 4/21/22, the resident was receiving wound vac therapy at times, but without an order, and therefore, the use of the wound vac therapy was not evidenced on the treatment administration record from the readmission on 4/21/22 through 4/29/22. Therefore, there was no evidence other than the sporadic nurses' note, that the treatment was provided daily, and that the required settings of 125 mmhg was	F 686		

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F 686	Continued From page 42 implemented, and that the three times a week associated dressing change for wound vac dressings was completed. Therefore, the facility could not evidence that the wound vac therapy, if provided, was provided in accordance with standards of wound vac therapy to include machine settings and dressing changes. Sacral stage 4 wound: A review of the physician's orders and TAR revealed the following: On 5/20/22, the wound physician ordered calcium alginate, dressing, daily, to the sacral wound. This order was discontinued on 10/17/22. A review of the TAR from May 2022 through October 2022 revealed this treatment was not provided on 8/1/22, 8/9/22, 9/24/22, 10/1/22, 10/5/22, and 10/10/22. On 8/25/22, an order was written for calcium alginate and Santyl, daily. This order was discontinued on 11/10/22. A review of the TAR from August 2022 through November 2022 revealed this treatment was not provided on 9/24/22, 10/1/22, 10/5/22, 10/10/22, 10/20/22, 10/22/22, 10/23/22, 11/5/22, and 11/6/22. On 11/10/22, an order was written for collagen sheet with silver alginate cream, daily. This order was discontinued on 3/17/23. A review of the TAR from November 2022 through March 2023 revealed this treatment was not provided on 11/30/22, 12/3/22, 12/12/22, 12/25/22, 1/9/23, 1/17/23, 1/31/23, 2/9/23, and 2/11/23. On 3/17/23 an order was written for collagen sheet and cover with gauze island with border,	F 686		

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F 686	Continued From page 43 daily. A review of the March 2023 TAR revealed this treatment was not provided on 3/19/23, 3/20/23, and 3/26/23. Lower right back wound: A review of the physician's orders and TAR revealed the following: On 8/25/22, an order was written for calcium and alginate. This order was discontinued on 11/10/22. A review of the TAR from August 2022 through November 2022 revealed this treatment was not provided on 9/24/22, 10/5/22, 10/10/22, 10/22/22, 10/23/22, 11/5/22, and 11/6/22. On 11/22/22 an order was written for collagen with silver sheet, daily. This order was discontinued on 3/17/23. A review of the TAR from November 2022 through March 2023 revealed this treatment was not provided on 11/30/22, 12/3/22, 12/12/22, 1/9/23, 1/17/23, 1/31/23, 2/9/23, and 2/11/23. On 3/17/23 an order was written for collagen with silver sheet and cover with boarder gauze, daily. A review of the TAR for March 2023 revealed this treatment was not provided on 3/19/23, 3/20/23, and 3/26/23. Re-emerged left ischial wound: On 1/12/23 an order was written by the wound physician on the wound evaluation notes for alginate calcium with silver, to be done daily. This order was not transcribed and not implemented. The wound physician documented on 1/19/23 on the weekly wound evaluation note to discontinue this order.	F 686		

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F 686	Continued From page 44 On 1/19/23 an order was written for alginate calcium and Santyl, daily. This order was discontinued on 3/17/23. A review of the TAR for January 2023 through March 2023 revealed this treatment was not done on 1/31/23, 2/9/23, and 2/11/23. On 3/17/23 an order was written for alginate calcium and island gauze with border. A review of the TAR for March 2023 revealed this treatment was not provided on 3/19/23, 3/20/23, and 3/26/23. On 3/29/23 at 10:23 AM, an interview was conducted with RN #1 (Registered Nurse). When asked what it means if a wound treatment is not signed off as being done, she stated that if it isn't charted it isn't done. On 3/29/23 at 11:33 AM, ASM #1 the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Clinical Consultant, and ASM #4 the Regional VP of Operations, were notified of the findings. No further information was provided.	F 686		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain 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.	F 755	F 755 1) Resident #7 narcotics are being reconciled appropriately and Resident #18 Ferrex 150 capsule was discontinued 3/28/2023 and a new order was received for Ferrous Sulfate 325 mg. Resident #18 Systane Ophthalmic Gel was discontinued on 3/28/2023 and a new order received for Refresh Ophthalmic Solution.	

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F 755	Continued From page 45 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide pharmacy services for two of 21 residents in the survey sample, Residents #7 and #18. The findings include: 1. For Resident #7, the facility staff failed to accurately reconcile a controlled substance. The facility staff failed to document the disposal of two tramadol pills (medication used to treat pain) and failed to visualize each pill during the reconciliation count, to ensure the number of pills documented matched the amount of pills present.	F 755	2) Change of shift observations completed to ensure licensed nurses are accurately reconciling narcotic counts. Current residents on Ferrex 150 capsule and Systane Ophthalmic Gel audited to ensure the medication is available. 3) Licensed staff re-educated on appropriate process of reconciling narcotics at change of shift and medication availability. 4) DON/designee will complete random narcotic reconciliation observation audits weekly x2 months. Ferrex 150 capusle and Systance Ophthalmic Gel will be audited weekly x2 months to ensure medication availability. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 4/26/2022.	

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F 755	Continued From page 46 A facility synopsis of events dated 3/5/23 documented, "On 3/5/2023, controlled drug count did not match on evening change of shift when two Nurses noted two tramadol hcl 50 mgs (milligrams) missing from card. Investigation commenced.... The following morning, (Name of LPN [licensed practical nurse] #7), LPN Charge Nurse called DON (Director of Nursing) to inform her that on 3/4/23, her and (name of LPN #3), LPN Charge Nurse wasted the two tramadol pills in the sharps container as they thought the count was over. Due to two nurse verification of wasted tramadol, controlled substance is accounted for. Nurses' statements congruent and validate disposal of the medication..." On 3/28/23 at 2:37 p.m., an interview was conducted with LPN #3 who was the nurse who worked the evening shift on 3/4/23. LPN #3 stated, "The first week I was here, I was leaving from the evening shift, and she [LPN #7] was coming on for the night shift. I counted with her. She pulled the card. I didn't look at the card. I told her a total [based on the controlled substance reconciliation sheet] and she said it wasn't right and pulled two [tramadol tablets] and put in the [sharps] box. Two were wasted to make the count right but it turned out the count was right." On 3/28/23 at 4:07 p.m., a telephone interview was conducted with LPN #5 who was the nurse who worked the day shift on 3/5/23. LPN #5 stated that when she arrived at the facility during the morning of 3/5/23, she and LPN #7 (the night shift nurse) completed the controlled substance count (reconciliation) for R7's tramadol. LPN #5 stated that LPN #7 reviewed the controlled	F 755		

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F 755	Continued From page 47 substance count sheet, and she [LPN #5] counted the medication cards that contained the pills. LPN #5 stated that while completing the count, R7's tramadol was in three different packs that were banded together with a rubber band. LPN #5 stated that she did not remove the rubber band and fully visualize each pill in each pack, but she should have done so. LPN #5 stated that she realized the tramadol count was incorrect (the number of pills documented on the count sheet did not match the number of actual pills in the packs) when she completed the controlled substance count with the evening shift nurse on 3/5/23. LPN #5 stated that at this time, the Director of Nursing was notified and began an investigation. On 3/29/23 at 8:09 a.m., a telephone interview was conducted with LPN #7 (the nurse who worked the night shift on 3/4/23 into 3/5/23). LPN #7 stated that on 3/4/23, she and LPN #3 (the evening shift nurse) completed the controlled substance count while she (LPN #7) was upset for personal reasons. LPN #7 stated the pills were packaged into three packs containing space for 30 pills and when she looked at each pack, she thought each pack contained 30 pills. LPN #7 stated she thought the count was over, meaning she thought the count sheet documented 88 pills while there were 90 pills present. LPN #7 stated she wasted two pills to correct the count. LPN #7 stated that she did not document the two wasted pills on the controlled substance count sheet. LPN #7 stated that the next morning, she realized what she had done and called the Director of Nursing. LPN #7 stated the pharmacy only dispensed 28 pills into the last pack instead of 30. Therefore, the count was accurate when she wasted the two pills.	F 755		

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F 755	Continued From page 48 On 3/29/23 at 8:57 a.m., an interview was conducted with ASM (administrative staff member) #2 (the Director of Nursing). ASM #2 stated that on the date a nurse realized R6's tramadol count was incorrect (3/5/23), she received a call from one of the nurses and went to the facility and began an investigation. ASM #2 stated LPN #7 later called her and said she had wasted two of R6's tramadol pills with another nurse because she thought the count was over (more pills documented on the count sheet than actual pills present) but there was nothing on paper to document this. ASM #2 stated she verified this with the other nurse. In regard to how a controlled substance reconciliation should be done, ASM #2 stated a reconciliation should be done at the beginning of each shift between the off going and oncoming nurses. ASM #2 stated both nurses should simultaneously look at the number of pills documented on the count sheet and verify the amount by observing each pill. ASM #2 stated that if the count is incorrect then the nurses should look for the discrepancy and immediately call her. ASM #2 stated that if nurses dispose of any controlled substances, then this should be documented. On 3/29/23 at 1:45 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. The facility policy titled, "Controlled Drug Medication Disposal" documented, "C. The disposal is documented on the Controlled Drug Declining Inventory Sheet on the line representing that dose and signed by the two nurses witnessing the destruction of the above	F 755		

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F 755	Continued From page 49 medication." The facility policy titled, "Controlled Drug Count" documented, "4. The 2 nurses will count the number of individual controlled drugs: A. Look at each medication and verify that the number of individual controlled drugs matches the number on the declining inventory sheet. B. If the number does not match, STOP: i. DO NOT SIGN THE CONTROLLED DRUG COUNT SHEET. ii. NO ONE IS TO LEAVE THE UNIT. iii. DETERMINE WHY THERE IS A DISCREPENCY. iv. CALL THE DIRECTOR OF NURSING..." 2. For Resident #18 (R18), the facility staff failed to administer Ferrex 150 mg (milligram) (1) and Systane ophthalmic gel (2) as ordered on multiple dates in January 2023, February 2023 and March 2023. These medications were documented as not administered and being on order from the pharmacy. On 3/28/2023 at 8:07 a.m., LPN (licensed practical nurse) #1 was observed preparing morning medications for R18. After preparing the available medications in a medication cup, LPN #1 stated that R18 was scheduled to received Ferrex 150 and Systane ophthalmic gel at that time, however they did not have the medications on the cart and they had been ordered "stat" (urgently) from the pharmacy. The physician orders for R18 documented in part, - "Ferrex 150 Capsule (Polysaccharide Iron Complex) Give 1 capsule by mouth one time a day related to Iron Deficiency Anemia, Unspecified. Order Date: 10/13/2022. Start Date: 10/14/2022." - "Systane Ophthalmic Gel 0.4-0.3 % (Polyethylene Glycol-Propylene Glycol (Ophth)) Instill 1 drop in both eyes two times a day for dry eyes. Order Date: 01/23/2023. Start Date:	F 755		

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F 755	Continued From page 50 01/23/2023." A review of R18's January 2023 MAR (medication administration record) failed to reveal evidence that Ferrex 150 was administered on 1/3/2023, 1/6/2023, 1/10/2023, 1/11/2023, 1/12/2023, 1/13/2023, 1/15/2023, 1/19/2023, 1/22/2023, 1/23/2023, 1/24/2023, 1/27/2023 and 1/31/2023. The MAR documented a "7" in the administration area for each of the dates listed. The MAR chart codes documented "7" meaning "7=Other/See Nurses notes." A review of R18's February 2023 MAR failed to reveal evidence that Ferrex 150 was administered on 2/5/2023, 2/7/2023, 2/9/2023, 2/10/2023, 2/13/2023, 2/14/2023, 2/15/2023, 2/16/2023, 2/18/2023, 2/19/2023, 2/21/2023, 2/22/2023, 2/24/2023 and 2/28/2023. The MAR further failed to evidence that Systane ophthalmic gel was administered on 2/2/2023 at 9:00 a.m., 2/4/2023 at 9:00 p.m., 2/5/2023 at 9:00 a.m. and 9:00 p.m., 2/9/2023 at 9:00 a.m., 2/10/2023 at 9:00 a.m., 2/12/2023 at 9:00 p.m., 2/13/2023 at 9:00 a.m., 2/14/2023 at 9:00 a.m., 2/15/2023 at 9:00 a.m., 2/16/2023 at 9:00 a.m., 2/18/2023 at 9:00 a.m., 2/19/2023 at 9:00 a.m., 2/21/2023 at 9:00 a.m., 2/22/2023 at 9:00 a.m., 2/23/2023 at 9:00 a.m., 2/24/2023 at 9:00 a.m. and 9:00 p.m., and 2/28/2023 at 9:00 a.m. The MAR documented a "7" in the administration area for each of the dates listed. The MAR chart codes documented "7" meaning "7=Other/See Nurses notes." A review of R18's March 2023 MAR failed to reveal evidence that Ferrex 150 was administered on 3/2/2023, 3/4/2023, 3/6/2023, 3/7/2023, 3/8/2023, 3/9/2023, 3/10/2023,	F 755		

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F 755	Continued From page 51 3/13/2023, 3/14/2023, 3/16/2023, 3/18/2023, 3/19/2023, 3/24/2023, 3/27/2023 and 3/28/2023. The MAR further failed to evidence that Systane ophthalmic gel was administered on 3/1/2023 at 9:00 a.m., 3/2/2023 at 9:00 a.m. and 9:00 p.m., 3/3/2023 at 9:00 a.m., 3/4/2023 at 9:00 a.m. and 9:00 p.m., 3/5/2023 at 9:00 a.m. and 9:00 p.m., 3/7/2023 at 9:00 a.m. and 9:00 p.m., 3/8/2023 at 9:00 a.m., 3/9/2023 at 9:00 a.m., 3/10/2023 at 9:00 a.m. and 9:00 p.m., 3/15/2023 at 9:00 a.m., 3/16/2023 at 9:00 a.m., 3/18/2023 at 9:00 a.m., 3/19/2023 at 9:00 a.m. and 9:00 p.m., 3/21/2023 at 9:00 a.m., 3/23/2023 at 9:00 a.m., 3/24/2023 at 9:00 p.m., 3/25/2023 at 9:00 p.m., and 3/28/2023 at 9:00 a.m. The MAR documented a "7" in the administration area for each of the dates listed. The MAR chart codes documented "7" meaning "7=Other/See Nurses notes." Review of the nurses notes for R18 included Medication Administration notes for the dates listed above which documented the Ferrex 150 and the Systane ophthalmic gel as being on order from the pharmacy. On 3/28/2023 at 1:45 p.m., an interview was conducted with LPN #1. LPN #1 stated that they had been calling the pharmacy every other day to request the Systane ophthalmic gel and Ferrex 150 for R18. LPN #1 stated that the pharmacy always told them that they would send the medication but it never came. LPN #1 stated that they had the medication for awhile but it had run out and had never come in. LPN #1 stated that normally the pharmacy was good about getting the medications to them the same day or the next day and they did not have to wait so long. LPN #1 stated that they had not spoken to the physician or the nurse practitioner about the	F 755		

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F 755	Continued From page 52 medication not being sent from the pharmacy. On 3/28/2023 at 2:06 p.m., an interview was conducted with OSM (other staff member) #3, pharmacist. OSM #3 stated that the Systane ophthalmic gel and Ferrex 150 ordered for R18 were not filled by the pharmacy. OSM #3 stated that they had not received any phone calls from the facility to fill the prescriptions and the facility staff had entered the order as a profile only order which meant that it would only show on the residents profile and would be filled as stock medication from the facility. OSM #3 stated that the facility normally did this for medications that they purchased from medical supply vendors in bulk and kept as house stock rather than filled for each resident. OSM #3 stated that the person who entered the electronic order completed the section to make the medication a profile only medication or one that they filled. OSM #3 stated that they would be able to fill these prescriptions for R18 if the facility requested them but had not done this. On 3/28/2023 at 2:47 p.m., a request was made to ASM (administrative staff member) #4, the regional vice president of operations for a list of the facility stock medications available. The facility policy "Medication Administration" dated 12/12 documented in part, "...If two consecutive doses of a vital medication are withheld or refused, the physician is notified..." The policy failed to provide information regarding medications not provided from pharmacy. On 3/28/2023 at 3:45 p.m., ASM #1, the administrator, ASM #3, the regional clinical consultant and ASM #4, the regional vice	F 755		

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F 755	Continued From page 53 president of operations were made aware of the above concern. On 3/28/2023 at approximately 4:45 p.m., ASM #1 stated that they were waiting for the pharmacy to send them a list of the facility stock medications. ASM #3 confirmed that Ferrex and Systane ophthalmic gel were not facility stock medications and were filled by the pharmacy. No further information was provided prior to exit. References: (1) Ferrex It is used to treat or prevent low iron in the body. This information was obtained from the website: https://www.drugs.com/cdi/ferrex-150-forte.html (2) Systane ophthalmic gel Systane is used in adults to relieve burning, irritation, and discomfort caused by dry eyes. This information was obtained from the website: https://www.drugs.com/mtm/systane.html	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		

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F 757	Continued From page 54 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure a resident was free from an unnecessary medication for one of 21 residents in the survey sample, Resident #6. The findings include: For Resident #6 (R6), the facility staff failed to ensure the correct type of insulin was administered to the resident on 3/2/23. A review of R6's clinical record revealed a physician's order dated 2/8/23 for insulin glargine (Lantus) (used to treat diabetes) 40 units two times a day (scheduled at 9:00 a.m. and 9:00 p.m.) and a physician's order dated 2/8/23 for insulin lispro (used to treat diabetes, the amount to be given based on the resident's blood sugar and not to exceed 12 units, before meals and at breakfast. A facility synopsis of events dated 3/8/23 documented that on 3/2/23 at 9:00 a.m., a nurse mistakenly administered the incorrect insulin to R6 (40 units of Lispro instead of the physician	F 757	Past noncompliance: no plan of correction required.	

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F 757	Continued From page 55 ordered 40 units of Lantus). Per the synopsis, the director of nursing attempted to notify the nurse practitioner but R6 called 911 to transfer to the hospital and would not allow staff to provide further care. R6 returned to the facility on the same date without any new orders. A physician's note dated 3/3/23 documented, "Patient was sent to the ER (emergency room) yesterday 3/2/23 after resident was given Lispro 40 units SC (subcutaneously). (The resident) was monitored for hypoglycemia (low blood sugar). Accuchecks were @ 144-190. (The resident) was sent back to the facility. Upon return to the facility, resident continues to be clinically stable with accuchecks of 167 and 254 mg/dl (milligrams/deciliter)..." The nurse who mistakenly administered the incorrect insulin to R6 was no longer employed at the facility and was not available for interview. On 3/28/23 at 2:37 p.m., an interview was conducted with LPN (licensed practical nurse) #3, in regard to ensuring the correct medication is administered to a resident. LPN #3 stated, "You compare it to the MAR (medication administration record). Look at the MAR, look at what you got, make sure it matches." On 3/29/23 at 1:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Medication Administration" documented, "3. Prior to administration, review and confirm medication orders for each individual resident on the	F 757		

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F 757	Continued From page 56 Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR (medication administration record) with the medication label." A facility plan of correction with an allegation of compliance date of 3/3/23 documented, "Nurse administered wrong insulin... 1. Resident audit of insulin, psychosocial follow-up. 2. MAR to CART audit of insulin/nurse med pass audits. 3. Education to nurses. 4. Med observations/insulin sheet observation/mar to cart audit weekly x 4. 5. QAPI (Quality Assurance Performance Improvement)." All credible evidence for the plan of correction was verified on 3/29/23. Past non-compliance.	F 757		
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---	F 758	F 758 1) The medication for Resident #11, Lorazepam tablet 0.5 MG was discontinued on 3/29/2023 2) Current residents on PRN psychoactive medication will be audited to ensure they are free from unnecessary psychotropic medications. 3) DON/designee will re-educate licensed nurses on unnecessary psychotropic medications.	

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F 758	Continued From page 57 §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 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 staff interview, facility document review, and clinical record review, the facility staff failed to administer medications in a manner to prevent unnecessary psychoactive medications for one of 21 residents in the survey sample,	F 758	4) DON/designee will audit PRN psychotropic medications weekly x 2 months to ensure residents are free from unnecessary psychotropic medications. Audits will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 4/26/2023	

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F 758	Continued From page 58 Resident #11. The findings include: For Resident #11 (R11), the facility staff failed to document the reason to continue the prn (as needed) use of Lorazepam (1) beyond 14 days, and failed to monitor for side effects of Lorazepam. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/17/23, R11 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). The resident was coded as having difficulty sleeping two to six days during the look back period. R11 was coded as having received an anti-anxiety medication one day during the look back period. A review of R11's physician orders revealed the following: "Lorazepam Oral Tablet 0.5 MG (milligrams) (Lorazepam) Give 0.25 mg by mouth every 12 hours as needed for anxiety." This order was written 3/7/23 and discontinued 3/25/23. A review of R11's March 2023 MAR (medication administration record) revealed the resident received the prn Lorazepam on 3/15/23, 3/23/23, and 3/24/23. Further review of R11's clinical record revealed no evidence that the resident was monitored for side effects of the Lorazepam. The review also revealed no evidence of physician documentation regarding the usage of the Lorazepam on an as needed basis beyond 14 days.	F 758		

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F 758	Continued From page 59 On 3/29/23 at 12:53 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated prn psychoactive medications like Lorazepam have a 14 day limit. She stated the nurse putting the order into the electronic medical record should have entered a stop date 14 days from the initial order. She stated the facility staff should be monitoring for side effects of the medication in case the resident does not have a typical response to it. She stated the side effect monitoring should be documented in the medical record. After reviewing R11's clinical record, she stated she could not locate documentation regarding the use of the medication beyond the 14 days, and could not locate any evidence that the facility staff monitored R11 for side effects of the Lorazepam. On 3/29/23 at 1:35 p.m., ASM #1, the administrator, ASM #2, ASM #3, the regional clinical consultant, and ASM #4, the regional vice president of operations, were informed of these concerns. On 3/29/23 at 2:55, ASM #4 stated the facility did not have a policy on the administration, ordering, or monitoring of psychoactive medications. No further information was provided prior to exit. Reference: (1) "Lorazepam (brand name Ativan) is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682053.h	F 758		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 758	Continued From page 60 tml.	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880	F880 1) Resident #13 is receiving wound care in a sanitary manner as re-education has occurred. 2) Current residents that receive wound care have the potential to be affected. 3) DON/Designee will complete education on infection control during wound care with licensed nurses. 4) DON/Designee will conduct Wound care observation audits for infection control practices weekly for 2 months. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 4/26/2023	

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F 880	Continued From page 61 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide wound care in a sanitary manner for one of 21 residents in the survey sample, Resident #12 (R12). The findings include:	F 880		

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F 880	Continued From page 62 For R12, the facility staff failed to change gloves and perform hand hygiene while performing a pressure injury dressing change. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/18/2023, the resident scored a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is moderately cognitively impaired for making daily decisions. In Section M - Skin Conditions, R12 was coded as having one unhealed pressure ulcer/injury, that was coded as a stage 4 (2). The physician order dated 3/13/2023 documented, "Cleanse sacrum with wound cleanser, apply collagen with silver and apply border dry dressing daily and PRN (as needed) when soiled. Monitor for s/s (signs and symptoms) of infection. For treatment of stage 4 pressure injury." On 3/28/2023 at 11:40 a.m. RN (registered nurse) #1 was observed performing the wound dressing change for R12. RN #1 proceeded to gather the supplies and place them on the clean field on the cleaned bedside table. RN #1 took gloves out of her pants pocket and put them on. RN #1 proceeded to remove the dressing from the resident's sacral area, sprayed the wound with wound cleanser, then pat it dry. She discarded the gauze in the trash can. RN #1 then took the collagen with silver dressing out of the package and applied it to the wound using her gloved fingers. She then placed the border dry dressing over the wound. RN#1 didn't change her gloves or perform hand hygiene after removing the old	F 880		

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F 880	Continued From page 63 dressing and before applying the new dressing. An interview was conducted with RN #1 on 3/25/2023 at 11:50 a.m. When asked if she is supposed to change gloves while performing a wound care dressing, RN #1 stated, "Yes, I had four gloves in my pocket, one for taking off the dressing and one for putting on the dressing, I forgot to change them." The facility policy provided, documented in part, "Hand Hygiene: Washing with soap and water is appropriate when hands are visibly soiled or contaminated with blood or other body fluids, when exposure to potential spore-forming pathogen (such as Clostridium difficile or Bacillus anthracis) is strongly suspected or proven, and after using the restroom,. Using an alcohol based hand sanitizer is appropriate for decontaminating the hands before director patient contact, before putting on gloves, before inserting an invasive device, after contact with the patient, when moving from a contaminated body site to a clean body site during patient care, after contact with body fluids, excretion, mucous membranes, nonintact skin or wound dressing (if hands aren't visibly soiled) after removing gloves, and after contact with inanimate objects in the patient's environment." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional clinical consultant, and ASM #4, the regional vice president of operations, were made aware of the above on 3/28/2023 at 5:30 p.m. No further information was provided prior to exit.	F 880		

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F 880	Continued From page 64 (1) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. This information was obtained from the following website: https://cdn.ymaws.com/npuap.siteym.com/resource/resmgr/npuap_pressure_injury_stages.pdf (2) Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-m.com/resource/resmgr/npuap_pressure_injury_stages.pdf	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 883	F883 1) Resident #11 no longer resides in the center. 2) An audit of current residents' Influenza consent forms conducted to ensure accuracy.	

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F 883	Continued From page 65 potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883	3) Licensed nurses, Admission Coordinator and Medical Records staff received re-education by the DON/Designee on ensuring Influenza consent form is accurately completed. 4) An audit will be conducted weekly x2 months to ensure new admit consent forms for Influenza immunizations are accurately completed. Audits will be submitted to QAPI for review and recommendations. 5) Compliance Date: 4/26/2023	

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F 883	Continued From page 66 was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to evidence documentation of influenza immunization consent and/or refusal, for one of five resident immunization record reviews, Resident #11. The findings include: For Resident #11 (R11), the facility staff failed to ensure the resident's clinical record contained documentation that the resident received the influenza immunization, or did not receive the immunization due to refusal. A review of R11's clinical record was conducted and revealed an influenza and pneumonia immunization consent form dated 3/7/23 that failed to document if the resident wished to receive or did not wish to receive the influenza immunization. The form documented a section for consent and a section for refusal but neither section was checked. On 3/29/23 at 9:12 a.m., an interview was conducted with ASM (administrative staff member) #2 (the Director of Nursing/Infection Control Nurse). ASM #2 stated the nurse who admits a resident is responsible for completing the immunization consent or declination forms.	F 883		

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F 883	Continued From page 67 ASM #2 was shown R11's influenza consent form. ASM #2 stated the nurse should have made sure that either the consent or the refusal section was checked to ensure the appropriate request was being followed. On 3/29/23 at 1:45 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. The facility policy titled, "Influenza Vaccine-Resident Health Program" documented, "Have resident/responsible party sign the consent, indicating the desire to receive the vaccine, or the wish to decline...viii. Document in Medical Record."	F 883		